



Group Administration Guide

Contents

I. Welcome to QualChoice!	5
About Your Group Administration Guide	5
II. Enrollment Requirements	5
A. Employee Eligibility	5
B. Dependent Eligibility	5
A Child Covered Under a Qualified Medical Child Support Order	5
An Adopted Child or a Child Pending Adoption	6
Disabled Dependent – Continuation of Coverage	6
New Child	6
Social Security Number (SSN) Requirement	6
Dependents NOT Eligible for Coverage	7
Help Prevent Health Plan Enrollment Fraud	7
C. Enrollment Periods	7
Special Enrollment Period (SEP)	7
Open Enrollment Period (OEP)	8
D. Employees Declining Coverage	8
E. New Hires	8
F. Condition of Coverage	8
G. Group Term Life Coverage	8
Life Insurance Election Requirement	9
Changes	9
H. My Account Online Eligibility Tool	9
III. Member Termination	10
A. Ending a Member’s Coverage	10
B. Continuation of Coverage under Federal Law (COBRA)	10
COBRA General Guidelines	10
C. Arkansas Law Governing Continuation of Coverage	11
D. Retroactive Terminations – ACA-Required Changes	11
E. Coverage for Non-Active Employee on Short-Term Disability Leave (if applicable)	12
IV. Family Medical Leave Act (FMLA) of 1993	12
Employer Responsibilities	12
Groups Subject to This Act	12
Eligibility	12
V. Using Your Medical Coverage	13

A. Member ID Cards	13
B. Choosing a Doctor or Hospital	13
In-Network	13
Out-of-Network	14
Pre-authorization	14
C. Prescription Drug Benefits	14
High Deductible Health Plan (HDHP) Members	14
D. Drug Formulary	15
Member Payment Tiers	15
90-Day Supply of Maintenance Drugs	15
Drugs Needing Pre-Authorization	16
E. Coordination of Benefits (COB)	16
How COB Works	16
Primary vs. Secondary	16
Dependent Coverage When Parents Are Divorced	16
Other COB Issues	17
Medicare and Small Group Coverage	17
Medicare Secondary Payer (MSP) Rules	17
F. Medical Claims	18
G. Prescription Drug Claims	18
H. Member Appeal Rights	18
VI. Using Your Dental Coverage	19
A. Dental Plan ID Cards	19
B. Choosing a Dentist	19
VII. Life Insurance Coverage	19
Claims Procedure	19
Processing Death Claims	19
Processing Dismemberment Claims	20
Processing Dependent Death Claims	20
Processing Waiver of Premium	20
Processing Accelerated Benefits	20
VIII. Summary of Benefits and Coverage	21
IX. Understand Your Group Bill	22

A. Billing Statements (see Section XIV: Sample Billing Statement)	22
B. Subscriber Changes	22
C. Premium Payments in Full	22
D. Payment Methods	23
Auto-Draft Payment	23
Online Payment	23
E. Retroactivity Guidelines	23
F. Terminations & Notice of Non-Payment	23
X. Value Added Services	23
QCARE Health and Wellness Programs	23
Managing Complex and Chronic Illness	23
One-on-One Health Coaching	24
XI. Other Services and Products	24
A. MediQ65® Medicare Supplement Insurance	24
B. Flexible Spending Account (FSA) Administration Services	24
XII. Frequently Asked Questions	25
A. Coverage/Benefits	25
B. Notification of Changes	25
C. Emergency Care	25
D. Network	26
XIII. Forms	27
XIV. Sample Billing Statement	28

I. Welcome to QualChoice!

About Your Group Administration Guide

This Guide has been made for you, the Group Administrator. It is designed to make your job as easy as possible, and to give you the facts you need to administer your QualChoice plan(s).

We look forward to working with you to give your covered employees and their eligible dependents the service they deserve.

This Guide is a resource for groups with varying benefits. As such, it includes only standard policies and procedures. For questions about your specific plan, please read your *Group Master Contract* or *Evidence of Coverage Certificate (EOC)*. In the case of conflicting language between this Guide and the EOC, the EOC will prevail. Approved plan documents are available on the *My Account* online portal. By registering for the portal and signing in, you can view these documents.

- ▶ **Vision Plan:** If you purchased a vision plan from QualChoice, your Vision Administration Guide is available online. Sign in to *My Account* on the QualChoice website to view this guide.

II. Enrollment Requirements

A. Employee Eligibility

Employees who meet the rules listed below are eligible to sign up for group coverage. Unless otherwise noted in your *Group Application for Coverage*, employees must:

- Be full time and active. This includes owners, proprietors, and partners
- Maintain permanent, active employment with the employer group covered under the group health plan, working a minimum of 30 hours per week for no fewer than 48 weeks annually.

B. Dependent Eligibility

These dependents are eligible for coverage:

- The legal spouse of an enrolled employee
- A dependent child(ren) to age 26 of an enrolled employee. To enroll a dependent child who is not a natural child, the employee must provide a copy of the legal court records

A Child Covered Under a Qualified Medical Child Support Order

A child under a Qualified Medical Child Support Order may become an eligible dependent with notice to the employer and to QualChoice.

If an employee without coverage is ordered by a court to provide coverage for a child, the employee can sign up with the child on the first day of the month after receiving the court notice. Both Parts A and B of the Qualified Medical Child Support Order must be sent to QualChoice along with the *Group Employee Application* or *Change Form* (whichever applies).

An Adopted Child or a Child Pending Adoption

Coverage for an adopted child or a child pending adoption shall start on the date of the adoption or of the filing of the petition for adoption. Either a *Group Employee Application* or *Change Form* (whichever applies) must be sent to QualChoice within 60 days after the adoption or the filing of the petition.

