QualChoice® HEALTH INSURANCE

Comprehensive

IQ Choice®

Healthcare Coverage Policy for Individual POS Plans

IMPORTANT NOTICES

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

Other valid and collectible insurance may reduce Benefits – read carefully.

Only permanent residents of Arkansas are eligible for coverage under this Policy. Guaranteed renewal conditioned upon residence in Arkansas – Premiums subject to change.

This Policy requires use of Primary Care Physicians and referrals for specialist care. Services will not be covered if requirements are not met.

If you purchase coverage through the Federally Funded Marketplace (FFM), you must re-enroll in the Marketplace each year to receive any subsidies for which you may be eligible.

This Policy has specific exclusions as described in Section 5.

Thank you for choosing QualChoice!

OUTLINE OF COVERAGE

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

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

PEDIATRIC DENTAL COVERAGE. This Policy does not include pediatric dental services, which are part of the essential health benefits under the Federal Patient Protection and Affordable Care Act ("PPACA"). This coverage is available in the commercial insurance market and may be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Marketplace if you wish to purchase pediatric dental coverage or a stand-alone dental services product. (See also, Section 3.9.)

RESIDENCY REQUIREMENT. Only persons who are permanent residents of the State of Arkansas are eligible to obtain or maintain coverage under this Policy, unless covered as a Dependent Child. You must notify QualChoice within thirty (30) days if you move outside the State of Arkansas. If you receive your coverage under Arkansas Works, you are required to notify the State and QualChoice within ten (10) days if you move outside of the State of Arkansas.

BENEFITS

Deductible: Your applicable Deductibles are as stated in your Benefit Summary.

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

Network Primary Care Physicians: Your plan requires designation of a Network Primary Care Physician, and you must obtain a referral from your Network Primary Care Physician when receiving care from other Network Providers in order for services to qualify as Covered Services and be payable as a Benefit.

Covered Services: Subject to payment of your Cost Sharing Amounts at the amounts reflected in the Benefit Summary, Covered Services generally include:

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

Age Limitations: Individuals who are eligible for Medicare due to age are not eligible to begin coverage under this Policy. A Dependent Child is eligible for coverage up to age 26.

Special Limitations: Some Covered Services have special limitations; see your Benefit Summary.

Benefits and services are *not* included for:

- Cosmetic surgery, unless required by the Women's Health and Cancer Rights Act of 1998.
- Dentistry, except for Dental - Accidental Injury (See Section 3.5), Dental – Anesthesia and Facility Care (See Section 3.6) and Dental - Oral Surgery (See Section 3.7).
- Health services and supplies not meeting Medical Necessity criteria or that are not associated with a Covered Service.
- 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.
- Services for intentional self-inflicted injuries, including drug overdose, unless the act causing the injury resulted from an act of domestic violence or a medical condition.
- Services and 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.
- Services and supplies that are experimental or investigational in nature, as determined by QualChoice.
- Services rendered in government hospitals (unless otherwise required by law).

Guaranteed Renewable – Conditioned on Residence in Arkansas
This Policy is guaranteed renewable as long as the Policy Holder remains a permanent resident of Arkansas. For additional information, please see Section 6 of this Policy.

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1. INTRODUCTION TO YOUR POLICY

1.1. Who Is QualChoice?

QCA Health Plan, Inc. ("QualChoice," also referred to in this Policy as "us," "we," or "our") is a 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 Comprehensive Healthcare Coverage Policy for Individual POS Plans (the "Policy") for healthcare Benefits with us.

1.2. Changes to This Policy

We may from time to time modify this Policy by attaching legal documents called Endorsements and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Endorsement or Amendment pages sixty (60) days prior to the change going into effect.

1.3. Key Information

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

We have capitalized certain words in this Policy. Those words have special meanings and are defined in Section 11, "Definitions."

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

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

Your coverage under this Policy begins at 12:01 a.m. on the Effective Date as reflected on your identification card. Coverage will end on the date this Policy is terminated for any of the reasons described in this Policy. We determine your and your Dependents' eligibility for Benefits as described in Section 6 of this Policy. This Policy and the Benefit Summary describe the covered Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. All Benefit coverage decisions are made in accordance with our Medical Coverage Policies. The attached Benefit Summary is an integral part of this Policy. In the event this Policy and the Benefit Summary conflict, this Policy will control. You should locate and familiarize yourself with the Benefit Summary. This Policy describes some special procedures with which you and your Dependents must comply.

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

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

2. HOW THIS POLICY WORKS

2.1. Designated Network Primary Care Physicians

Your plan requires designation of a Network Primary Care Physician. If you do not select one, then you may be assigned a Network Primary Care Physician. You may obtain a list of Network Primary Care Physicians at www.qualchoice.com or by calling (501) 228-7111 or toll free (800) 235-7111. Each person covered under this Policy should select a Network Primary Care Physician. You may select any Network Primary Care Physician who is accepting new patients. You should select a Network Primary Care Physician (usually a pediatrician or family practitioner) to care for your newborn child at least thirty (30) days before that child's expected date of birth. You must notify us of this selection by using the appropriate selection form, which is available at www.qualchoice.com.

You may change your selection of a Network Primary Care Physician by indicating your selection of a new Network Primary Care Physician on a Change Form and sending it to QualChoice. Change Forms received on or before the 25th of the month will become effective on the 1st day of the next month. Change Forms received after the 25th of the month will become effective on the 1st day of the second following month. You will not be permitted to make retroactive changes to your Network Primary Care Physician.

Your Network Primary Care Physician will be responsible for coordinating all healthcare services and arranging for services from other Network Providers. All Preventive and Wellness Health Services must be obtained from your designated Network Primary Care Physician to be considered Covered Services. If you seek care for Covered Services from a Network Primary Care Physician that is not your designated Network Primary Care Physician, such services will not be considered Covered Services and will not be covered. Your designated Network Primary Care Physician also must coordinate all care received from Network Specialists; if your Network Primary Care Physician does not coordinate your care from a Network Specialist, services will not be covered. A Network Specialist cannot send you to another Network Specialist without coordination from your Network Primary Care Physician.

You do not need a referral from your Network Primary Care Physician for obstetrical or gynecological treatment and may seek care directly from a network obstetrician or gynecologist. You also do not need a referral for the following types of services: (a) Emergency Services and care ordered by an emergency room doctor and received in connection with your emergency room visit. Following any emergency room visit you should follow-up with your Network Primary Care Physician to coordinate any care from a Network Specialist; (b) Family Planning and Maternity services; and (c) Ancillary services (e.g. lab or x-ray) ordered by your Network Primary Care Physician or by a Network Specialist to whom your Network Primary Care Physician has arranged for Covered Services.

You also may have the option to select Out-of-Network Benefits as further described in this Policy. You are encouraged to consult with your Network Primary Care Physician in order to receive proper coordination of care. Consult the Benefit Summary to identify Covered Services and Cost Sharing amounts for both In-Network and Out-of-Network Benefits.

2.2. 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.

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

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in the Benefit Summary. The network you belong to is identified on your QualChoice identification card.

In order to receive In-Network Benefits, you are responsible for ensuring that all corresponding or related services are provided by or received from a Network Provider. For example, if your healthcare provider (e.g., a physician, APN, etc.), refers you for laboratory, diagnostic testing, or for medical supplies or equipment, then make sure these are provided by a Network Provider so that you receive In-Network Benefits. It is your responsibility to discuss with your treating healthcare provider whether these services will be provided by a Network Provider at a Network Facility. You should validate the status of a Network Provider or Network Facility by contacting our customer service department or accessing the online directory at any time. Our online directory is located on the QualChoice website at www.qualchoice.com.

Any Dependent of a Policy Holder, including an adult Child that has not attained the age of 26, that resides outside of the State of Arkansas is subject to all of the above requirements when receiving Covered Services.

2.3. Out-of-Network Benefits

As reflected in the Benefit Summary, some Covered Services may be provided directly by an Out-of-Network Provider. The amounts allowed for Covered Services accessed under your or your Dependent's Out-of-Network Benefits will be subject to the Maximum Allowable Charge, unless otherwise stated. You or your Dependent 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 for details.

Covered Services provided by Out-of-Area Providers are limited. See Section 2.10 for additional requirements related to Out-of-Area Services.

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

1. **Policy Provision:** The Benefit Summary or this Policy specifically provides a different Co-payment, if applicable, 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:** If prior to the effective date of coverage, an Enrollee was scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Policy and that such procedure or treatment is for a condition requiring immediate care, then in order for the Enrollee to receive In-Network Benefits, the Enrollee or the Out-of-Network Provider must request In-Network Benefits in writing 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 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 coverage under this Policy, an Enrollee was in the third trimester of a pregnancy covered under the terms of this Policy 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 or the Out-of-Network Provider 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 for the Enrollee to continue to receive In-Network Benefits for care for the acute condition from the Out-of-Network Provider, the Enrollee or the Out-of-Network Provider must request In-Network Benefits in writing. If QualChoice, in its sole discretion, approves In-Network Benefits for the requested ongoing treatment, 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 end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** If an 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 Policy and the Enrollee was in the third trimester of pregnancy on the date that the provider ceased to be a Network Provider, then in order for the Enrollee to receive continuation of such obstetrical care at In-Network Benefits, the Enrollee or the Out-of-Network Provider must request In-Network 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; or

7. **Prior Authorization:** Before services are provided to an Enrollee at an In-Network Benefit level by an Out-of-Network Provider, the Enrollee's Network Provider must notify QualChoice of the absence of or the exhaustion of all network resources resulting in Enrollee's need to seek care from an Out-of-Network Provider for a Covered Service. 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 for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Requests for payment by an Enrollee or provider of an Out-of-Network Provider for services or supplies at the In-Network Benefit level must be made in writing to:

QCA Health Plan, Inc.
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 the receipt of such services or supplies.

2.4. 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 Policy, 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 you or your Dependent. 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.

If we publish a Referenced-Based Pricing list of select Covered Services that will be paid to Network Providers, you may request an exception to the Referenced-Based Price that we will pay for any listed services. To request an exception, call our customer service department to ask for the exception form or click on the link on our website containing the list of Covered Services subject to Referenced-Based Pricing, complete the form, and submit it by fax or electronically through our secure website as directed on the form. Reasons for requesting an exemption may include: you are unable to access a provider at the Referenced-Based Price within Arkansas network adequacy standards; your physician provides a clinical justification for using a higher-priced setting or facility; the service cannot be scheduled within the required timeframe; or a provider of reasonable quality charging the Reference-Based Price is not available. We will make a decision with respect to a written exception request within 5 business days.

2.5. Provider Network

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. The network in which you participate is indicated on your identification card. If you access providers outside of your network, then you will receive Out-of-Network Benefits for those services unless this Policy 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 can change, you should verify that a physician, provider, or facility is a Network Provider before care is sought.

We do not practice medicine or provide medical supplies. We are not responsible for any action or inaction of any healthcare provider. We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider

or any other provider and the decision to receive or decline to receive healthcare services is yours and your Dependents' responsibility.

