QualChoice® HEALTH INSURANCE

This benefit summary is part of the Policy, Form QCLHIC Individual PPO (1-2019). It is subject to all benefit terms and conditions, limitations and exclusions stated in the Policy. It is meant only to highlight your benefits. It should not be relied upon solely to determine coverage. Refer to the Policy for a list of all services, limitations, exclusions and a description of all terms and conditions of coverage. If the language in the Policy varies from this summary, the Policy prevails.

For both In-and Out-of-Network Benefits, some services require pre-authorization (pre-approval) by QualChoice. For a list of services that require pre-authorization, visit QualChoice.com. You also must coordinate your care through your designated Network Primary Care Physician. All Covered Services are subject to the Deductible and Coinsurance, unless otherwise specified in this Benefit Summary or the Policy.

Out-of-Network[9] Provider benefit payments are based on a Maximum Allowable Charge. If you use an Out-of-Network[9] Provider, you may be balance billed and have higher out-of-pocket costs. Balance billed amounts you must pay over the Maximum Allowable Charge generally do not count toward the annual Deductible or Maximum Out-of-Pocket limits. See the "Cost Sharing Requirements" and the "Member Financial Responsibility Comparison" sections in the Policy.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network[9] (You Pay)
Deductible		
▪ The Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a calendar year will not carryover to the next calendar year ▪ Copayments are not included in the Deductible ▪ All Individual Deductible amounts will count toward the satisfaction of the Family Deductible, but an Individual will not have to pay more than the Individual Deductible	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000
Out-of-Pocket Limit		
▪ Out-of-Pocket Limit is calculated on a Calendar Year basis ▪ The Out-of-Pocket Limit is the most that you could pay for covered charges ▪ Out-of-Pocket Limit includes Deductible, Coinsurance and Copayments ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the Individual or Family Out-of-Pocket Limit is satisfied, whichever applies ▪ All Individual Out-of-Pocket amounts will count toward the satisfaction of the Family Out-of-Pocket Limit, but an individual will not have to pay more than the Individual Out-of-Pocket Limit for covered charges	Individual: $4,000 Family: $8,000	Individual: $8,000 Family: $16,000

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network[9] (You Pay)
Immunizations[1] (see QualChoice Medical Coverage Policies for covered immunizations)		
Adult (age 19 and older)	No Cost to You	Not Covered
Child (up to age 19)	No Cost to You	Not Covered
Preventive Services[2]		
Annual Physical	No Cost to You	Not Covered
Pap Smear (1 per 3 years)	No Cost to You	Not Covered
Screening Mammogram (including breast exam) age 40 and older	No Cost to You	Not Covered
Prostate Screening for men age 40 and older	No Cost to You	Not Covered
Bone Density Screening tests, preventive for women age 65 and older	No Cost to You	Not Covered
Colon Cancer Screening, age 50 and older	No Cost to You	Not Covered
Family Planning		
Tubal Ligation and Associated Services	No Cost to You	Not Covered
Insertion or Implantation of Birth Control Pellets, Capsules or IUDs	No Cost to You	Not Covered
Fitting and Insertion of Diaphragms, Rings or Caps	No Cost to You	Not Covered
Injection of Long Acting Contraceptives	No Cost to You	Not Covered
Primary Care Physician Office Visit		
Evaluation	$25	50% after Deductible
Services and procedures provided in the office other than evaluation	30% after Deductible	50% after Deductible
Specialist Physician Office Visit		
Evaluation/Management	$50	50% after Deductible
Services and procedures provided in the office other than evaluation/management	30% after Deductible	50% after Deductible
Inpatient Care		
Physician Services	30% after Deductible	50% after Deductible
Room and Board	30% after Deductible	50% after Deductible
Skilled Nursing and Inpatient Rehab (60 days per member per calendar year)	30% after Deductible	Not Covered
Neurological Rehabilitation Facility Services (60 days lifetime maximum)	30% after Deductible	50% after Deductible
Outpatient Care		
Physician Services	30% after Deductible	50% after Deductible
Facility Services	30% after Deductible	50% after Deductible
Observation Services	30% after Deductible	50% after Deductible
Diagnostic Services[3]	30% after Deductible	50% after Deductible
Hospice Services	30% after Deductible	50% after Deductible
Surgical Services	30% after Deductible	50% after Deductible
Home Health Care (50 visits per member per calendar year)	30% after Deductible	50% after Deductible