- Coverage starts from the date of birth if the petition for adoption or adoption occurred and application was sent within 60 days of the child's birth
- Coverage will start based on payment of all applicable premiums
- Coverage will end upon dismissal, denial, abandonment or withdrawal of the adoption

Disabled Dependent — Continuation of Coverage

A disabled dependent may stay eligible after reaching age 26 if:

- The dependent is totally disabled due to ongoing developmental or physical incapacity
- The disability began before the dependent's 19th birthday
- The Social Security Administration or a doctor has attested to the disability

A *Disabled Dependent Request for Extension of Coverage* form must be filled out by the employee and the treating doctor. After review, we will let the employee know if the application is approved or denied. Depending on the type of disability, we may ask for yearly proof of disabled status.

New Child

Coverage for a newborn child is effective from the date of birth if we receive a *Group Employee Application* or *Change Form* within 90 days. To ensure timely coordination of benefits, the child's Social Security Number should be sent as soon as possible.

Social Security Number (SSN) Requirement

In accordance with federal requirements and Centers for Medicare & Medicaid Services (CMS) guidance, a Social Security Number (SSN) is required for all enrolled members. The SSN is used to verify eligibility and to support required reporting and coordination of benefits. The SSN must be provided to QualChoice within six (6) months of the member's enrollment date. Send to:

- ▶ QualChoice
ATTN: Enrollment Department
P.O. Box 25610
Little Rock, AR 72221
Email: QCA_Enrollment@QualChoice.com

Dependents NOT Eligible for Coverage

- An ex-spouse. If a court decree calls for one ex-spouse to cover the other, the ex-spouse's only choice is an individual policy or a separate COBRA policy, if eligible
- An employee's parents
- A child or spouse on active duty in the Armed Forces of any country, except for temporary duty of 31 days or less
- Children who are past the plan's maximum age rules (unless physically or mentally disabled)
- Grandchildren (unless they meet eligibility rules)
- Sisters or brothers (unless employee is appointed the legal guardian by the court and may claim the sibling as a dependent on their federal income tax return, and all other eligibility rules are met)
- Any spouse or child who is eligible for Medicare by reason of age (except when the employee stays working on a full-time basis, the spouse may have the right to stay covered as a dependent)

Help Prevent Health Plan Enrollment Fraud

Health plan enrollment fraud occurs when a person or group purposely misrepresents facts to get coverage for healthcare products and care. This includes letting employees who are no longer eligible stay on the plan, or adding an ineligible dependent to the plan. QualChoice reserves the right to ask for records that support the adding of members and/or continuation of members under the plan.

If you suspect that QualChoice and/or our members are victims of healthcare fraud and abuse, please report it to our Compliance Department right away. All communication is confidential.

- ▶ To report suspected fraud and abuse:

QualChoice Healthcare Fraud Line, 501.228.7111, ext. 6740 or 501.707.6740

C. Enrollment Periods

Employees and their eligible dependents may sign up:

- During the initial group enrollment period
- During the eligibility period after the group's new-hire waiting period. New employees must be offered coverage on or before day 90 of their employment. The ACA prohibits groups from having a waiting period of more than 90 days
- During the group's Open Enrollment Period only (often the month before the group's yearly renewal date) for those who did not sign up at the initial enrollment and do not have a qualifying event (such as marriage, divorce, birth, adoption, placement for adoption, loss of other coverage or the end of COBRA)

Special Enrollment Period (SEP)

A member is eligible for a SEP if they have any of these qualifying events:

- Addition of a child through a Qualified Medical Child Support Order
- Addition of stepchild(ren)
- Adoption
- Birth or death
- Marriage or divorce
- Permanent legal custody of a child
- Loss of Medicaid coverage or coverage under the state's Children's Health Insurance Program (such as ARKids First)
- Reinstatement of civilian status of active duty military personnel
- Voluntary or involuntary loss of other group health coverage

Additions, deletions or changes in coverage are not allowed more than 30 days after the qualifying event (90 days for newborns; 60 days for adoption or loss of Medicaid coverage).

The start date of a court-ordered addition of a dependent child(ren) will be the first of the month after QualChoice receives proof of the court order.

All special enrollment changes must include supporting documents such as: marriage certificate, court appointed adoption papers, divorce papers, or military reinstatement papers.

Open Enrollment Period (OEP)

OEP is the period of time when employees can select from a choice of benefit programs, if applicable. During OEP employees who have not yet signed up for group coverage may do so.

Eligible dependents may be added for any reason during a group's OEP. Applications received during the OEP will be effective on the group's renewal date. Applications received after the OEP will not be accepted unless they are due to a qualifying event/SEP.

D. Employees Declining Coverage

If an employee declines coverage, he or she must fill out the Decline Coverage section of the *Group Employee Application* and return it to the Group Plan Administrator. Employees and/or their eligible dependents that decline coverage are not allowed to join the plan unless they qualify for a SEP.

E. New Hires

As new employees join your company, it is your responsibility to help them make an informed decision about their health benefits. This includes providing the ACA-required *Summary of Benefits and Coverage (SBC)*. You could be penalized by the Department of Health and Human Services for not providing an SBC to newly eligible employees. Once a new employee has met your group's waiting period, he/she may sign up for a QualChoice health plan if they meet all other eligibility rules.

F. Condition of Coverage

When you submit the *Group Employee Application* or *Change Form* and pay your premiums, you are agreeing to the terms of the *Master Group Contract*, as well as its duties, benefits, limits and exclusions.