If you or one of your Dependents has a medical condition that we believe needs special services, then we may direct you or your Dependent to an appropriate facility or other provider chosen by us. If you or your Dependent requires certain complex Covered Services for which QualChoice determines expertise among Network Providers is limited, then we may direct you or your Dependent to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if Covered Services for that condition are approved by us 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 you or one of your Dependents are 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 you or your Dependent to utilize a single Network Provider to provide and coordinate all future Covered Services. If you or your Dependent do not make a change to a single Network Provider within thirty-one (31) days of the date we notify you, then we will assign a single Network Provider to you or your Dependent. If you or your Dependent fail to use the assigned Network Provider and you have no Out-of-Network Benefits available, then Covered Services will be denied.

2.6. Cost Sharing Requirements

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

You and your Dependents are required to pay the Cost Sharing Amounts under the terms of this Policy. The requirement that you and your Dependents pay the applicable Cost Sharing Amounts cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required Cost Sharing Amounts, the Claim may be denied, in which case you or your Dependent will be responsible for payment of the entire Claim. The Claim(s) may be reconsidered if you or your Dependent provide satisfactory proof that you or your Dependent paid the Cost Sharing Amounts under the terms of this Policy. 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 you or your Dependent 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 for each Enrollee or family. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply, if applicable.
3. **Coinsurance:** Coinsurance is a fixed percentage of Maximum Allowable Charges for the cost of Covered Services you or your Dependent must pay. Coinsurance payments are paid by you in addition to Deductibles or Co-payments, if applicable. The Benefit Summary contains the Coinsurance

percentage applicable to specific Benefits. You and your Dependents are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided.

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 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 apply to your plan.
   A. **Plans That Are Not HDHPs:** If your plan is not an HDHP, then after the Maximum Out-of-Pocket Limit has been met during the Calendar Year, Cost Sharing will no longer be required for Covered Services for the remainder of the Calendar Year. For Enrollees under Arkansas Works, you will have a quarterly Maximum Out-of-Pocket Limit; after the Maximum Out-of-Pocket Limit is met each quarter, Cost Sharing will no longer be required for Covered Services for the remainder of that quarter. The Benefit Summary lists the Maximum Out-of-Pocket Limit. Deductible, Coinsurance, Co-payments, and Reference Cost Sharing are the only amounts that will apply towards your Maximum Out-of-Pocket Limit. Once your Maximum 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. The Maximum Out-of-Pocket Limit applies separately to In-Network and Out-of-Network Benefits.
   B. **Plans That Are HDHPs:** If your plan is an HDHP, then after 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. For Enrollees under Arkansas Works, you will have a quarterly Maximum Out-of-Pocket Limit; after the Maximum Out-of-Pocket Limit is met each quarter, Cost Sharing will no longer be required for Covered Services for the remainder of that quarter. Your Benefit Summary lists the HDHP Out-of-Pocket Limit. Deductible, Coinsurance, and Reference Cost Sharing are the only amounts that will apply towards your 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.
6. **Out-of-Network Cost Sharing:** We will provide advance written notice, when required, that additional costs may be incurred for non-emergency essential health benefits provided by an Out-of-Network Provider of ancillary services in a Network Facility, including balance billing charges, and that any additional charges may not count towards the In-Network Deductible or Maximum Out-of-Pocket Limit. When advance written notice is not provided when required, we will count the Cost Sharing Amounts paid by an Enrollee for an essential health benefit provided by an Out-of-Network Provider of ancillary services in a Network Facility towards the Enrollee's annual In-Network Deductible and Maximum Out-of-Pocket Limit.

2.7. Member Financial Responsibility Comparison

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

	In-Network	Out-of-Network
Facility Billed Charges	$50,000	$50,000
Maximum Allowable Charge	25,000	25,000
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:		
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

2.8. Medically Necessary Services

We reimburse for Covered Services only when determined to be Medically Necessary as defined in Section 11. This standard applies to all sections of this Policy.

Regardless of anything else in this Policy, and regardless of any other communications or materials you may receive in connection with this Policy, you and your Dependents 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 who rendered the service has agreed in a contract with QualChoice not to bill you or your Dependents for the service unless you agreed in writing to be responsible for payment before the service was provided.

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

We make a determination of Medical Necessity as discussed in Section 2.14 after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your or your Dependents' condition and the care provided, including the reason your or your Dependents' provider prescribed or provided the care, and any unusual circumstances, which necessitated attention. However, the fact your or your Dependents' physician prescribed the care or service does not automatically mean the care is Medically Necessary nor that it qualifies for payment under this Policy. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 5.

2.9. Exclusions and Limitations

While some services have specific limitations, certain exclusions may preclude coverage in full or in part. Consult the Benefit Summary and Section 5 for information on Benefit limitations and exclusions.

This Policy refers to Medical Coverage Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may review all our established Medical Coverage Policies on our website at www.qualchoice.com.

2.10. Out-of-the-Service Area Services

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 providers participating in our travel network 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 provider in the travel network, which is identified on the member identification card. Coverage for routine and follow-up care after

Emergency health services have been provided will be denied if such services are obtained in an emergency room setting.

The QualChoice identification card contains contact information for our travel network. Travel network providers may be identified by calling the number on the identification card. The Enrollee must present his or her identification card to the servicing provider indicating participation in the travel network in order to receive this Benefit. Provisions for Emergency health services as set forth in Section 3.12 must also be followed to receive maximum Benefits.

Except for Emergency health services or services for Dependent Enrollees residing outside the Service Area, **if an Enrollee wishes to receive Benefits for Covered Services from an Out-of-Area Provider, then the Enrollee must ensure that the Out-of-Area Provider requests pre-authorization for the services or supplies as set forth in Section 2.13 – Pre-Authorization of Services.** We will apply our Medical Coverage Policies when evaluating the Medical Necessity for the Out-of-Area Provider services, which includes considering the absence of or the exhaustion of all network resources. Failure to request pre-authorization will result in denial of coverage. Pre-authorization does not guarantee payment or assure coverage; all Claims for Benefits delivered by an Out-of-Area Provider must still meet all other terms, conditions, exclusions, and limitations of coverage.

2.11. 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 the Policy. A final determination of eligibility is made at the time the Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a 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.

2.12. Administration and Interpretation of this Policy

Subject to applicable law or regulation, we reserve the right to interpret Benefits or terminate this Policy as permitted by the terms of this Policy. 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 Policy will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.13. 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, and determinations regarding services, equipment, or supplies cannot be made with information submitted by vendors. Medical Necessity determinations will only be made upon request of a prescribing healthcare provider acting within the scope of that healthcare provider's license.

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. Pre-authorizations are all time-limited to the time period and specific services set forth in the pre-authorization. **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.**

Pre-authorizations may include a requirement for the Enrollee to receive the authorized services from a specific provider as set forth in the 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. The Medical Necessity for an Out-of-Network Referral or for Out-of-Area Provider services will include the absence of or the exhaustion of all network resources.

The responsibility for obtaining pre-authorization varies depending on whether an Enrollee uses a Network Provider or an Out-of-Network Provider. Subject to the General Conditions for Payment set forth in Section 2.11 above, Network Providers are responsible for obtaining the necessary pre-authorizations. Out-of-Network Providers, including Out-of-Area Providers, have no contractual relationship with QualChoice, and therefore are not responsible for obtaining required pre-authorization in order for an Enrollee to receive Benefits. When care is sought from Out-of-Network Providers (including situations in which Network Providers refer Enrollees to Out-of-Network Providers for care), Enrollees are responsible for ensuring all providers obtain the required pre-authorization(s) prior to services being rendered. Under these circumstances, it is your responsibility to ensure that your Out-of-Network Provider (or Out-of-Area Provider) obtains all required pre-authorizations, and the Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will not grant pre-authorization where required in order for an Enrollee to receive Benefits from an Out-of-Network Provider or Out-of-Area Provider absent the necessary clinical information.

IMPORTANT – OUT-OF-AREA PROVIDERS: Except for Dependent Enrollees living outside the Service Area, Enrollees travelling outside of the Service Area will be responsible for ensuring that their Out-of-Area Providers obtain pre-authorization to be eligible for Benefits for *any* non-Emergency health services, including admissions to Out-of-Area Facilities. We apply our Medical Coverage Policies to all requests when evaluating the Medical Necessity for the Out-of-Area Provider services, which includes considering the absence of or the exhaustion of all network resources. Failure to request pre-authorization will result in denial of coverage.

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. An Enrollee's 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 8. 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 Enrollee's physician believes the services are urgent due to the Enrollee's medical condition.

2.14. Medical Necessity Determinations

We cover Medically Necessary services as described in Section 2.8. Determinations of Medical Necessity are made using QualChoice's Medical Coverage Policies. We make decisions regarding whether a particular service, equipment, or supply is or was Medically Necessary based on information provided by your or your Dependents' provider(s). Medical Necessity determinations regarding services, equipment, or supplies cannot be made with information submitted by vendors and will only be made upon request of a prescribing healthcare provider acting within the scope of that healthcare provider's license.

When we review services after care has already been provided, we may review your medical records. A provider may request the criteria or guidelines used by QualChoice in making any decision.

2.15. Case Management

We provide a Case Management program. Case Management assists 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 may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology, and neonatology.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this Section subject to the General Conditions for Payment specified in Section 2.11, Pre-Authorization of Services described in Section 2.13, and to all other applicable conditions, limitations and exclusions of this Policy. **Consult the 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 Policy.

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 Policy 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 2.13, 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 Policy. 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. 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 you or your Dependent has been admitted and you or your Dependent return after the test or service is completed;
   C. To transport you or your Dependent from an Out-of-Network Facility to a Network Facility; or
   D. To transport you or your Dependent 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 2.13 of this Policy 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. Treatment provided at a school or day-care is not a Covered Service unless the treatment is provided by a School-Based Network Provider and otherwise qualifies as a Covered Service under this Policy and QualChoice's Medical Coverage Policies.

3.5. 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:

A. 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;
B. 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;
C. Double abutments are not covered;
D. Any health intervention related to dental cavities or tooth decay is not covered;
E. Removal of teeth is not covered; and
F. Dental implants, regardless of the material used to make an implant, are not covered.

3.6. Dental – Anesthesia and Facility Care

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

1. The procedure is performed in a Network Facility; and
2. The provider treating the patient certifies that because of the patient's age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and the patient is:
   A. A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
   B. A person has a diagnosed serious mental or physical condition; or
   C. A person with a significant behavioral problem (as certified by a Network Physician); and
3. The procedure is subject to pre-authorization under Section 2.13 and meets Medical Necessity criteria. It is not necessary for the procedure to be a Covered Benefit under this Policy so long as the procedure is Medically Necessary.

Benefits are not provided for dental care. All network requirements, terms, conditions, and such other limitations as are applied to other Covered Services will apply, including Cost-Sharing requirements. This Benefit does not apply to treatment for temporomandibular joint (TMJ) disorders.

3.7. 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 this Policy.

3.8. Dental – Other

Unless covered under Section 3.5, Section 3.6, or Section 3.7, no dental care or orthodontic services are covered.

