

This benefit summary is part of the Policy, Form QCA Individual POS (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. This plan does not require cost-sharing for services received at an Indian Health Care Provider (IHCP) or with IHCP referral to another provider.

Out-of-Network<sup>9</sup> Provider benefit payments are based on a Maximum Allowable Charge. If you use an Out-of-Network<sup>9</sup> 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<br>(You Pay)                         | Out-of-Network <sup>9</sup><br>(You Pay)         |
|--|---|--|
| <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>▪ The Deductible is calculated on a Calendar Year basis</li> <li>▪ Deductible amounts applied in the last quarter of a calendar year will not carryover to the next calendar year</li> <li>▪ Copayments are not included in the Deductible</li> <li>▪ 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</li> </ul>   | <p>Individual: \$6,500<br/>Family: \$13,000</p> | <p>Individual: \$13,000<br/>Family: \$25,000</p> |
| <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>▪ Out-of-Pocket Limit is calculated on a Calendar Year basis</li> <li>▪ The Out-of-Pocket Limit is the most that you could pay for covered charges</li> <li>▪ Out-of-Pocket Limit includes Deductible, Coinsurance and Copayments</li> <li>▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the Individual or Family Out-of-Pocket Limit is satisfied, whichever applies</li> <li>▪ 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</li> </ul> | <p>Individual: \$7,350<br/>Family: \$14,700</p> | <p>Individual: \$14,700<br/>Family: \$25,000</p> |

| <b>Medical Benefits and Covered Services</b>  | <b>In-Network<br/>(You Pay)</b> | <b>Out-of-Network<sup>9</sup><br/>(You Pay)</b> |
|---|---------------------------------|---|
| <b>Immunizations<sup>1</sup></b> (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                                     |
| <b>Preventive Services<sup>2</sup></b>  |                                 |   |
| 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                                     |
| <b>Family Planning</b>  |                                 |   |
| 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                                     |
| <b>Primary Care Physician Office Visit</b>  |                                 |   |
| Evaluation  | \$45                            | 50% after Deductible                            |
| Services and procedures provided in the office other than evaluation                                  | 50% after Deductible            | 50% after Deductible                            |
| <b>Specialist Physician Office Visit</b>  |                                 |   |
| Evaluation/Management   | \$80                            | 50% after Deductible                            |
| Services and procedures provided in the office other than evaluation/management                       | 50% after Deductible            | 50% after Deductible                            |
| <b>Inpatient Care</b>   |                                 |   |
| Physician Services  | 50% after Deductible            | 50% after Deductible                            |
| Room and Board  | \$800 per Day before Deductible | 50% after Deductible                            |
| Skilled Nursing and Inpatient Rehab (60 days per member per calendar year)                            | \$800 per Day before Deductible | Not Covered                                     |
| Neurological Rehabilitation Facility Services (60 days lifetime maximum)                              | 50% after Deductible            | 50% after Deductible                            |
| <b>Outpatient Care</b>  |                                 |   |
| Physician Services  | 50% after Deductible            | 50% after Deductible                            |
| Facility Services   | 50% after Deductible            | 50% after Deductible                            |
| Observation Services  | 50% after Deductible            | 50% after Deductible                            |
| Diagnostic Services <sup>3</sup>  | 50% after Deductible            | 50% after Deductible                            |
| Hospice Services  | 50% after Deductible            | 50% after Deductible                            |
| Surgical Services   | 50% after Deductible            | 50% after Deductible                            |
| Home Health Care (50 visits per member per calendar year)   | 50% after Deductible            | 50% after Deductible                            |