G. Group Term Life Coverage

These eligibility rules apply:

- If an eligible employee is not actively at work on the start date of the group's policy or the start date of his/her policy, coverage does not start until the date the employee returns to work.
- Employees who are not W-2 wage earners (such as 1099 workers) are not eligible for group term life and cannot enroll. Owners must work a minimum of 30 hours a week to be eligible.
- The Group Plan Administrator must keep *Designation of Beneficiary* forms on file to be sent to QualChoice at the time of a claim. The form is available at QualChoice.com.

Life Insurance Election Requirement

Employees are required to actively elect life insurance coverage, regardless of the employer's contribution or benefit arrangement. If an employee selects **"Decline Coverage"** on the enrollment application, this election applies to **all offered coverages**, including the Life Insurance policy. In such cases, no life insurance coverage will be issued, and no benefits will be payable.

Changes

All employee changes must be sent on a *Change Form*. Types of changes are:

1. Change in an employee's earning or job classification
 - a. If a covered employee is not actively at work on the start date of an increase in insurance amount, the increase will not start until the employee returns to active work
 - b. Decreases in the amount of a covered employee's insurance will take effect on the first of the month or the next premium due date after the date of change
 - c. Salary updates are very important on groups with salary-based benefits. Death and disability claims are decided using the latest reported salary, before loss. No salary updates will be allowed once a death claim is sent
2. Addition or change of a dependent's coverage, if applicable.

H. My Account Online Eligibility Tool

Our secure online tool helps you handle your employee enrollment data efficiently. With *My Account*, you can:

1. Enroll new hires
2. Make year-round changes
3. Enter open enrollment selections upon renewal
4. View eligibility details
5. Generate reports
6. View monthly billing statement

My Account users must complete a webinar training session, then fill out a *My Account* Training Certificate form and send it to QualChoice.

▶ To register or for more information:

Enrollment Department, 501.228.7111 or 800.235.7111

Email: QCA_Enrollment@QualChoice.com

QualChoice.com → [Already a Member?](#) → [Using My Account](#)

III. Member Termination

A. Ending a Member's Coverage

Employers will be given a 10 calendar day grace period after the end of the prior month to send in termination requests for an effective date of the last day of the prior month. Termination requests greater than 10 days will be denied and processed for the last day of the month in which the termination form was received.

B. Continuation of Coverage under Federal Law (COBRA)

Continuation of coverage may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law applies to employers with at least 20 or more employees on 50% of its normal business days during the prior calendar year.

COBRA is available to qualified beneficiaries upon any of the following qualifying events. (For those who were covered as an employee or dependent under the group health plan on the day before the qualifying event.)

- Voluntary or involuntary termination of employment for any reason other than gross misconduct
- Reduction in hours that would result in loss of group health coverage
- Death of the covered employee
- Covered employee entitled to Medicare coverage
- Divorce or legal separation from the covered employee
- Dependent child no longer a dependent or has reached the age limit

Under the **Master Group Contract**, QualChoice does not bear the employer's duty to give benefits under COBRA if the employer fails to give COBRA notices at the time set. QualChoice is not responsible for giving any COBRA notices to employees or dependents.

COBRA General Guidelines

If a group is subject to COBRA, the Group Plan Administrator has certain responsibilities. These include, but are not limited to:

- Telling all employees and their covered dependents of their rights under COBRA when they first become covered under the group health plan, using correct and up-to-date language
- Giving notice to all employees and their covered dependents of their continuation rights, benefits and premium rates for the plan(s) in which they are eligible within 14 days of a qualifying event, using correct and up-to-date language
- Adhering to the election rights of qualified beneficiaries
- Correctly administering coverage of COBRA continuants until rights to benefits are used up

The above information is a summary only.

- ▶ For more information on COBRA regulations, visit [DOL.gov](https://www.dol.gov).

An employer not in full compliance with COBRA may be liable for an IRS excise tax of up to \$200 per employee for each day of noncompliance, and Employment Retirement Income Security Act of 1974 (ERISA) penalties of \$110 per employee per day of non-compliance. Court awards may involve claims costs, attorneys' fees and other costs.

C. Arkansas Law Governing Continuation of Coverage

Groups not subject to COBRA (less than 20 employees) may be subject to the State of Arkansas' Continuation of Coverage Law, which in certain situations allows coverage to be extended up to 120 days.

A covered person, whose employment ends or dependency status changes, has the right to choose Continuation of Coverage under the group plan as outlined below. To be eligible for this option, the covered person must:

- Have been continuously covered under the group policy for at least three months in a row before employment termination or change in dependency status; and
- Make the election by letting the employer know in writing no later than 10 days after employment termination or change in dependency status

Continuation ends on the earliest of:

- 120 days after continuation of coverage begins
- The end of the period for which the individual made a timely contribution
- The contribution due date following the date the individual becomes eligible for Medicare
- The date on which the individual is covered for similar benefits under another group or individual policy
- The date on which the individual becomes eligible for similar benefits under another group or individual policy
- The date on which the Group terminates the Group Master Contract or withdraws from us

- ▶ For more information:

QualChoice.com → Already a Member? → Find a Form or Document → Employers/Groups →
AR State Group Continuation Coverage Election Form

D. Retroactive Terminations — ACA-Required Changes

The Affordable Care Act (ACA) does not allow the rescission (cancellation) of health plan coverage except for an act, practice, or omission that makes up fraud, or an intentional misrepresentation of a material fact. Rescission is not permitted in the case of inadvertent misstatements of fact. As defined by law, a rescission is a retroactive cancellation or discontinuance of coverage, except to the extent attributable to a failure to pay timely premiums towards coverage.