3.9. Dental – Pediatric

This Policy does not include pediatric dental services, which are part of the essential health benefits under PPACA. This coverage is available in the commercial insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Marketplace if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

3.10. 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 4.7 for diabetes supplies covered under the prescription drug Benefit.

3.11. Durable Medical Equipment

Durable Medical Equipment (DME) is subject to Medical Necessity, QualChoice review, and the Cost-Sharing requirements of your Benefit Summary. DME may require pre-authorization as described in Section 2.13. We will not cover DME if primarily used for the convenience of the Enrollee or any other person. DME is equipment serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME delivery or set up charges are included in the Maximum Allowable Charge for the DME.

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.

DME coverage is provided for one (1) high frequency chest wall oscillator per Enrollee per lifetime for an Enrollee meeting QualChoice's Medical Coverage Policies.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.30 and 3.36 below.

Important Note: See your Benefit Summary to determine whether DME provided by an Out-of-Network Provider is a Covered Service. If DME provided by an Out-of-Network Provider is not a Covered Service, the following requirements apply: 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 your responsibility to confirm this with the physician. If DME dispensed by the physician is not from a Network DME Provider, a prescription may be obtained from the physician for the DME followed by contact with us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.12. Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set forth in Section 11.24.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 11) 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 2.3.2 above.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you or your Dependent are outside of the Service Area, but within the United States are paid as shown in your Benefit Summary and as stated in Section 2.3.2 above. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the travel network. QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the travel network in an emergency when outside the Service Area.

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 travel network 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 travel network provider, then the Enrollee may have to pay any charges that exceed the Maximum Allowable Charge in addition to the 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.

IMPORTANT - IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK OR OUT-OF-SERVICE- AREA FACILITY: If treatment of an Emergency is sought at an Out-of-Network Facility's emergency room (including Out-of-Area Facilities) and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, then *you, a family member, or the Out-of-Network Facility must notify our Care Management Department within twenty-four (24) hours of admission or the next business day if on a weekend or holiday.* **Failure to notify us within the specified time requirement may result in a denial of Benefits.**

Upon receipt of such notification we may either authorize the admission to, or further treatment at, the Out-of-Network Facility, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Facility, the admitting physician, and the Enrollee's Network Provider. If you or your Dependent stay at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, then you and your Dependent will be responsible for all charges billed by the facility and other providers providing the care. Remember: Except for Medically Necessary

services for an Emergency or as otherwise provided in Section 2.10, this Policy provides no Benefits for services or supplies provided by Out-of-Service Area Providers or Facilities unless pre-authorization for such services has been obtained.

3.13. 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. Refraction is only covered when provided as part of an examination for active illness or injury.

3.14. 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 your and your Dependent'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 making it Medically Necessary for 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 in-patient stay related to a mastectomy;
5. We do not provide Benefits while you or your Dependent are waiting for Custodial Care;
6. We do not provide Benefits while 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. As demonstrated in Section 2.7 above, this may have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility; 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. As demonstrated in Section 2.7 above, this may have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.
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 2.13. 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.

3.15. 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;
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.

3.16. Gastric Pacemakers

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

3.17. Habilitative Services

Coverage for outpatient Habilitative Services provided by chiropractors, physical, and occupational and speech therapists up to a maximum of thirty (30) visits per Enrollee per year is available for Enrollees who have either not attained a skill or function, or require services to maintain a skill or function that was never learned or acquired and is due to a disabling condition.

Habilitative Developmental Services are covered for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder, and mixed developmental disorder when performed by a fully licensed Developmental Delay Treatment Clinic or Provider up to a maximum of 180 visits per Enrollee per year.

Coverage for DME for Habilitative Services is provided in accordance with Section 3.11 of this Policy.

Habilitative Services require pre-authorization and an approved treatment plan with measurable goals designed to insure that a skill or function not previously learned or acquired can be attained and maintained. Habilitative Services are subject to Benefit limits as noted in your Benefit Summary.

No Benefits will be paid for Habilitative Services that are provided for treatment of substance use disorders.

3.18. Hearing Aids and Hearing Instruments

Coverage is provided for Hearing Aids and Hearing Instruments. Coverage for the Hearing Aid or Hearing Instrument, and for repair and fitting of such, is limited to $1,400 per ear. Hearing Aids and Hearing Instruments must be obtained from a professional licensed by the State of Arkansas to dispense a Hearing Aid or Hearing Instrument. Unless your plan is a HDHP, this benefit is not subject to Deductible or Copayments. If your plan is a HDHP, this benefit is not subject to Copayments.

Coverage also includes:

1. Hearing Aid examination and selection, monaural;
2. Hearing Aid check, monaural; and
3. Electroacoustic evaluation for Hearing Aid, monaural.

Hearing Aid or Hearing Instrument replacement is covered only when necessitated by normal growth, when it no longer meets minimum specifications, or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse are the responsibility of the Enrollee.

3.19. Home Health Services

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

We count each visit by a member of a home care team as one (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.

3.20. 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 (if applicable) 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.

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.

3.21. Hospice Care Services

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

3.22. 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 the Benefit Summary. Self-Injectable Prescription Medications and supplies will only be covered if obtained from a Network Pharmacy.

3.23. 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.

3.24. 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. **In-patient Hospital Stays:** We will pay for an in-patient 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 in-patient 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.*, your

physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

3. **Maternity Care and Obstetrical Care:** Coverage is provided for Maternity Care and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient 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 you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your 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 in-patient facility setting.
6. **Newborn Care in the Hospital:** A newborn Child of the Policy Holder or the Policy Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services for up to five (5) days or until the mother is discharged, whichever is the lesser period of time, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 6 being met.

3.25. 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.

3.26. Medical Supplies

Subject to all terms, conditions, exclusions, and limitations of this Policy, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when 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 is limited to not more than a thirty-one (31) day supply per month;
3. Coverage for Medical Supplies used in connection with Durable Medical Equipment is subject to the Cost Sharing Amounts specified in the Benefit Summary; and
4. Coverage for Medical Supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used.

3.27. Mental Health or Substance Use Disorder

QualChoice covers mental health and substance use disorders at parity with other medical and surgical disorders. We cover the following services for Medically Necessary evaluation and treatment of mental health and substance use disorders:

1. **Professional Services:** Professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license. This includes psychiatrists, psychologists, clinical social workers, licensed professional counselors, and marriage and family therapists. Covered Services include diagnostic evaluations, crisis intervention, medication evaluation and management, psychological and neuropsychological testing, counseling (including individual or group therapy visits), detoxification, intensive outpatient treatment, and electroconvulsive therapy.

2. **Diagnostics:** Inpatient or outpatient diagnostic tests provided by licensed mental health and substance abuse practitioners, laboratories, hospitals, or other covered facilities.
3. **Inpatient Facilities:** Inpatient services provided by a hospital or other covered facility, including a residential treatment center, to include room and board, general nursing care, meals and special diets, and other hospital services.
4. **Outpatient Facilities:** Services provided in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment.

Diagnosis, treatment, crisis stabilization, medical management, psychological and neuropsychological testing services may be provided by a hospital or other (non-hospital) covered eligible facility. Covered eligible facilities include licensed, accredited treatment modalities such as outpatient, intensive outpatient, or residential treatment. Eligible facilities must be licensed by the State of Arkansas or the state in which the provider operates and be accredited by The Joint Commission, CARF International, or Council on Accreditation (COA) for the specific mental health or substance use disorder treatment services they are providing. Outpatient care includes care provided by an accredited, non-hospital facility. It is expected that care will be delivered in the least restrictive setting.

Pre-authorization may be required for mental health or substance use disorder treatments, services, or supplies. For a current list of those mental health or substance use disorder treatments, services, or supplies requiring pre-authorization, access our website at www.qualchoice.com. *We do not cover Out-of-Network drug testing.*

3.28. Newborn Care in an Out-of-Network Facility

If a child *who is an Enrollee* is born in an Out-of-Network Facility, the child's coverage for Out-of-Network 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 who is an Enrollee is born in an Out-of-Network Facility because the Policy Holder's spouse has other health benefit coverage, or if such child is an adopted child born in an Out-of-Network Facility, nursery charges are covered up to the Maximum Allowable Charge and processed as an In-Network Benefit.

3.29. 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 3.10.

3.30. 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 2.13.

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 Policy, 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:

i. 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
ii. 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, if applicable, Deductibles, and Coinsurance as set out in your Benefit Summary.

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

3.31. Outpatient Services

Outpatient Covered Services are as follows:

1. **Outpatient Facility Services:** Subject to all of the terms, conditions, limitations and exclusions of this Policy, 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 Out-of-Network Facility or ambulatory surgery center is used, payment will be limited to the Maximum Allowable Charge for the service. You will be responsible for the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge.

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

3.32. Pediatric Vision Benefits

For a Child under the age of nineteen (19), Benefits include:

1. One (1) routine vision exam, including refraction, to detect vision impairment once every twelve (12) months. Refraction is only covered when provided in conjunction with a covered routine vision examination;
2. One (1) pair of glasses (standard frames and standard lenses) per year;
3. Repair of glasses if glasses were originally covered;
4. Replacement of lost or broken glasses, only one time within a year;
5. Examination and treatment for eye diseases, including surgical evaluation;
6. Contact lenses when Medically Necessary to treat specific eye diseases, not for refraction;
7. Vision therapy developmental testing once per lifetime. Pre-authorization is required;

8. Sensorimotor examinations with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report once per lifetime for any diagnosis. Additional exams may be covered if pre-authorized for members undergoing orthoptic and/or pleoptic training, as detailed in our Medical Coverage Policies;
9. Up to two (2) visits per year for orthoptic and/or pleoptic training for convergence insufficiency or amblyopia, as detailed in our Medical Coverage Policies. Pre-authorization is required; and
10. Eye prosthesis and polishing services.

3.33. Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefit Summary. Care provided by a Network Specialist must be coordinated by your Network Primary Care Physician. Covered Services performed in a medical office will be eligible for Benefits depending on the type of services performed in the office setting as determined in the sole discretion of QualChoice as follows:

1. "**Routine**" services are those that are performed or ordered in connection with an office visit for screening or management of commonly encountered conditions or diagnoses. Examples include blood drawn or medications administered for a physical exam or for monitoring and management of high blood pressure, high cholesterol, diabetes, chronic kidney disease, heart disease, or hormone imbalances. Other examples include testing and treatment for acute infections, X-rays and splinting/casting/stitches for an acute injury, drainage of an abscess, IV fluids for dehydration, breathing treatments for exacerbations of asthma or emphysema, or testing and medications given for acute exacerbations of diabetes or heart disease. Routine services performed in a medical office are covered under the Cost Sharing Amounts paid for office visit evaluation and management services.
2. "**Complex**" services are those that may be performed or ordered in connection with an office visit, but are for less commonly encountered conditions or procedures. Examples include genetic tests and administration of chemotherapy, biologic agents, or other specialized medications that are not considered first line treatments. These types of office testing or treatments may require pre-authorization. Other examples include office-based minor surgeries or procedures that involve the use of scopes, other specialized equipment, assistants, or anything more than a local anesthetic. **Complex** services performed in a medical office will require payment of Cost Sharing Amounts in addition to the Cost Sharing Amounts for evaluation and management services as specified by your Benefit Summary.
3. "**Advanced**" services may be, but are not typically performed/administered in an office setting. These services are usually performed in a surgical center, a hospital, an imaging center, or other specialized setting and may require pre-authorization. **Advanced** services performed in a medical office will require payment of Cost Sharing Amounts in addition to the Cost Sharing Amounts for evaluation and management services as specified by your Benefit Summary.