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network[9] (You Pay)
Emergency Services		
Emergency Room	$100	$100
Urgent Care	$60	50% after Deductible
Transportation Services[4, 5]		
Ground and Water Ambulance ($1,000 per trip)	30% after Deductible	30% after Deductible
Air Ambulance ($5,000 per trip)	30% after Deductible	30% after Deductible
Rehabilitation Services (combined 30 visits per calendar year excluding cardiac rehab)		
Physical Therapy	$50	Not Covered
Occupational Therapy	$50	Not Covered
Speech Therapy and Audiology Testing	$50	Not Covered
Chiropractic Care	$50	Not Covered
Cardiac Rehab (36 visits per member per calendar year)	30% after Deductible	Not Covered
Habilitative Services (combined 30 visits per calendar year)[6]		
Physical Therapy	$50	Not Covered
Occupational Therapy	$50	Not Covered
Speech Therapy	$50	Not Covered
Chiropractic Care	$50	Not Covered
Maternity Services		
Initial Office Visit *All other services are subject to your inpatient and outpatient benefits*	$50	50% after Deductible
Infertility Counseling and Diagnostic Services	30% after Deductible	Not Covered
Infertility Treatment (1 cycle of in vitro fertilization treatment per lifetime)	30% after Deductible	Not Covered
Mental Health and Substance Use Disorder[3]		
Office Visit - Consultation, Evaluation and Psychotherapy	$50	50% after Deductible
Outpatient (other services and procedures provided in office or outpatient facility)	30% after Deductible	50% after Deductible
Partial Hospitalization	30% after Deductible	50% after Deductible
Inpatient Physician Services	30% after Deductible	50% after Deductible
Inpatient Facility Services	30% after Deductible	50% after Deductible
Allergy Services		
Office Visit	$50	50% after Deductible
Allergy Testing	30% after Deductible	50% after Deductible
Allergy Shots	30% after Deductible	50% after Deductible
Allergy Serum	30% after Deductible	50% after Deductible
Medical Supplies		
Provided in a Physician's Office	30% after Deductible	50% after Deductible
Home Infusion Therapy Supplies	30% after Deductible	50% after Deductible

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network[9] (You Pay)
Transplantation Services[8]		
Inpatient Physician Services	30% after Deductible	Not Covered
Inpatient Facility Services	30% after Deductible	Not Covered
Outpatient Care	30% after Deductible	Not Covered
Diabetes Management Services		
Supplies[7] and Equipment	30% after Deductible	Not Covered
Insulin Pump	30% after Deductible	Not Covered
Diabetic Education (1 training per lifetime)	30% after Deductible	50% after Deductible
Other Medical Services		
Durable Medical Equipment and Related Supplies	30% after Deductible	Not Covered
Home Phototherapy Devices	30% after Deductible	Not Covered
Genetic Counseling	30% after Deductible	50% after Deductible
Genetic Testing	30% after Deductible	Not Covered
Prosthetic and Orthotic Devices (1 per 3 years unless medically necessary)	30% after Deductible	50% after Deductible
[4]Hearing Aids ($1,400 per ear)	30%	50%
Temporomandibular Joint Disorder	30% after Deductible	50% after Deductible
Smoking Cessation (two 12-week programs per calendar year)	No Cost to You	Not Covered
Vision		
Routine Vision Exam (1 per 24 months, age 19 and older)	Not Covered	Not Covered
Routine Pediatric Vision Exam (1 per calendar year, up to age 19)	$50	50% after Deductible
Glasses (lenses and frames) (1 per calendar year, up to age 19)	30% after Deductible	50% after Deductible
Dental		
[4]Accidental Injury ($2,000 per accident)	30% after Deductible	50% after Deductible
Cleaning (2 per calendar year, up to age 19)	Not Covered	Not Covered
Exam (2 per calendar year, up to age 19)	Not Covered	Not Covered
Basic Services (up to age 19)	Not Covered	Not Covered
Major Services (up to age 19)	Not Covered	Not Covered
Orthodontic Services (up to age 19)	Not Covered	Not Covered
Prescription Drugs		
Deductible	Not Applicable	Not Applicable
Tier 1	$10	Not Covered
Tier 2	$35	Not Covered
Tier 3	$65	Not Covered
Tier 5	$200	Not Covered

[1]Immunizations for travel, school, work or recreation are not covered. Refer to QualChoice Medical Coverage Policies for complete list and access rules for Immunizations.

[2]QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice Medical Coverage Policies.

[3]Out-of-network drug testing is not covered.

[4]This benefit is limited to the Maximum Allowable Charge or the applicable limit in this Benefit Summary, whichever is less, and is subject to member Cost Sharing Amounts.

[5]Ambulance is only covered if it is deemed Medically Necessary by QualChoice, and only to the closest appropriate facility. 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

[6]Medically necessary developmental services are limited to 180 units per calendar year.

[7]Combinations of either test strips and lancets or insulin and syringes are covered under the pharmacy benefit and treated as a single prescription with a single pharmacy Copayment.

[8]All transplants and transplant-related services must be coordinated by QualChoice, performed at a facility approved by QualChoice, and will be paid at the in-network benefit level.

[9]**Out-of-Area Provider Services for non-Emergency health services require pre-authorization.**

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.

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 ທ່ານເວ ້ົາພາສາ ລາວ, ການບລ ິການຊ ວ ຍເຫ ອ ຼ ືດ ້ານພາສາ, ໂດຍບ ່ເສ ັ ຽ ຄ ່າ, ແມ ນ ມ ີ ພ ້ ອ ມ ໃຫ ້ ທ ່ ານ. 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 مات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-1117 (رقم هاتف 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: यदद आप द ि ंदी बोलते ै तो आपके ललए मुफ्त में भाषा स ायता सेवाएंि उपलब्ध ै। 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)