If the rescission is permitted under Federal and State law, the coverage may be retroactively terminated. Thirty calendar days' advance written notice is needed when coverage is to be rescinded. The notice must give the appeal rights as stated by law and as supplied in the member's plan documents. The purpose of the advance notice is to allow the affected person(s)/group(s) to explore other coverage and their rights.

Terminations must be processed in a timely manner. If the member has paid any part of the premium after the requested end date, QualChoice must extend coverage through the time the premium covers. In many cases this will cause us to end coverage prospectively.

The Department of Labor has made clear many important eligibility matters. For example:

- Some employers' HR departments may reconcile lists of eligible people with their plan only once per month
- If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Department does not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission
- Also, if a plan does not cover ex-spouses (based on the COBRA continuation coverage provisions) and the plan is not told of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Department does not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may call for coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary)
- The legal prohibition is not limited to rescissions based on fraudulent or intentional misrepresentations of past medical history. An example in the Department's interim final rules on rescissions makes clear that some plan errors (such as mistakenly covering a part-time employee and supplying coverage upon which the employee relies for some time) may be canceled prospectively once pointed out, but not rescinded after the fact unless there was fraud or intentional misrepresentation by the employee

We rely on Group Plan Administrators to provide the start dates of their employees' enrollments, terminations or other eligibility changes.

E. Coverage for Non-Active Employee on Short-Term Disability Leave (if applicable)

QualChoice lets a non-active employee on short-term disability keep health coverage during the group's short-term disability (STD) coverage, but for no more than six months. QualChoice can also ask for a copy of the STD plan document to check STD rules and eligibility of the non-active employee. At the end of STD coverage, the non-active employee may do one of these things:

- Return to work (defined as a full-time employee working at least 30 hours a week)
- Enroll in Arkansas' 120-day continuation coverage (see section on AR Continuation of Coverage)
- Change to COBRA, if applicable
- Drop coverage

IV. Family Medical Leave Act (FMLA) of 1993

Employer Responsibilities

Groups Subject to This Act

If your group employed 50 or more employees for each working day during each of 20 or more calendar work weeks in the current or previous calendar year, the FMLA law applies to your group.

Eligibility

If your group is subject to FMLA, you are required to give an employee up to 12 weeks unpaid leave for:

- The birth or placement of a child for adoption or foster care
- Care of an immediate family member (spouse, child, or parent) with a serious health issue
- Medical leave when the employee is not able to work because of a serious health issue

For an employee to be eligible for FMLA leave, ALL of these qualifications must be true:

1. Work for a covered employer
2. Have worked for the employer for at least a total of 12 months
3. Have worked at least 1,250 hours over the prior 12 months
4. Worked at a place where at least 50 employees are employed by the employer within 75 miles

If an employee takes FMLA leave, the employer must keep paying for the employee's health coverage just as if the employee were at work. We suggest that the employer make sure that the employee's part of the premium, if any, is paid during FMLA leave to ensure that coverage continues unabated during the leave.

Keeping the employee's coverage in place during FMLA leave will keep the employer in compliance with the requirement that the coverage resume unchanged when the employee returns from leave. If coverage lapses for non-payment during the employee's FMLA leave, the coverage would not resume as before. The employer would then have to find alternative coverage for the employee. If the employee does not return to work at the end of the FMLA period, the employer may recover the unpaid premium — unless the employee is not coming back to work due to serious illness or other events beyond the employee's control.

► For more information:

Call the nearest U.S. Department of Labor, Wage and Hour Division office

V. Using Your Medical Coverage

A. Member ID Cards

Members should check their ID cards for accuracy when they receive them. They should carry their card with them at all times and show it when seeking medical treatment or service. ID cards are to be used only by members of health plans offered or administered by QualChoice. Use of an ID card by a person other than the members covered by the subscriber named on the card is fraud.

Having an ID card does not guarantee coverage. Providers are encouraged to verify coverage and eligibility at the time of service.

- ▶ To check coverage before getting care:
Customer Service, 501.228.7111 or 800.235.7111

B. Choosing a Doctor or Hospital

In-Network

“Network” or “in-network” refers to those healthcare experts and/or facilities that have a written agreement with QualChoice to give care to our members. When an in-network provider schedules a procedure or service needing pre-authorization, the provider is responsible for getting the needed pre-authorization from us.

Members can make sure that each doctor or facility involved in any scheduled procedure is in the QualChoice network by using the **Provider Search** at QualChoice.com. They should also make sure that all specialists (such as anesthesiologists, medical equipment and lab tests) are in-network. Benefits will be paid at a lower rate or not covered if the provider is out-of-network.

Members should let us know if they live, work or go to school outside the service area for more than 90 days in a row. Covered services will be paid at the **in-network level** when care is received from:

- A QualChoice provider while in the service area, or
- A QualChoice National Network (QCNN) provider while outside the service area.

Services received from providers who are not QualChoice providers (inside the service area) or QCNN providers (outside the service area) will be paid as **out-of-network**.

When using a QCNN provider, the member is responsible for getting any required pre-authorization.

Out-of-Network

“Out-of-network” refers to those healthcare experts and/or facilities that do not have a written agreement with QualChoice. Members whose plans include out-of-network benefits and who use out-of-network providers will have a greater cost share. The member is responsible to make sure that the out-of-network provider gets any needed pre-authorization before getting care.

If a member receives services from an out-of-network provider, even if it’s in an in-network setting, QualChoice has the right to reimburse the member for the service given at the out-of-network cost share. The member is then responsible to pay the out-of-network provider.