| Medical Benefits and Covered Services   | In-Network<br>(You Pay)         | Out-of-Network <sup>9</sup><br>(You Pay) |
|---|---------------------------------|--|
| <b>Emergency Services</b>   |                                 |  |
| Emergency Room  | 50% after Deductible            | 50% after Deductible                     |
| Urgent Care   | \$100                           | 50% after Deductible                     |
| <b>Transportation Services<sup>4, 5</sup></b>   |                                 |  |
| Ground and Water Ambulance (\$1,000 per trip)   | 50% after Deductible            | 50% after Deductible                     |
| Air Ambulance (\$5,000 per trip)  | 50% after Deductible            | 50% after Deductible                     |
| <b>Rehabilitation Services</b> (combined 30 visits per calendar year excluding cardiac rehab)           |                                 |  |
| Physical Therapy  | \$80                            | Not Covered                              |
| Occupational Therapy  | \$80                            | Not Covered                              |
| Speech Therapy and Audiology Testing  | \$80                            | Not Covered                              |
| Chiropractic Care   | \$80                            | Not Covered                              |
| Cardiac Rehab (36 visits per member per calendar year)  | 50% after Deductible            | Not Covered                              |
| <b>Habilitative Services</b> (combined 30 visits per calendar year) <sup>6</sup>                        |                                 |  |
| Physical Therapy  | \$80                            | Not Covered                              |
| Occupational Therapy  | \$80                            | Not Covered                              |
| Speech Therapy  | \$80                            | Not Covered                              |
| Chiropractic Care   | \$80                            | Not Covered                              |
| <b>Maternity Services</b>   |                                 |  |
| Initial Office Visit<br><i>All other services are subject to your inpatient and outpatient benefits</i> | \$80                            | 50% after Deductible                     |
| Infertility Counseling and Diagnostic Services  | 50% after Deductible            | Not Covered                              |
| Infertility Treatment (1 cycle of in vitro fertilization treatment per lifetime)                        | Not Covered                     | Not Covered                              |
| <b>Mental Health and Substance Use Disorder<sup>3</sup></b>   |                                 |  |
| Office Visit - Consultation, Evaluation and Psychotherapy   | \$80                            | 50% after Deductible                     |
| Outpatient (other services and procedures provided in office or outpatient facility)                    | 50% after Deductible            | 50% after Deductible                     |
| Partial Hospitalization   | 50% after Deductible            | 50% after Deductible                     |
| Inpatient Physician Services  | 50% after Deductible            | 50% after Deductible                     |
| Inpatient Facility Services   | \$800 per Day before Deductible | 50% after Deductible                     |
| <b>Allergy Services</b>   |                                 |  |
| Office Visit  | \$80                            | 50% after Deductible                     |
| Allergy Testing   | 50% after Deductible            | 50% after Deductible                     |
| Allergy Shots   | 50% after Deductible            | 50% after Deductible                     |
| Allergy Serum   | 50% after Deductible            | 50% after Deductible                     |
| <b>Medical Supplies</b>   |                                 |  |
| Provided in a Physician's Office  | 50% after Deductible            | 50% after Deductible                     |
| Home Infusion Therapy Supplies  | 50% after Deductible            | 50% after Deductible                     |

| Medical Benefits and Covered Services                                      | In-Network<br>(You Pay)         | Out-of-Network <sup>9</sup><br>(You Pay) |
|--|---------------------------------|--|
| <b>Transplantation Services<sup>8</sup></b>                                |                                 |  |
| Inpatient Physician Services   | 50% after Deductible            | Not Covered                              |
| Inpatient Facility Services  | \$800 per Day before Deductible | Not Covered                              |
| Outpatient Care  | 50% after Deductible            | Not Covered                              |
| <b>Diabetes Management Services</b>  |                                 |  |
| Supplies <sup>7</sup> and Equipment  | 50% after Deductible            | Not Covered                              |
| Insulin Pump   | 50% after Deductible            | Not Covered                              |
| Diabetic Education (1 training per lifetime)                               | 50% after Deductible            | 50% after Deductible                     |
| <b>Other Medical Services</b>  |                                 |  |
| Durable Medical Equipment and Related Supplies                             | 50% after Deductible            | Not Covered                              |
| Home Phototherapy Devices  | 50% after Deductible            | Not Covered                              |
| Genetic Counseling   | 50% after Deductible            | 50% after Deductible                     |
| Genetic Testing  | 50% after Deductible            | Not Covered                              |
| Prosthetic and Orthotic Devices (1 per 3 years unless medically necessary) | 50% after Deductible            | 50% after Deductible                     |
| <sup>4</sup> Hearing Aids (\$1,400 per ear)                                | 50%                             | 50%                                      |
| Temporomandibular Joint Disorder   | 50% after Deductible            | 50% after Deductible                     |
| Smoking Cessation (two 12-week programs per calendar year)                 | No Cost to You                  | Not Covered                              |
| <b>Vision</b>  |                                 |  |
| 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)          | \$80                            | 50% after Deductible                     |
| Glasses (lenses and frames) (1 per calendar year, up to age 19)            | 50% after Deductible            | 50% after Deductible                     |
| <b>Dental</b>  |                                 |  |
| <sup>4</sup> Accidental Injury (\$2,000 per accident)                      | 50% 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                              |
| <b>Prescription Drugs</b>  |                                 |  |
| Deductible   | Not Applicable                  | Not Applicable                           |
| Tier 1   | \$20                            | Not Covered                              |
| Tier 2   | \$80                            | Not Covered                              |
| Tier 3   | \$100                           | Not Covered                              |
| Tier 5   | \$350                           | Not Covered                              |

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

<sup>2</sup>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.

<sup>3</sup>Out-of-network drug testing is not covered.

<sup>4</sup>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.

<sup>5</sup>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

<sup>6</sup>Medically necessary developmental services are limited to 180 units per calendar year.

<sup>7</sup>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.

<sup>8</sup>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.

<sup>9</sup>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 Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe aṃ ejjelok wōñāñ. Kaalok 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**

ໂປດລາວ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ຊີວິດພາສາ, ໂດຍບໍ່ຄ່າ, ແມ່ນມີຮັບໃຫ້ທ່ານ. ໂທ 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 انكلمات 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)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 सेवाएँ 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)