3.34. 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, www.qualchoice.com. 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.

3.35. Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Policy and related 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, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we 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.

3.36. 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 2.13.

A "Prosthetic Service" is an evaluation and treatment of a condition that requires the use of a "Prosthetic Device".

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

1. The device is: (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, if applicable, Deductibles, and Coinsurance as set out in your Benefit Summary.

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

3.37. 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 Policy, 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 (12^{th}) 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 Policy, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including 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 Deductibles and 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 cleft-craniofacial team approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, NC. This coverage requires a treatment plan coordinated by the 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 your appearance or for your 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.

3.38. Rehabilitation Services

Services for rehabilitative outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor, or 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.

3.39. Skilled Nursing Facility, Inpatient Rehabilitation, and Neurological Rehabilitation Services

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

3.40. Temporomandibular Joint Services

Coverage is provided for Medically Necessary treatment of temporomandibular joint disorder in accordance with QualChoice's Medical Coverage Policies, which are available at www.qualchoice.com. Medical treatment

includes both surgical and nonsurgical procedures, but does not include orthodontia or other dental services. Pre-authorization is required.

3.41. Tobacco Cessation Services

We cover tobacco cessation treatments for Enrollees enrolled in our Kick the Nic™ tobacco cessation program. You can learn more about the details of the Kick the Nic™ program by going to our website www.qualchoice.com, and you 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 tobacco cessation prescription drugs and over-the-counter nicotine replacement products. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain tobacco cessation drugs through your QualChoice Kick the Nic™ coach. You may access these counseling and medication treatments without any cost-sharing.

3.42. Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 5, and to all other applicable terms, conditions, limitations and exclusions of this Policy. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitations.

1. **Pre-Authorization Required:** ***You 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 2.13 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 Policy. Cornea transplantation does not require pre-authorization.

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

3.43. Testing and Evaluation

Subject to all other terms, conditions, exclusions, and limitations of this Policy, coverage is provided for the following testing and evaluation, limited to fifteen (15) hours per Enrollee per Calendar Year. This Benefit is subject to the Cost Sharing Amounts. Pre-authorization is required.

1. Psychological testing, including, but not limited to, assessment of personality, emotionality, and intellectual abilities;
2. For a Child under the age of six (6), childhood developmental testing, including, but not limited to, assessment of motor, language, social, adaptive, or cognitive function by standardized developmental instruments;
3. Neurobehavioral status examination, including, but not limited to, assessment of thinking, reasoning, and judgment; and
4. Neuropsychological testing, including, but not limited to, Halstead-Reitan, Luria, and WAIS-R.

3.44. Urgent Care Center or After Hours Clinic

Subject to all other terms, conditions, exclusions, and limitations of this Policy, coverage is provided for Covered Services provided in an urgent care center or after-hours clinic.

4. PRESCRIPTION DRUG BENEFITS

You only have prescription drug Benefits from Network Pharmacies. Subject to the Cost Sharing Amounts in your Benefit Summary, the exclusions and limitations described in this Section 4, and all other applicable conditions, limitations, and exclusions of this Policy and the Benefit Summary, Benefits are available for those outpatient prescription drugs specified in this Section 4. Under this prescription drug Benefit, you will pay one or more of the following as reflected in the Benefit Summary: a fixed Co-payment, if applicable, a Deductible, and/or Coinsurance for each Covered Prescription Drug obtained. ***Consult the Benefit Summary for your 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 4.11 or 4.12 of this Policy, (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 4.12 of this Policy. 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 4.10 below and your 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 Policy and the 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.

Participating retail Network Pharmacies can dispense up to a thirty (30) day maximum supply per fill. You can look up retail Network Pharmacies participating in **your network**, which is shown on your QualChoice identification card, on 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. 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.

4.5. 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. Most 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.

4.6. 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.

4.7. Diabetes Supplies

The following diabetes supplies are covered under your prescription drug Benefit as reflected in the 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.

4.8. 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.

4.9. 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. You 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 your 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.

4.10. Cost Sharing Amounts

1. The Enrollee will be responsible for paying the member Cost Sharing Amounts reflected in the Benefit Summary. The Cost Sharing Amounts will be different for drugs on different Tiers.

2. The amount an Enrollee pays towards any non-Covered Prescription Drugs is not included in determining the amount of any Out-of-Pocket Limits stated in this Policy and/or Benefit Summary.
3. Amounts paid by you or your Dependents for prescription drugs may or may not accumulate toward satisfying your medical Deductible responsibility. Amounts paid by you or your Dependents for prescription drugs will accumulate toward satisfying your Out-of-Pocket Limits shown in your Benefit Summary.
4. All QualChoice formularies are subject to changes during the year. These changes may affect your Cost Sharing Amounts.

4.11. 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;
   M. Drugs included on the DESI (Drug Efficacy Study Implementation) drug list; and
   N. 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 Policy, 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.

4.12. Limitations of Coverage

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

1. Covered Prescription Drugs are subject to a maximum thirty (30) day supply per fill.
2. 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.

3. We do not cover smoking cessation drugs and devices unless an Enrollee is enrolled in QualChoice's tobacco cessation program described in Section 3.41 of this Policy.
4. 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.
5. 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.

4.13. 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.

4.14. Pre-Authorization May Be Required

Prior to certain Covered Prescription Drugs being covered, you or your physician must obtain pre-authorization from us as described in the Policy. The list of Covered Prescription Drugs requiring pre-authorization is subject to review and change. A current list of those Covered Prescription Drugs requiring pre-authorization may be accessed at our website at www.qualchoice.com.

4.15. Exception Request for Non-Formulary Drugs

An exception request for coverage of a Non-Formulary (non-covered) prescription drug may be made by the Enrollee, the Enrollee's Authorized Representative, or the prescriber on behalf of the Enrollee. If the initial request is denied, the Enrollee may request a second review by an independent review organization. Both requests will be processed within seventy-two (72) hours for standard requests or within twenty-four (24) hours if the Enrollee requests an expedited review and a healthcare professional, with knowledge of the Enrollee's medical condition, certifies there are exigent circumstances that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function or is undergoing a current course of treatment with a Non-Formulary drug.

5. NON-COVERED SERVICES, EXCLUSIONS, AND LIMITATIONS

Some services, treatments, medications and supplies do not constitute Covered Services. Others have certain 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 such changes. Please also refer to the Benefit Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for certain 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 accessible online or by written request.

5.1. 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. **Admission to a Facility before Becoming Covered under This Policy:** We will not cover an inpatient admission commencing before the Effective Date of this Policy. We will not cover any portion of the facility or medical services related to the stay. This applies to admissions to an acute hospital, sub-acute hospital, skilled nursing facility, rehabilitation unit, or any other inpatient facility.
4. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted child. Maternity charges incurred by an Enrollee acting as a surrogate mother and complications resulting therefrom are not covered charges. For the purpose of this Policy, 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 for information regarding coverage of adopted children.
5. **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.
6. **Against Medical Advice:** We will not cover any services related to complications resulting from the Enrollee's discharge against medical advice.
7. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice 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. Aromatherapy;
   G. Reflexology;
   H. Mind/body control such as dance or prayer therapies;
   I. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as, but not limited to, metabolic therapy; and
   J. Massage therapy (except as provided for in QualChoice's Medical Coverage Policies).
8. **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.
9. **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.
10. **Blood Derived Growth Factors:** Blood derived growth factors are not covered.
11. **Blood Typing for Paternity Testing:** Blood typing or DNA analysis exclusively used in connection with paternity testing is not covered.
12. **Cannabis:** Medical cannabis (marijuana) or supplies are not covered.
13. **Care Plan Oversight:** Except as covered in Section 5.1.105. **Telephone and Other Electronic Communication**, multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
14. **Care Provided by a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
15. **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 non-covered 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 (except as covered under Section 3.27);
   D. Health resorts, camps, safe houses, spas, sanitariums, or tuberculosis hospitals;
   E. Infirmaries at camps;

F. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.38);
G. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.39);
H. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Sections 3.38 and 3.39);
I. Schools (except for Covered Services provided by a school-based Network Provider); or
J. Other facilities and institutions that do not meet our criteria for short-term acute care general hospitals or skilled nursing facilities.

16. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
17. **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.
18. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
19. **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.
20. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology are not covered.
21. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. Subject to all terms, conditions, limitations and exclusions of this Policy, complications resulting from a smallpox vaccination is a Covered Service.
22. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the–counter (without a prescription) are not covered.
23. **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.
24. **Cosmetic or Reconstructive Services:** Cosmetic services are intended primarily to improve your appearance or for your 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.
25. **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 policy subject to the terms and conditions of the policy, 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 Policy.
26. **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 hospital, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.

27. **Dental Care:** This Policy does not provide Benefits for dental care. Except as otherwise stated in this Policy, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess 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 you or your Dependents may receive.
28. **Dental Implants:** Dental implants, regardless of the material used to make an implant, are not covered.
29. **Dietary and Nutritional Services:** Except as provided in Section 3.25 – Medical Foods or Section 3.29 – Nutritional Counseling or Nutritional Supplements, 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.
30. **Domestic Partners:** We do not provide coverage for domestic partners.
31. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
32. **Electrogastrography**: Electrogastrography is not covered.
33. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
34. **Enteral Nutrition:** Except as set forth in Section 3.25 – Medical Foods or Section 3.29 – Nutritional Counseling or Nutritional Supplements, services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, are not covered unless such dietary supplies are the sole source of nutrition for the Enrollee and are medically prescribed by a licensed physician. When such services and supplies are covered, they are subject to pre-authorization as described in Section 2.13.
35. **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.
36. **Exercise Programs:** Unless expressly authorized in Section 3.38, 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.
37. **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. *EXCEPTION: QualChoice will not deny a qualified individual from participating in an approved clinical trial in or out of the state for treatment of cancer or another life-threatening condition, nor impose additional conditions or limitations on such participation other than those applied to other medical services. Pre-authorization*

is required. Only trials that are federally funded or approved or conducted under or an FDA investigational new drug application (or exempt from a new drug application) will be considered for approval. Additional restrictions apply. Refer to QualChoice's Medical Coverage Policies for specific details.