Pre-authorization

Below are examples of services needing pre-authorization:

- Admission to an inpatient facility or partial hospital unit
- Referral to an out-of-network provider
- OB ultrasounds, other than one routine fetal ultrasound between 16–22 weeks
- Home healthcare, home infusion services or hospice (inpatient or outpatient)
- Transplant services (inpatient or outpatient)
- Advanced imaging (when performed on an outpatient basis)
- Specialty drugs (Tier 5)
- X-rays done by a chiropractor
- Genetic testing

▶ See Pre-authorization of Services in your EOC

QualChoice.com → Already a Member? → Services Needing Pre-Authorization

C. Prescription Drug Benefits

Express Scripts (ESI) is our contracted Pharmacy Benefit Manager (PBM).

To get full benefits, covered members must use the Alliance Pharmacy Network and show their QualChoice ID card. The Pharmacy Help Desk toll free number is on the member's ID card.

When traveling, members may use any out-of-state pharmacy as long as it is in the QualChoice Pharmacy Network. The program is designed to remove the need for claim forms when using a network pharmacy.

▶ For more information:

About a specific drug: ESI, 800.417.8164

About our Prescription Drug Benefit Program: QualChoice, 501.228.7111 or 800.235.7111

High Deductible Health Plan (HDHP) Members

For our HDHP members their health plan and pharmacy benefits share the same deductible. Their prescription costs help them meet the deductible and out-of-pocket maximum faster. By showing the QualChoice ID card at the pharmacy, the member receives the QualChoice discounted rate. This also ensures the proper credit is applied to the deductible and coinsurance.

D. Drug Formulary

QualChoice drug lists are developed with a team of healthcare providers to ensure quality coverage. The lists show drugs by therapeutic groupings and tier level. We encourage members to take a copy of their specific drug list when seeing their doctor.

- ▶ [QualChoice.com](#) → Already a Member? → Pharmacy and Drug Formularies
Members can also sign in to *My Account* to view or print their formulary.

Member Payment Tiers

Each drug falls into one of four member payment categories or “tiers.” Each tier has a different cost share.

Tier 1 – Lowest Copayment

Most (but not all) generic drugs are in Tier 1. For the lowest out-of-pocket cost, members should ask their doctor if a Tier 1 drug would work.

Pharmacy copayments are not applicable to high deductible health plans.

Tier 2 – Middle Copayment

If a drug is in Tier 2, members should ask their doctor if a Tier 1 drug might work.

Tier 3 – Highest Copayment

If a drug is in Tier 3, members should ask their doctor if a Tier 1 or Tier 2 drug might work.

Tier 4 – Generic Specialty Drugs (if applicable)

Specialty drugs need special handling. They are used to treat complex or rare health problems and are very costly. These drugs must be filled by an in-network specialty pharmacy (e.g., Allcare Specialty Pharmacy, BriovaRx).

Tier 5 – Specialty Drugs

Specialty drugs need special handling. They are used to treat complex or rare health problems and are very costly. These drugs must be filled by an in-network specialty pharmacy (e.g., Allcare Specialty Pharmacy, BriovaRx).

Specialty drug coverage varies by plan. Most specialty drugs are covered by a copayment. But some plans cover them based on deductible and coinsurance. Members should check their Benefit Summary about specialty drug coverage.

90-Day Supply of Maintenance Drugs

QualChoice allows members to receive up to a 90-day supply of maintenance drugs from their in-network Retail pharmacy. ESI Pharmacy mail service pharmacy also allows members to get up to a 90-day supply of maintenance drugs delivered to their home. Specialty drugs are limited to a 30-day supply. They must be obtained through a contracted specialty pharmacy and may require pre-authorization.

- ▶ Complete the Home Delivery Order Form located at [QualChoice.com](#)
- ▶ [QualChoice.com](#) → Already a Member? → Pharmacy and Drug Formularies → 2026 Forms & Information → ESI Home Delivery Order Form

Drugs Needing Pre-Authorization

Some prescription and specialty drugs must be pre-authorized (pre-approved). They may be right only for certain diseases or require other drugs to be tried first. Visit Services Needing Pre-authorization and select Medications (for drugs covered under medical benefit) or Medications (drugs covered under Rx benefit) for a list of these drugs. You may also access the criteria for Medications covered under the Rx benefit under the Forms and Information section to the right.

E. Coordination of Benefits (COB)

Coordination of benefits helps members who are covered by more than one plan get the benefits to which they are entitled while avoiding overpayment by either plan. COB is one way we work to keep costs under control for our members.

How COB Works

When an employee is covered by more than one health plan (for example, one of your employees is covered under your group plan as well as their spouse's health plan), one plan is the primary carrier and the other is the secondary carrier. The primary carrier covers the major part of the bill according to plan allowances, and the secondary carrier covers any leftover approved costs.

The COB rules of your group plan decide which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is most often paid by the second plan to the limit of its responsibility.

Benefits are thus "coordinated" between both health plans. This ensures payments do not pass 100% of allowed charges for the covered services.

Primary vs. Secondary

These rules apply when deciding which insurance carrier is primary:

- Any plan without a COB provision always pays first
- If the employee getting benefits is the subscriber under a QualChoice plan, then QualChoice will be primary. The spouse's health plan is secondary
- If a dependent child is covered by two or more health plans, the plan of the parent whose birthday falls first in the calendar year will be primary. This is known as the birthday rule. If the parents have the same birthday, the plan that has the earliest start date will be primary. The birthday rule is superseded when a court order or custody rule applies

Dependent Coverage When Parents Are Divorced

If the dependent is a child of divorced or separated parents, primary payor status is decided by these rules:

- If the divorce decree places responsibility on one parent, that parent's health plan is primary
- If the divorce decree states that both parents have the same responsibility, the birthday rule applies and the health plan of the parent whose birthday occurs earlier in the calendar year is primary
- If the divorce decree gives joint custody, the birthday rule applies and the health plan of the parent whose birthday occurs earlier in the calendar year is primary

- If there is no court order allocating responsibility, the order is:
 - Custodial parent
 - Custodial parent’s new spouse
 - Non-custodial parent
 - Non-custodial parent’s new spouse

Other COB Issues

Often, some or all of the costs of medical care are the responsibility of an insurance party other than QualChoice.

- Members who are injured or become ill as a result of work-related accidents or environment are eligible for benefits under Workers’ Compensation. QualChoice excludes coverage for treatment or complications of any injury, condition or disease rising from any activity linked to work or that rises from a work-related injury or event
- QualChoice will not pay for benefits if coverage would be available to the member under government programs, except for Medicare. In certain cases, Medicare may be a participant’s primary or secondary coverage. QualChoice coordinates benefits with Medicare according to Medicare Secondary Payer rules

Medicare and Small Group Coverage

Eligibility rules for your Medicare-eligible employees can be confusing. The responsibility for compliance often rests with the employer group and there are fines for not complying.

As a rule,

- If a group employs 19 or fewer employees, Medicare is considered primary
- If a group employs 20 or more employees, the group health plan is considered primary

We process all Medicare claims as if the member has both Medicare Parts A and B. If the member is only enrolled in Part A, he or she will be responsible for Medicare Part B allowable charges.

Medicare Secondary Payer (MSP) Rules

Medicare is a government-sponsored health plan. It covers certain medical costs for persons who are entitled to benefits due to their age or disability. Medicare Part A covers certain inpatient medical costs and Part B covers certain outpatient medical costs.

The federal Medicare Secondary Payer (MSP) rules say that for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain cases. This means that the group health plan must not take Medicare into account when:

- Deciding whether these people are eligible to take part in the plan, or
- Supplying benefits under the plan
 - ▶ For more information: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview>

NOTE: The above information is broad in nature. It is meant only to describe the basic MSP rules. As MSP laws and rules change often, it is important for you and your company’s legal counsel to review them to ensure compliance.

F. Medical Claims

There are no claim forms to file when members get care from an in-network provider and show their ID card. Our in-network providers file claims with us for their services and we reimburse them directly. The member most often pays a deductible, copayment and/or coinsurance at the time services are given. Members should fill out a *Medical Claim Form* only if their provider is not sending a claim on their behalf.

- ▶ For more information: Customer Service, 501.228.7111 or 800.235.7111
- ▶ QualChoice.com → Already a Member? → Find a Form or Document → Medical Claim Form
- ▶ Members can also sign in to *My Account* to view or print their medical claims.

G. Prescription Drug Claims

When a member shows their QualChoice ID card at an in-network pharmacy and pays their cost share, the pharmacy files a claim on the member's behalf. There is no out-of-network benefit for pharmacy.

Prescription claim reimbursement checks and the *Explanation of Benefit (EOB)* are mailed to the member. It is the member's responsibility to pay the healthcare provider, if applicable.

- ▶ ESI Pharmacy Help Desk, 833.750.9906
- ▶ QualChoice.com → Already a Member? → Pharmacy and Drug Formularies → ESI Standard Prescription Drug Claim Form

H. Member Appeal Rights

The member has a right to appeal any ruling made by QualChoice to not cover or pay for an item or service (in whole or in part). Information about a member's right to appeal and a *Member Appeal Request Form* are available at QualChoice.com.

What if a health issue is urgent? An urgent care claim is when a member, or his/her doctor, feels that the member's health, life or recovery is at high risk – or at a high level of pain. In this case, the member or his/her doctor may ask for an **expedited** internal appeal.

Appeals must be filed within 180 days from when the member received notice of the denied claim. As plans differ, members should check their plan brochure, or *Summary Plan Description*. The member also has the right to name someone else to act on their behalf in filing an appeal. That person is called an authorized representative.

- ▶ To understand a decision to deny a service or coverage or to have a member appeal form mailed: Customer Service, 501.228.7111 or 800.235.7111
- ▶ QualChoice.com → Already a Member? → Find a Form or Document → Member Appeal Request Form

VI. Using Your Dental Coverage

A. Dental Plan ID Cards

When ID cards are received it's important to make sure the card is correct. An ID card does not guarantee coverage for dental benefits. Its main role is to give providers the facts needed to check eligibility at the time of service. Benefits and eligibility will be decided at the time claims are received. If you have dental, it will appear on your medical ID card. There is not a separate ID card just for dental.

- ▶ To check coverage before getting services:
QualChoice Customer Service, 800.235.7111

B. Choosing a Dentist

To find a dentist in the Delta Dental network, visit deltadentalar.com or call the Delta Dental Customer Contact Center at 800.462.5410.

VII. Life Insurance Coverage

Claims Procedure

In the event of a member death, please call Customer Service or your Account Service Representative. At the time of the claim, payroll records will be needed on all covered employees.

Processing Death Claims

All of the following must be sent to QualChoice. Incomplete information will cause delays.

1. *Group Life Insurance Claim Form* – must be filled out by the employer on behalf of the claimant
2. A certified (raised seal) copy of the Death Certificate
3. The original *Group Employee Application* and any other applicable forms with beneficiary changes noted
4. For accidental death claims, a copy of the accident report, investigating officer's report and a coroner's report, if applicable

Any death benefit will be paid to the beneficiary chosen by the insured. If the covered employee has died and no beneficiary is living or named, we will pay the applicable amount to the member(s) of the first surviving class in this order:

The covered employee's:

- Spouse
- Child(ren)
- Parent(s)
- Sibling(s)
- Executors and administrators

QualChoice is not liable for any payment so made, unless written notice of a valid claim by some other person is received before payment is made. Payment made for a minor is conditional upon receipt of guardianship papers. In community property States, the spouse may have the right to 50% of the proceeds from the insurance policy unless he/she waived his/her rights to the proceeds. If a member has been covered by QualChoice for less than 2 years and the death is due to suicide, proof of previous life insurance coverage must be sent.