38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition is not covered, except as specified in our Medical Coverage Policies.
39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
40. **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 as set forth in this Policy, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy. See also Section 5.2.19. We also cover foot orthotics for treatment of post-traumatic and congenital foot deformities that cause unsteadiness of gait, subject to pre-authorization and all terms, conditions, exclusions, and limitations of this Policy.
41. **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.
42. **Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter, are not covered. However, subject to all terms, conditions, exclusions, and limitations set forth in this Policy, coverage is provided for medical foods and low protein modified food products for the treatment of Single Gene Inborn Errors of Metabolism (see Section 3.25 – Medical Foods).
43. **Fraud or Misrepresentation:** Health interventions or health services, including but not limited to medications obtained by unauthorized or fraudulent use of an Enrollee's identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered. For Enrollees with coverage under Arkansas Works, failure to notify QualChoice and the State of Arkansas within ten (10) days that you have permanently moved out of the State of Arkansas will be considered a material misrepresentation. For all other coverage, failure to notify QualChoice within thirty (30) days that you have permanently moved out of the State of Arkansas will be considered a material misrepresentation.
44. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you, your Dependent, your provider, or your Dependent's provider thought the services were not covered by insurance at the time that the provider chose not to charge for the care.
45. **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.
46. **Group Therapy**: Except as provided in Section 3.27, group therapy or group counseling at any time in any setting by any provider is not covered.
47. **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.
48. **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. Hearing Aids and Hearing Instruments, which are covered as set forth in Section 3.18, and cochlear implants and other implantable hearing devices, which are covered as specified in Section 5.2.4, are the only exceptions to this exclusion.
49. **Heat Bandage:** Treatment of a wound with a warm active wound therapy device or a non-contact radiant heat bandage is not covered.
50. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, autologous transplants, allogeneic

transplants or nonmyeloablative allogeneic stem cell transplantation are not covered, except in the circumstances set forth in Section 3.42.

51. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
52. **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. We will not pre-authorize Benefits for additional inpatient care days through a Concurrent Care Request when an avoidable, hospital acquired condition has been identified, and medical records will be required for our subsequent review of the Medical Necessity of any claim for eligible Benefits.
53. **Hyaluronate (Viscosupplement) Injections:** Hyaluronate (viscosupplement) injections are not covered.
54. **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.
55. **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.
56. **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.
57. **Infertility Treatment:** With the exception of certain services to diagnose infertility, which are limited as set forth in Section 3.15, we will not cover any diagnosis, treatments, surgeries, procedures, medications, or any other services related to infertility.
58. **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 as set forth in this Policy, where the Enrollee is on a cardiac transplant list at a hospital and where there is an ongoing cardiac transplantation program, then the Policy will cover infusion of inotropic agents.
59. **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 3.10.
60. **Intoxicants and Controlled Substances:** We shall not be liable for any loss sustained or contracted in consequence of an Enrollee being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.
61. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
62. **Learning Disabilities or Perceptual Disorders:** Services or supplies provided for learning disabilities or perceptual disorders, such as reading disorder or dyslexia, are not covered.
63. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
64. **Maintenance Therapy:** We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, speech therapy, or mental health therapy; provided, however, this exclusion does not apply to Habilitative Services.
65. **Mammoplasty:** Except as provided in Section 3.37, 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.
66. **Marriage and Relationship Counseling**: Except as provided in Sections 3.27 and 5.2.14, marriage and relationship counseling services are not covered.
67. **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.

68. **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.
69. **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.
70. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
71. **Orthoptic or Pleoptic Therapy:** Except as provided in Section 3.32, orthoptic or pleoptic therapy is not covered.
72. **Outside United States:** Except in our sole discretion, we do not cover services or supplies obtained outside of the United States.
73. **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.
74. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
75. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
76. **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.
77. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
78. **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.
79. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
80. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.
81. **Premarital Laboratory Work:** We will not cover premarital laboratory work even if such premarital laboratory work is required by any state or local law.
82. **Private Duty Nurses:** We will not cover private duty nurses.
83. **Private Room:** At QualChoice's sole discretion for an exception, we do not cover a private hospital room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, then you and your Dependent must pay the difference between the charges for a private room and our payment.
84. **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.
85. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered; provided, however, subject to all terms, conditions, exclusions, and limitations of this Policy, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.
86. **Recreational Therapist:** Services or supplies provided by a recreational therapist are not covered.
87. **Remote Intraoperative Neurophysiologic Monitoring:** Services for remote intraoperative neurophysiologic monitoring will not be covered. Services for on-site intraoperative neurophysiologic monitoring require pre-authorization and are subject to our Medical Coverage Policies.

88. **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.
89. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials, except as noted in Section 5.1.37.
90. **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.
91. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
92. **Seasonal Affective Disorder (SAD):** The use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
93. **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.
94. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, unless the act causing the injury resulted from an act of domestic violence or a verifiable medical condition.
95. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
96. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Sections 3 or 4 of this Policy as being a Covered Service.
97. **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.
98. **Smoking or Tobacco Cessation or Caffeine Addiction:** Except as set forth in Section 3.41 and Section 4.12, treatment of caffeine, smoking, or nicotine addiction, tobacco cessation prescription drugs, and over-the-counter nicotine replacement products are not covered.
99. **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).
100. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos.
101. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization.
102. **Substance Addiction:** We will not cover medications used to sustain or support an addiction or substance dependency.
103. **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.
104. **Tanning Equipment:** Tanning equipment is not covered.
105. **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 telemedicine policy and communications made by a physician responsible for the direct care of an Enrollee in case management with involved healthcare providers.
106. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.

107. **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 another party's insurer, for past or future medical or facility or other healthcare charges. If an Enrollee makes a Claim for Benefits under this Policy prior to receiving payment from a third party, or its insurer, then 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 9 and Section 10.7 for further information concerning repayment of Benefits.
108. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
109. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
110. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions, and limitations as set forth in this Policy, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
111. **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.
112. **Travel, School, Recreation, or Work Related Immunizations**: Except to the extent coverage is specifically provided in this Policy as a preventive health benefit, we will not cover immunizations to fulfill requirements for travel, school, recreation, or work.
113. **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; (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.
114. **Vision and Hearing Services:** Except as set forth in Section 3 of this Policy and in the Benefit Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.
115. **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).
116. **Vitamins:** We do not cover vitamins, food, or nutrient supplements, except those that are prescription medications on a QualChoice Formulary as described in Section 4 of this Policy and are not available over the counter or except as provided in Section 3.29 – Nutritional Counseling or Nutritional Supplements.
117. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.
118. **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.
119. **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.
120. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
121. **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 if the Enrollee is required to be covered by law under Workers' Compensation, Defense Base Act, TRICARE, or other applicable laws. 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.

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 2.11, Pre-Authorization of Services described in Section 2.13, and to all other applicable conditions, limitations, and exclusions of this Policy.

1. **Ambulance:** Transportation by ambulance 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 may 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 and other Benefits covered hereunder. Neither any provider, nor QualChoice, shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
4. **Cochlear Implants and Other Implantable Hearing Devices:** 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.
   C. Coverage for bone anchored hearing aids (BAHA) is limited to persons age five (5) years and older with a unilateral conductive or mixed hearing loss with normal hearing in the other ear. The hearing loss must be caused by one of the following:
      i. Congenital or surgically induced malformation of the external ear canal or middle ear;
      ii. Chronic external otitis or otitis media;
      iii. Tumors of the external canal and/or tympanic cavity; or
      iv. Sudden permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.
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, constitutes a Covered Service 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 2.13, 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 as specified in our Medical Coverage Policies.
7. **Eyeglasses and Contact Lenses:** We do not cover eyeglasses or contact lenses, except: (a) eyeglasses for a Child under the age of nineteen (19) as specified in Section 3.32, (b) eyeglasses or contact lenses to treat a refractive error resulting from traumatic injury or corneal disease (infectious or non-infectious), or (c) the initial acquisition of one 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 your 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. **High Frequency Chest Wall Oscillator:** DME coverage is provided for one (1) high frequency chest wall oscillator per Enrollee per lifetime for an Enrollee meeting QualChoice's Medical Coverage Policies.
10. **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 the 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 Limits:** Consult your Benefit Summary, our Medical Coverage Policies, and this Policy for various lifetime limits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, then 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 an unavailability of facilities or personnel.
14. **Mental Health or Substance Use Disorder:** Psychoanalysis, hypnotherapy, maintenance therapy, or any other counseling or treatment that is not designed, in the sole discretion of QualChoice, to treat a specific disease process is not covered. Marriage counseling is only covered when it is designed to treat a specific disease and is covered under the terms of Section 3.27 of this Policy. *We do not cover Out-of-Network drug testing.*
15. **Newborn Care:** We will cover newborn children of the Policy Holder or the Policy Holder's spouse from date of birth provided (a) *the newborn child is otherwise eligible for Benefits as described in this Policy* and (b) *the Policy Holder enrolls the newborn in writing within the required time period following the date of birth*. See Section 6 of this Policy for eligibility information. Out-of-Network newborn coverage is limited to Maximum Allowable Charge or $2,000, as applicable, for all Out-of-Network Services received during the first ninety (90) days following birth.
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 set forth 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 Policy. 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, if applicable, Deductibles, and Coinsurance as set out in your Benefit Summary.
18. **Refusal to Accept Treatment:** You or your Dependent 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 you later recant the refusal and agree 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 Policy in accordance with the following conditions:
    A. We do not cover all transplants. This Policy must provide Benefits for the requested transplant type, and the Enrollee must meet all required criteria necessary for coverage set forth in this Policy.
    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. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation and/or lodging costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department.
    C. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the limitations in this Policy and the Deductible, Coinsurance and Co-payments as reflected in your Benefit Summary.
    D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (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.
    E. **Transplants that are not pre-authorized by QualChoice's Care Management Department are not covered.**

6. ELIGIBILITY CRITERIA

6.1. Policies Purchased Through the Marketplace

The provisions of this Section 6.1 apply to Policies that are purchased through the Marketplace. This Section sets forth QualChoice's eligibility and termination rules, but all final determinations are made by the Marketplace.

1. **Age Limitations**

Individuals who are eligible for Medicare due to age are not eligible to begin coverage under this Policy. Dependent children are eligible for coverage up to age 26.

2. **Who is Eligible for Coverage and When Does Coverage Begin**

Coverage selected during open enrollment and special enrollment periods will begin on the Effective Date as defined in Section 11.23. The initial Premium payment must be received by QualChoice prior to the Effective Date of this Policy. ***Only*** a person who is a permanent resident, as defined by the Internal Revenue Service, of the State of Arkansas is eligible to be a Policy Holder or spouse under this Policy and to maintain coverage under this Policy. QualChoice reserves the right to request documentation necessary to demonstrate that a Policy Holder's and spouse's permanent residency is within the State of Arkansas. The following members of your family may be eligible as Dependents if such Dependents are approved for coverage by the Marketplace:

    A. Your opposite sex spouse (as recognized by the State of Arkansas) or your same sex spouse is eligible for coverage under this Policy if you and your spouse are legally married in a jurisdiction that recognizes marriage between people of the same sex. Domestic partners are not eligible for coverage as a Dependent under this Policy.
    B. Your Child until s/he becomes twenty-six (26) years of age. Child Dependents are not required to be residents of the State of Arkansas to be eligible for coverage under this Policy.
    C. 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 and state 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 Policy or 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.

D. Subject to payment of all applicable Premiums, coverage for your newborn, a Child whom you have adopted, or a Child for whom you have filed a petition for adoption shall begin on the date established by the Marketplace. If your covered Dependent gives birth, the newborn grandchild is not eligible for coverage. See Section 11.14 for the definition of a Child who is eligible for coverage under this Policy.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your and your Dependent's eligibility requirements. Be advised that there is no coverage or eligibility for Benefits if that person had previous coverage with us and was terminated for causes described in subsection 3 below.