Death claims on groups with salary-based benefits will be decided using the latest reported salary, prior to loss. No salary updates will be permitted at claim time.

The employer will be notified in writing when the claim is paid.

Processing Dismemberment Claims

Dismemberment claims must be sent on a *Dismemberment Claim Form*. Contact QualChoice at 800-235-7111 and speak to the Life Claim Department for this form. Incomplete forms will be returned to the covered employee or employer for completion and will delay processing of the claim.

Processing Dependent Death Claims

Dependent death claims are sent on the same claim form as an employee death claim. A certified (raised seal) copy of the Death Certificate and a copy of the respective *Group Employee Application* are also needed. The covered employee is the chosen beneficiary for this benefit.

Processing Waiver of Premium

Waiver of Premium, when approved by QualChoice, waives the life premium for an eligible disabled employee. For the member to be eligible for the Waiver of Premium, the claim must be filed within 12 months of the date of total disability. See your *Life Contract* (4.1.2) for details.

Upon written notice of approval, the employee will automatically be removed from the bill. If you get a Billing Statement that still includes the employee after you have received written approval, please call our Enrollment Department with the employee's name and date of the approval notice.

Processing Accelerated Benefits

To ask for accelerated benefits, contact QualChoice at 800-235-7111 and speak to the Life Claim Department for an *Application for Accelerated Benefits*. The member must be covered under the group life policy for 12 months before being eligible. Proof of terminal illness certified by the attending doctor and one other doctor must be supplied. Terminal illness is defined as life expectancy of 12 months or less as decided by the attending doctor.

VIII. Summary of Benefits and Coverage

Group health plans must provide members with a *Summary of Benefits and Coverage (SBC)*. This 8-page document, designed by the Department of Health and Human Services (HHS), describes a plan’s benefits and coverage clearly and in a specified format. This helps consumers better grasp the details of their coverage and makes it easier to compare coverage choices.

SBC rules apply to all:

- Health insurance companies
- Health insurance agents and brokers
- Employers supplying employee coverage (fully-insured or self-funded)

HHS’ timeline by which an SBC must be provided is below. Fines of up to \$100 per day per member may apply for not meeting these timelines. In the case of a willful failure to not provide the SBC, the fine goes up to \$1,000 per member.

Requirements	Time Frame	What a Plan Sponsor Must Do
Newly eligible (new hires)	SBC must be provided with enrollment and application materials. If enrollment materials are not distributed, no later than 1st day of enrollment period. (Delivery option: PDF or Print if requested)	Provide SBC (created by QualChoice) to plan participant.
Special enrollment period (i.e., those subject to HIPAA special enrollment)	90 calendar days from enrollment	Provide SBC (created by QualChoice) to plan participant.
Upon request by plan participant	Within 7 days of receipt of request	Provide SBC (created by QualChoice) to plan participant.
Material modifications, legal amendment for all plan holders	If coverage changes the content of the SBC for all plan holders, a Notice of Material Modification must be sent no later than 60 calendar days before the start date of the coverage change(s).	Provide notice (created by QualChoice) to plan participant.
Open enrollments and renewals after Sept. 23, 2012	For active enrollments in which employees actively sign up for a plan, the SBC must be provided with enrollment materials (Delivery option: PDF or Print if requested)	Provide SBC (created by QualChoice) to plan participant. Note: If information in the SBC changes between the date the enrollment/ application materials are provided to employees and the first day of coverage, a new SBC must be provided to the employee by the first day of coverage.
New group (sold)	SBC production is started after we get a signed Group Application for Coverage. SBC sent to the agent and the group within 7 business days. (Delivery option: PDF or Print if requested)	Provide SBC (created by QualChoice) to plan participant.

IX. Understand Your Group Bill

A. Billing Statements (see Section XIV: Sample Billing Statement)

Billing statements will be available via the MyAccount portal. You will only receive paper billing statements if you opt out of the electronic delivery.

- Statements reflect a one-month billing period.
- Statements consist of four sections:
 - Group summary
 - Product summary
 - Subscriber listing
 - Retro subscriber listing
- Statements include:
 - Coverage period being billed
 - Membership
 - Payment transactions for an activity period
 - Total amount due
- The remittance address on the Billing Statement must be used for quick and accurate processing. Do not send enrollment forms or member changes to the remittance address.
- You must include your group number on all remittance check stubs and any correspondence.

B. Subscriber Changes

1. Subscriber change requests (such as, additions, terminations, COBRA changes) must be sent on the *Change Form* or *Termination Form* found at QualChoice.com and not on the Billing Statement
2. Changes made between billing periods are shown in a separate section of the Billing Statement
3. To make sure they are on the next Billing Statement, we must get any change requests by the 5th of each month for the next billing period

C. Premium Payments in Full

- Premium payments are due in full by the first day of each month. Statements must be paid in full as billed to guarantee eligibility for the month. Adjustments will be on the next month's bill.
- **NOTE: Do not strike through terminated employees on your bill and short pay. A *Termination Form* or *Change Form* must be submitted before billing adjustment will be made on the following month's bill.**
- Late premium payments get a Notice of Non-Payment letter indicating that the group is subject to Claim and Pharmacy Hold and/or cancellation for non-payment
- If premium payments are not received by the 20th of the month, the group is placed on Claims and Pharmacy Hold
- If the premium is not paid by the last day of the coverage month, the group is terminated under the Non-Payment Provision of the Group Master Contract

D. Payment Methods

Auto-Draft Payment

QualChoice offers auto-draft payment for ease in paying your monthly premium.