3. **Termination of Coverage**

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

A. **Default in Payment of Premiums:** The initial Premium payment is due prior to the Effective Date. Subsequent Premiums are due on or before the first day of each month of coverage under this Policy. Failure to make Premium payments to us will result in termination of all Enrollees under this Policy.

B. **Grace Periods:**

i. Policy Holders who receive coverage pursuant to Arkansas Works and/or receive advanced premium tax credit, and have paid at least one full month's Premium within the Calendar Year are entitled to a three (3) month grace period for non-payment of Premium, as follows:

a. For the first calendar month of non-payment, QualChoice will continue to pay Claims under this Policy.

b. For the second and third calendar months of non-payment, this Policy will continue in force, but QualChoice will suspend all coverage under this Policy;

c. If payment in full has not been made by the end of the third calendar month, this Policy shall terminate as of the last day of the first month of the grace period.

If we terminate this Policy due to a default in the payment of Premiums, then, unless you qualify for a special enrollment period, you are not eligible to reapply until the next open enrollment period.

ii. For Policy Holders who do NOT receive coverage pursuant to Arkansas Works and/or receive advanced premium tax credit, a grace period of thirty-one (31) days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the policy shall continue in force. If Premiums are not paid within thirty-one (31) days after they become due and payable, then this Policy shall terminate retroactive to the last day of the month for which Premium payment was received. Further:

a. Any payments made by us for charges incurred by you or your Dependent, following the retroactive termination date, must be returned to us within sixty (60) days;

b. In accordance with applicable law, we may reduce future payments to you or your Dependent in order to recover any such payments. We may recover such payments made to providers directly from them; and

c. If we terminate this Policy due to a default in the payment of Premiums, then, unless you qualify for a special enrollment period, you are not eligible to reapply until the next open enrollment period.

Failure to make Premium payments to us within the applicable grace period(s) will result in termination of all Enrollees under this Policy.

In the event of termination, Premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded within thirty (30) days or in the next scheduled billing cycle.

Subject to the grace periods provided above, QualChoice reserves the right to recoup any Claim paid and for which Premium was not received under the Policy.

C. **On Death:** Coverage for the Policy Holder and the Policy Holder's covered Dependents under this Policy will automatically terminate on the date of the Policy Holder's death. All Premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death. Coverage for the Policy Holder's covered Dependents under this Policy will automatically terminate on the date of that Dependent's death.

D. **Termination of Your Marriage:** If the Policy Holder becomes divorced, legally separated, or the marriage is annulled, the coverage of the Policy Holder's spouse will automatically terminate on the date of the divorce, legal separation, or annulment due to that former spouse no longer meeting the eligibility requirements set out in this Policy.

E. **Termination**

i. **Termination of Coverage of A Dependent Child:** The coverage of a Dependent Child under this Policy 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 children incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support.

ii. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:

a. We may terminate this Policy at the end of a Calendar Year if permitted by applicable federal and Arkansas state law;

b. If coverage is provided under Arkansas Works, as amended, we may terminate this Policy effective as of the date the State of Arkansas notifies us to terminate coverage;

c. If an unauthorized person is allowed to use the Enrollee's identification card or if it is determined that an Enrollee otherwise cooperated in the unauthorized use of such Enrollee's identification card or Benefits constituting fraud (note that such determination may include a police report indicating that a Policy Holder or Enrollee's wallet was stolen, etc.) may result in termination under this Policy; thirty (30) days written notice will be issued to the Policy Holder and/or Enrollee that is terminated under this Policy;

d. Each Policy Holder and Enrollee represents all statements made in his or her Enrollment Application for coverage, and any Enrollment Applications of Dependents, are true to the best of his or her knowledge and belief. If a Policy Holder or Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement in connection with acceptance of his or her enrollment under this Policy, then we may rescind his or her coverage under this Policy and the coverage of his or her Dependents back to the original Effective Date of this Policy pursuant to Section 10.16;

e. If a Policy Holder or spouse permanently moves outside the State of Arkansas, then that Policy Holder and/or spouse are no longer eligible for coverage under this Policy. This Policy will terminate as of the end of the month that the Policy Holder is no longer a resident of the State of Arkansas. Coverage will terminate for a spouse as of the end of the month that the spouse is no longer a resident of the State of Arkansas. Failure to notify QualChoice within thirty (30) days following a permanent move to another state

(within ten (10) days for a Policy Holder whose coverage is provided under Arkansas Works) will be deemed to be an intentional misrepresentation of a material fact. In addition:

1. All Premiums paid for coverage beyond the date of termination will be refunded.
2. QualChoice reserves the right to request documentation necessary to demonstrate that a Policy Holder and/or spouse's residency is inside or outside the State of Arkansas. A Policy Holder or spouse must be able to demonstrate residency in the State of Arkansas as of the date(s) Covered Services were received. The production of two (2) of the following items in such individual's name will satisfy the requirement to demonstrate residency: (a) deed, mortgage, monthly mortgage statement, or residential rental/lease agreement; (b) U.S. or Arkansas income tax return form from the previous year along with evidence of acceptance of the return by the appropriate tax agency; (c) utility bill, not more than two (2) months old, issued to Policy Holder or spouse (examples include gas, electric, sewer, water, cable or phone bill - cellular phone and pager bills are not accepted); (d) U.S. Postal Service change of address confirmation form or postmarked U.S. mail with forwarding address label; (e) Arkansas Voter Registration Card mailed by the local registrar; (f) Arkansas driver's license, commercial driver's license, learner's permit, or DMV-issued ID card displaying the current Arkansas address; (g) monthly bank statement not more than two (2) months old issued by a bank; (h) payroll check stub issued by an employer within the last two (2) months; (i) U.S. Internal Revenue Service tax reporting W-2 form or 1099 form not more than eighteen (18) months old; (j) receipt for personal property taxes or real estate taxes paid within the last year to the State of Arkansas or an Arkansas locality; (k) current homeowners insurance policy or bill; (l) current automobile or life insurance bill (cards or policies are not accepted.); (m) cancelled check not more than two (2) months old with both name and address imprinted; (n) annual Social Security Statement for the current or preceding calendar year; or (o) certified copy of school records/transcript issued by a school accredited by a U.S. state, jurisdiction or territory (a report card is not accepted) in which the Policy Holder or spouse is currently enrolled.

Except as otherwise specifically set forth herein, an Enrollee's coverage under this Policy terminates at the end of the month of the date that an Enrollee is no longer eligible to be an Enrollee under this Policy.

In the event of QualChoice's termination of the Policy, as described herein, all Premium payments received on account of the terminated Policy Holder or Enrollee (applicable only to those periods after the effective date of termination) shall be refunded within thirty (30) days or in the next scheduled billing cycle.

iii. **Policy Holder or Enrollee Opts to Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice and the Marketplace.

iv. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.

Guaranteed Renewability. This Policy is guaranteed renewable as long as the Policy Holder remains a permanent resident of Arkansas. We may change the Premium rate due to a change in age, use of tobacco products, move to a different Marketplace service area as established by the Arkansas Insurance Department, and/or rate increase as approved by the Arkansas Insurance Department.

6.2. Policies Not Purchased Through the Marketplace

The provisions of this Section 6.2 apply to Policies that are not purchased through the Marketplace.

1. **Age Limitations**

Individuals who are eligible for Medicare due to age are not eligible to begin coverage under this Policy. Dependent children are eligible for coverage up to age 26.

2. **Who is Eligible for Coverage and When Does Coverage Begin**

Coverage selected during open enrollment periods will begin on the Effective Date as defined in Section 11.23. The initial Premium payment must be received by QualChoice prior to the Effective Date of this Policy. You must list yourself and any of your eligible Dependents you are electing to cover on the Enrollment Application to be eligible for coverage. ***Only*** a person who is a permanent resident, as defined by the Internal Revenue Service, of the State of Arkansas is eligible to be a Policy Holder or spouse under this Policy and to maintain coverage under this Policy. QualChoice reserves the right to request documentation necessary to demonstrate that a Policy Holder's and spouse's permanent residency is within the State of Arkansas.

The following members of your family may be eligible as Dependents:

A. Your opposite sex spouse (as recognized by the State of Arkansas) or your same sex spouse is eligible for coverage under this Policy if you and your spouse are legally married in a jurisdiction that recognizes marriage between people of the same sex. Domestic partners are not eligible for coverage as a Dependent under this Policy.

B. Your Child until s/he becomes twenty-six (26) years of age. Child Dependents are not required to be residents of the State of Arkansas to be eligible for coverage under this Policy.

C. 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 and state 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 Policy or group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as, an incapacitated Child. 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.

D. 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 a written or online 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 written or online Enrollment Application 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. If this Policy is a family policy (that is, it is not an individual only policy), then coverage for a newborn Child will be effective on the date of the Child's birth as long as you submit to us an Enrollment Application within ninety (90) days of the Child's birth and the necessary Premium is paid. If this Policy is an individual only policy or if this Policy is a family policy, however you fail to submit to us an Enrollment Application within ninety (90) days of the Child's birth, coverage for a newborn Child will be subject to our approval. If your covered Dependent gives birth, the newborn grandchild is not eligible for coverage. See Section 11.14 for the definition of a Child who is eligible for coverage under this Policy.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your and your Dependent's eligibility requirements. Be advised that there is no coverage or eligibility for Benefits if that person had previous coverage with us and was terminated for causes described in subsection 4 below.

3. **Enrollment Policies Due to Change in Circumstances**

This subsection explains coverage for individuals who join your family after the Effective Date of this Policy because of:

A. Marriage, or
B. Birth, or
C. Adoption, including adoption of step-children; or
D. Legal custody of a Child.

i. Marriage – To receive coverage for your new spouse, you must complete and send us an Enrollment Application within sixty (60) days of your marriage.
ii. Newborn Child – To receive coverage for your newborn Child, you must complete and send us an Enrollment Application within ninety (90) days of the child's date of birth. If you provide this written notification and you pay the appropriate Premium to cover the child, coverage for your child will become effective as of the child's date of birth.
iii. Adopted Child – To receive coverage for your adopted Child, you must complete and send us an Enrollment Application within sixty (60) days after the filing of the petition for adoption. If you provide this written notification and you pay the appropriate Premium to cover the child, coverage for your child will become effective as of the date the petition for adoption is filed.
iv. Legal Custody of a Child - To receive coverage for a Child for whom you are granted legal custody as established by a court order from a court of competent jurisdiction, you must complete and send us an Enrollment Application within sixty (60) days after the date legal custody is granted. If you provide this notification and you pay the appropriate Premium to cover the Child, then coverage for the Child will become effective as of the date legal custody was granted.

For any other qualifying event as allowed by law permitting addition of a Dependent to this Policy, you must complete and send us an Enrollment Application within sixty (60) days of the event.

If coverage is approved by us, then the Premium for the Policy will be adjusted, and the first Premium payment is due on the effective date of the change in coverage. Except as otherwise set forth above, QualChoice has sole discretion in determining the effective date of the change in coverage. Until the effective date of the change in coverage, you and your Dependent(s) (if any) currently covered by your Policy will continue to be covered under your Policy.

4. **Termination of Coverage**

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

A. **Default in Payment of Premiums:** The initial Premium payment is due prior to the Effective Date. Subsequent Premiums are due on or before the first day of each month of coverage under this Policy. Failure to make Premium payments to us will result in termination of all Enrollees under this Policy.
B. **Grace Period:** A grace period of thirty-one (31) days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the policy shall continue in force. If Premiums are not paid within thirty-one (31) days after they become due and payable, then this Policy shall terminate retroactive to the last day of the month for which Premium payment was received. Further:
i. Any payments made by us for charges incurred by you or your Dependent, following the retroactive termination date, must be returned to us within sixty (60) days;
ii. In accordance with applicable law, we may reduce future payments to you or your Dependent in order to recover any such payments. We may recover such payments made to providers directly from them; and
iii. If we terminate this Policy due to a default in the payment of Premiums, then, unless you qualify for a special enrollment period, you are not eligible to reapply until the next open enrollment period.

Failure to make Premium payments to us within the applicable grace period will result in termination of all Enrollees under this Policy.

In the event of termination, Premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded within thirty (30) days or in the next scheduled billing cycle.

Subject to the grace period provided above, QualChoice reserves the right to recoup any Claim paid and for which Premium was not received under the Policy.

C. **On Death:** Coverage for the Policy Holder and the Policy Holder's covered Dependents under this Policy will automatically terminate on the date of the Policy Holder's death. All Premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death. Coverage for the Policy Holder's covered Dependents under this Policy will automatically terminate on the date of that Dependent's death.

D. **Termination of Your Marriage:** If the Policy Holder becomes divorced, legally separated, or the marriage is annulled, the coverage of the Policy Holder's spouse will automatically terminate on the date of the divorce, legal separation, or annulment due to that former spouse no longer meeting the eligibility requirements set out in this Policy.

E. **Termination**

i. **Termination of Coverage of A Dependent Child:** The coverage of a Dependent Child under this Policy 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 children incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support.

ii. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:

a. We may terminate this Policy at the end of a Calendar Year if permitted by applicable federal and Arkansas state law;

b. If an unauthorized person is allowed to use the Enrollee's identification card or if it is determined that an Enrollee otherwise cooperated in the unauthorized use of such Enrollee's identification card or Benefits constituting fraud (note that such determination may include a police report indicating that a Policy Holder or Enrollee's wallet was stolen, etc.) may result in termination under this Policy; thirty (30) days written notice will be issued to the Policy Holder and/or Enrollee that is terminated under this Policy;

c. Each Policy Holder and Enrollee represents all statements made in his or her Enrollment Application for coverage, and any Enrollment Applications of Dependents, are true to the best of his or her knowledge and belief. If a Policy Holder or Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement in connection with acceptance of his or her enrollment under this Policy, then we may rescind his or her coverage under this Policy and the coverage of his or her Dependents back to the original Effective Date of this Policy pursuant to Section 10.16;

d. If a Policy Holder or spouse permanently move outside the State of Arkansas, then that Policy Holder and/or spouse are no longer eligible for coverage under this Policy. This Policy will terminate as of the end of the month that the Policy Holder is no longer a resident of the State of Arkansas. Coverage will terminate for a spouse as of the end of the month that the spouse is no longer a resident of the State of Arkansas. Failure to notify QualChoice within thirty (30) days following a permanent move to another state will be deemed to be an intentional misrepresentation of a material fact. In addition:

1. All Premiums paid for coverage beyond the date of termination will be refunded.
2. QualChoice reserves the right to request documentation necessary to demonstrate that a Policy Holder and/or spouse's residency is inside or outside the State of Arkansas. A Policy Holder or spouse must be able to demonstrate residency in the

State of Arkansas as of the date(s) Covered Services were received. The production of two (2) of the following items in such individual's name will satisfy the requirement to demonstrate residency: (a) deed, mortgage, monthly mortgage statement, or residential rental/lease agreement; (b) U.S. or Arkansas income tax return form from the previous year along with evidence of acceptance of the return by the appropriate tax agency; (c) utility bill, not more than two (2) months old, issued to Policy Holder or spouse (examples include gas, electric, sewer, water, cable or phone bill - cellular phone and pager bills are not accepted); (d) U.S. Postal Service change of address confirmation form or postmarked U.S. mail with forwarding address label; (e) Arkansas Voter Registration Card mailed by the local registrar; (f) Arkansas driver's license, commercial driver's license, learner's permit, or DMV-issued ID card displaying the current Arkansas address; (g) monthly bank statement not more than two (2) months old issued by a bank; (h) payroll check stub issued by an employer within the last two (2) months; (i) U.S. Internal Revenue Service tax reporting W-2 form or 1099 form not more than eighteen (18) months old; (j) receipt for personal property taxes or real estate taxes paid within the last year to the State of Arkansas or an Arkansas locality; (k) current homeowners insurance policy or bill; (l) current automobile or life insurance bill (cards or policies are not accepted.); (m) cancelled check not more than two (2) months old with both name and address imprinted; (n) annual Social Security Statement for the current or preceding calendar year; or (o) certified copy of school records/transcript issued by a school accredited by a U.S. state, jurisdiction or territory (a report card is not accepted) in which the Policy Holder or spouse is currently enrolled.

Except as otherwise specifically set forth herein, an Enrollee's coverage under this Policy terminates at the end of the month of the date that an Enrollee is no longer eligible to be an Enrollee under this Policy.

In the event of QualChoice's termination of the Policy, as described herein, all Premium payments received on account of the terminated Policy Holder or Enrollee (applicable only to those periods after the effective date of termination) shall be refunded within thirty (30) days or in the next scheduled billing cycle.

iii. **Policy Holder or Enrollee Opts to Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice in writing in advance of the requested termination date that will be effective no sooner than the end of the calendar month that QualChoice received the notice of termination. Premiums will only be refunded for any period already paid beyond the end of the month in which the notice of termination was received.

iv. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.

Guaranteed Renewability. This Policy is guaranteed renewable as long as the Policy Holder remains a permanent resident of Arkansas. We may change the Premium rate due to a change in age, use of tobacco products, move to a different Marketplace service area as established by the Arkansas Insurance Department, and/or rate increase as approved by the Arkansas Insurance Department.

7. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail 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 policy will pay a claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 7.3 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 does not have a COB provision, then that policy is primary.
2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.
3. Unless there is a Court decree stating otherwise, when a Dependent Child is covered by more than one health policy the order of benefits is determined as follows:
   A. For a child whose parents are married or are living together, whether or not they have ever been married:
      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 Policy, 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 determines 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 7.2.3.A.i or 7.2.3.A.ii, above, determine the order of benefits as if those individuals were the parents of the child.
4. The health policy that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in 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 covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result,

the health policy or policies do not agree on the order of benefits, 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 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 Policy will not pay more than it would have paid had it been primary.

7.3. 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 or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover 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 or policies 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 you are covered under multiple plans or policies 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.

7.4. Reduction of Benefits

When this Policy 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 of the primary policy.

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 of the primary policy 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.

7.5. Enforcement of Provisions

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Policy 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 this Policy 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. You or your Dependent must provide QualChoice any facts or information that

we need to apply those rules and determine Benefits payable. If you fail to provide this information, then we may delay Benefit payments.

7.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Policy. If it does, then QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a Benefit paid by QualChoice under this Policy. 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.

7.7. Medicare Primary Payer

If you are a Medicare beneficiary, your Medicare benefits will be considered primary to this Policy. When Medicare pays as the primary coverage, Medicare must approve and allow all services. If you have Medicare Part A, we will consider the services that are covered by Medicare for reimbursement under this Policy as follows:

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

Benefits for Covered Services incurred by a Medicare eligible individual for services and supplies provided by a Medicare opt-out practitioner will be determined as if the services and supplies had been provided by a Medicare participating practitioner. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a Medicare participating practitioner.

You must first file all charges with Medicare. You will receive the Explanation of Medicare Benefits (EOMB) giving payment or denial information. Send a copy of the EOMB to us with our Claim for Benefits form.

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 Policy and immediately prior to such Effective Date was covered by a 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. COMPLAINTS AND APPEALS

We have authority to make determinations in connection with the administration of the Benefits in this Policy. Any problem or Claims dispute, such as a determination of eligibility or Medical Necessity, classification of treatment as Experimental or Investigational, or resolution of an Expedited Appeal, between an Enrollee and us must go through our complaint and appeals process.

8.1. Initial Communication and Resolution of a Problem or Dispute

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

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "Appeal" as described in Section 8.3 below. An "Appeal" must be initiated and conducted as described in Section 8.3 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

8.2. 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 8.6.

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 Policy. We will provide notice of our determination of your Pre-Service Request within thirty (30) days following our receipt of your 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 your Post-Service Claim within sixty (60) days following our receipt of your 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 your Urgent Care Request within seventy-two (72) hours following our receipt of your request; provided, however, if you do not provide sufficient information to determine Benefits for an Urgent Care Request, 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 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."

8.3. Appeals

1. **Appeal of an Administrative or Medical Issue:** An Enrollee (or the Enrollee's Authorized Representative) 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. 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, under this Section 8. 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

   The Enrollee must submit a written Appeal request to Appeal an Administrative Issue. The Enrollee may submit a written or verbal Appeal request to Appeal a Medical Issue. 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.

   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.
2. **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 be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation. Appeals of Urgent Care Requests shall be reviewed no later than 72 hours after we receive your request to review a denied claim.

8.4. 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.

8.5. 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.

8.6. 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;
   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; or
   F. If the Enrollee is deceased, then the executor, administrator, or other person with authority to act on behalf of the Enrollee or the Enrollee's estate may act as the Authorized Representative or may designate an Authorized Representative.
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. If the Enrollee has an Authorized Representative, then references to the terms "The Enrollee" or "Enrollee" in this document shall include the Authorized Representative.
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. 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.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent, legal guardian, attorney in fact under a durable power of attorney, or due to death of the Enrollee, then we shall send all correspondence, notices, and benefit determinations to the Authorized Representative.

   In other situations, 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.

8.7. External Medical Review

After you have exhausted your internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your Appeal, a voluntary external review process may be available to you. If QualChoice fails to adhere to the internal Appeal process timelines, you will be deemed to have exhausted the internal Appeal process and 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. Costs for the external review process will be paid by QualChoice.

The external review process is only available if the Adverse Benefit Determination you 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 Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made, in writing, within four (4) months of your or your Dependent's 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, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization. You or your Dependent will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, your Dependents, and QualChoice, except to the extent you, your Dependents, or QualChoice have other remedies available under applicable law.

8.8. Explanation of Benefit Determination

All notices of Adverse Benefit Determinations will include:

1. Information sufficient to identify the claim involved, including date of service, health care 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.

9. SUBROGATION

If you or your Dependent have 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 you, and, if your Dependent is over the age of eighteen (18), by your Dependent. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 9 extend to workers' compensation and uninsured/underinsured motorist coverage.

You and your Dependents agree to protect our lien rights if an injury or illness is suffered and caused by a third party. You or your Dependent may be due money from a third party for the cost of Covered Services. If so, our liability for Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your or

your Dependent's name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, then you and your Dependent are obligated to reimburse us. Reimbursement to us may be reduced by our pro rata share of reasonable attorney's fees and costs incurred in obtaining such recovery.

You and your Dependent agree to cooperate fully to facilitate enforcement of our rights under this Section 9. This may include executing, delivering and filing further documents and instruments. You and your Dependent also agree to furnish such information and assistance, as we may reasonably require to fully enforce the terms of this Section 9. You and your Dependent agree to take no action that may prejudice our rights and interests under this Section 9.

10. GENERAL PROVISIONS

10.1. Amendment

Subject to applicable law or regulation, QualChoice reserves the right to modify the Benefits, terms, conditions, exclusions, and limitations covered under the Policy upon renewal. Except for riders or endorsements by which QualChoice effectuates a request made in writing by the Policy Holder or exercises a specifically reserved right under this Policy, all riders or endorsements added to this Policy after the date of issue or at reinstatement or renewal which reduce or eliminate Benefits or coverage in the Policy will require signed acceptance by the Policy Holder. After date of Policy issue, any rider or endorsement which increases Benefits or coverage with a concomitant increase in Premium during the Policy term must be agreed to in writing signed by the Policy Holder, except if the increased Benefits or coverage is required by law.

10.2. Assignment

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

10.3. Notice

General notices that we issue to a Policy Holder will be in writing, and will be mailed to the Policy Holder at the home address as it appears in our records. Subject to all other terms, conditions and provisions under this Policy, general notices to QualChoice that are not otherwise addressed in this Policy 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 Policy are subject to specific notice requirements addressed elsewhere within this Policy. Please review all notice and request time limitations carefully. **Failure to meet specific notice requirements may result in loss of Benefits under this Policy.**

10.4. 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 8 of this Policy, hereby agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Policy, an Enrollee authorizes and directs any person or entity to furnish us with information and copies of records related to healthcare services provided by them to that Enrollee. If an Enrollee 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.

10.5. Notice of Claim

Enrollees should file a Claim for Benefits within twenty (20) days from the first date upon which the Enrollee received the treatment, service or supply, or as soon as reasonably possible thereafter. Notice of Claim constitutes a condition precedent to receipt of Benefits under this Policy, which means it is an absolute requirement prior to receipt of any payment under the Policy.

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

10.6. Who Receives Payment Under This Policy

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

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

10.7. Recovery of Overpayments

On occasion, an incorrect payment may be made to an Enrollee or to a Provider on behalf of 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 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 the Enrollee may be entitled to such payment. In accordance with applicable law, we may reduce future payments to the Enrollee in order to recover any mistaken payment. At our option, we may recover overpayments and mistaken payments made to providers from you or directly from the providers.

10.8. 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 your or your Dependent'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.

10.8.1. 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 your 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 your benefit plan; and
viii. Other general administrative activities, including data and information systems management and customer service.

10.8.2. 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, 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 you believe violated the requirements of the HIPAA or related rules; and
C. Be filed within 180 days of when you knew that the act or omission complained of occurred.

10.9. 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 8 of the Policy.

10.10. Right to Develop Guidelines

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

10.11. Limitation on Benefit of This Policy

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

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

10.13. Applicable Law
Unless otherwise stated herein, this Policy, 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.

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

10.15. 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.

10.16. Rescission
Subject to the time limits set out in Section 10.19, we may rescind coverage under this Policy if a Policy Holder or Enrollee performs an act, practice, or omission that constitutes fraud, or the Policy 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 you, your Dependents, or on your or your Dependent's behalf during the period of time that you or your Dependent should not have been covered under this Policy. In these circumstances, we may also obtain reimbursement from providers that we paid for Covered Services rendered to you or your Dependent when coverage should not have been provided. In that instance, the provider may seek to obtain reimbursement from you or your Dependent for the amount obtained by us from that provider.

In the event we rescind coverage, Premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded within thirty (30) days or in the next scheduled billing cycle.

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

10.18. Legal Actions
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written notice has been furnished in accordance with the requirements of this Policy, including, but not limited to, Section 8 of the Policy. 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.

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

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

10.21. Entire Policy; Changes

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

10.22. 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; coupons or discounts on goods or services; 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. The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon an Enrollee's health status.

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

11. DEFINITIONS

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

11.1. **"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.

11.2. **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury) 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.

11.3. **"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.

11.4. **"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.

11.5. **"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.

11.6. **"Arkansas Health Insurance Exchange" or "Marketplace"** means an online marketplace where Arkansas individuals, families, and small businesses can compare health plans and select a plan that

fits their needs and budget. All plans offered through Arkansas Health Insurance Exchange will be qualified health plans (QHPs), meeting federal guidelines, including those defined under PPACA. The Arkansas Health Insurance Exchange will also provide information on the individual premium tax credits and public assistance programs.

11.7. **"Arkansas Works"** means the Arkansas Works Act of 2016, as amended, which is a state program to provide Medicaid coverage to eligible adults through private individual health insurance policies.

11.8. **"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.

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

11.10. **"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.

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

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

11.13. **"Calendar Year"** means the period of one year beginning 12:01 AM January 1 and ending on December 31.

11.14. **"Child"** means your natural child, legally adopted child, child for whom you are the legal guardian, or stepchild. "Child" also includes a child for whom you are the adoptive parent during the waiting period prior to completing the adoption. Foster children are not included in the definition of "Child." (See also, Eligibility Requirements.)

11.15. **"Claim for Benefits" or "Claim"** means: (a) a request for payment or prior approval (when required under the Policy) for a service, supply, medication, equipment or treatment covered by the Policy; and (b) that is submitted to us by an Enrollee, a healthcare provider, or an Enrollee's authorized representative; and (c) is submitted consistent with QualChoice's standard Claim filing policies and procedures (copies of which are available on request).

11.16. **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge the Enrollee must pay toward the cost of certain Covered Services. Those Covered Services that are subject to the application of Coinsurance are identified in the Enrollee's Benefit Summary.

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

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

11.19. **"Covered Services"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Policy. Covered Services do not include services or supplies and care excluded pursuant to Section 5 or which do not meet the definition of "Medically Necessary" as defined in Section 11.39 and the other qualifications set forth in Section 3.

11.20. **"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 Policy.

11.21. **"Deductible"** means a certain fixed-dollar amount you or the Enrollee must pay for non-preventive Covered Services before QualChoice begins to pay.

11.22. **"Dependent"** means any member of the Policy Holder's family, including a spouse, who is eligible for Benefits under this Policy, who is enrolled under the Policy, and for whom we have received all required Premiums.

11.23. **"Effective Date"** means the date your Policy goes into effect. If you purchase your Policy through the Marketplace, the Effective Date will be established by the Marketplace. If you do not purchase your Policy through the Marketplace, and we receive your Enrollment Application and first month's Premium payment by the fifteenth (15^{th}) of the month, then your Effective Date generally will be the first day of the following month. If you do not purchase your Policy through the Marketplace, and we receive your Enrollment Application and first month's Premium payment after the fifteenth (15^{th}) of the month, then your Effective Date generally will be the first day of the second following month.

11.24. **"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.

11.25. **"Enrollee"** means a Policy Holder and the Dependent(s) of the Policy Holder.

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

11.27. **"Habilitative Developmental Services"** include instruction in areas of self-help, socialization, communication, social/emotional skills. Examples include, but are not limited to, toileting; dressing, using fine motor skills; crawling/walking; categorization; expressing oneself (making wants and needs known); picture recognition; identifying letters, numbers, shapes, etc.; appropriate play skills; and coping mechanisms.

11.28. **"Habilitative Services"** means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

11.29. **"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 Policy and your Benefit Summary.

11.30. **"Hearing Aid" or "Hearing Instrument"** means an instrument or device, including repair and replacement parts, that is: (1) designed and offered for the purpose of aiding persons with or compensating for impaired hearing; (2) worn in or on the body; and (3) is generally not used in the absence of a hearing impairment.

11.31. **"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.

11.32. **"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.

11.33. **"Marketplace"** is defined in Section 11.6, above.

11.34. **"Maternity Care and Obstetrical Care"** means any services and supplies associated with pregnancy or delivery.

11.35. **"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 Policy are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much a healthcare provider may bill for a given service, the Benefits under this Policy will be limited by the Maximum Allowable Charge established under this Policy. If a Network Provider is used, then that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, if an Out-of-Network Provider is used, then you will be responsible for all amounts billed in excess of the Maximum Allowable Charge.

11.36. **"Maximum Out-of-Pocket Limit"** means the maximum amount you pay for Covered Services every Calendar Year as set out in this Policy and your Benefit Summary.

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

11.38. **"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 Policy 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 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 written request, or the Medical Coverage Policies can be reviewed on QualChoice's website at www.qualchoice.com.

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

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury, or medical condition in relation to any overall medical/health conditions (*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);
3. 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;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. 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 3 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.*

11.40. **"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.

11.41. **"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.

11.42. **"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.

11.43. **"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.

11.44. **"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 and who will be responsible for coordinating all healthcare services and making referrals for services from other Network Providers and Network Specialists. The following will be considered to be primary care physicians: (a) pediatricians; (b) family or general practice physicians; (c) internal medicine physicians; and (d) geriatric physicians.

11.45. **"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.

11.46. **"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 Network Specialists: (a) pediatricians; (b) family or general practice physicians; (c) internal medicine physicians; and (d) geriatric physicians.

11.47. **"Out-of-Area Provider" or "Out-of-Area Facility"** means a physician, facility, or other provider that is an Out-of-Network Provider that makes Covered Services available to Enrollees outside the Service Area.

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

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

11.50. **"Out-of-Pocket Limits"** means the HDHP Out-of-Pocket Limit and the Maximum Out-of-Pocket Limit, as applicable to your plan, and as set out in this Policy and your Benefit Summary.

11.51. **"Policy"** means Comprehensive Healthcare Coverage Policy for Individual POS Plans.

11.52. **"Policy Holder"** means you, the individual (who is not a Dependent) to whom this Policy is issued.

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

11.54. **"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.

11.55. **"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 Policy. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you or your Dependent are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

11.56. **"School-Based Network Provider"** means a provider that is an essential community provider authorized to provide services in a school setting and which also has an agreement with us to make Covered Services available to Enrollees in a school setting, appearing on our online list of School-Based Network Providers.

11.57. **"Service Area"** means the State of Arkansas.

11.58. **"Single Gene Inborn Errors of Metabolism"** is a group of disorders in which a single gene defect causes a clinically significant block in a metabolic pathway such that the patient cannot metabolize certain proteins, fats, or carbohydrates causing certain compounds to accumulate to toxic levels while leading to a deficiency in other compounds needed for maintenance of the body.

11.59. **"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.

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

ARKANSAS CONSUMER INFORMATION NOTICE

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

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

If QualChoice is unable to respond to your questions, please contact:

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

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).