- ▶ To set up electronic funds transfer:
QualChoice.com → Already a Member? → Find a Form or Document → Employers/Groups → Authorization for Automatic Payments - Groups

Online Payment

Pay your premiums quickly, accurately and securely from your bank account. QualChoice now offers online payment.

- ▶ To set up online payments:
QualChoice.com → Already a Member? → Pay My Bill

E. Retroactivity Guidelines

Employers will be given a 10 calendar day grace period after the end of the prior month to send in termination requests for an effective date of the last day of the prior month. Termination requests greater than 10 days will be denied and processed for the last day of the month in which the termination form was received.

F. Terminations & Notice of Non-Payment

Premium payments are due in full by the first of each month. Late payments receive a 'Notice of Non-Payment' letter. This states that the group is subject to Claim and Pharmacy Hold and/or cancellation. A group whose contract is terminated for non-payment must send a new *Group Application for Coverage* to be reinstated. If reinstated, a fee of \$250 will be assessed. It is at QualChoice's sole discretion to decide terms and conditions for reinstatement.

If the requested termination date is more than 30 days before the date the Termination Form is sent, the Group/Plan Administrator is responsible to check that the employee did not pay any premiums for health coverage after the requested termination date.

X. Value Added Services

QCARE Health and Wellness Programs

QCARE, our medical management and health and wellness program, gives employees and their covered dependents valuable services and tools to help them manage chronic health problems and maintain or improve their health. The program is led by an in-house Medical Director and a team of nurse Care Managers.

Managing Complex and Chronic Illness

Nurse Care Managers offer support for members dealing with complex diseases and chronic health issues. Programs target the most frequent high-cost health issues: asthma, cancer, congestive heart failure, high blood sugar, high-risk pregnancy, high blood pressure and organ transplant. A nurse Care Manager serves as the single point of contact to make sure the member gets the training, support and guidance needed, even when being treated for multiple conditions.

Our nurse Care Managers provide:

- One-on-one support and guidance
- Help following the doctor's plan
- Ongoing help with long-term illness
- Help preventing related problems

One-on-One Health Coaching

Our QCARE health coaches help members reduce or control out-of-pocket costs by helping them change their habits. They help members in setting and reaching overall health and well-being goals. We give support and educational resources on such things as tobacco cessation, nutrition, stress management and weight management.

Our QCARE Programs include:

- Diabetes Management
- Heart Health
- CARES Cancer Awareness
- Kick the Nic! Stopping Tobacco Use
- Maternity Management, assisting with pregnancy concerns
- Post Discharge Care
- Transplant Management

NOTE: Some programs may differ by group and benefit plan.

► For more information:

Call 501.228.7111 or 800.235.7111 and ask for your Account Service Representative
QualChoice.com → Already a Member? → QCARE Program

XI. Other Services and Products

A. MediQ65® Medicare Supplement Insurance

For our covered members 65 or older who are Medicare-eligible.

- ▶ MediQ65 Sales, 855.MEDIQ65 (855.633.4765)
Email: MediQ65@QualChoice.com
QualChoice.com

B. Flexible Spending Account (FSA) Administration Services

An FSA is a tax-saving program that lets employees contribute pre-tax dollars from their earnings to pay for qualified expenses such as healthcare costs and dependent care. QualChoice offers full- service FSA administration for healthcare and dependent care. We follow industry best practices and all ERISA and IRS requirements, to keep plans in compliance with federal regulations.

- ▶ For more information:
Call 501.228.7111 or 800.235.7111 and ask for your Account Service Representative

XII. Frequently Asked Questions

A. Coverage/Benefits

Q: When does coverage begin?

A: Initial enrollees and eligible dependents are covered on the first day of the month after the employer's group waiting period, a qualifying event or open enrollment.

Q: When living or traveling outside of Arkansas, how do members get benefits?

A: Members living outside Arkansas (i.e., dependents in college) should call the toll free number listed on their ID card to find in-network providers in their specific area or use the First Health provider directory link on the QualChoice website.

If the member lives in Arkansas but travels outside the state, they should call the toll free number listed on their ID card to find in-network providers in their specific area.

The member is responsible to notify QualChoice about any services received while traveling away from home. If services are received out of network, the member may be required to pay for services as given.

Members should let us know if they live, work, or go to school outside the service area for more than 90 days in a row. Covered services will be paid at the **in-network level** when care is received from:

- A QualChoice provider while in the service area, or
- A QualChoice National Network (QCNN) provider while outside the service area.

Services received from providers who are not QualChoice providers (inside the service area) or QCNN providers (outside the service area) will be paid as **out-of-network**.

When using a QCNN provider, the member is responsible for getting any required pre-authorization.

B. Notification of Changes

Q: How do I change an address or make other group administrative changes?

A: The Group Plan Administrator is required to submit all changes and terminations through the My Account portal or via the designated Change Form (for changes) and Termination Form (for terminations). Submissions through any other method, including the monthly invoice, are not permitted.

Q: How do I change the waiting period on our group policy?

A: Waiting periods are not changed outside of open enrollment unless the employer has changed the company policy. In this case, one change each year is permitted, subject to approval. The waiting period cannot exceed 90 days. As a rule, we offer start dates on the first day of the month after 30 days or 60 days of employment.

C. Emergency Care

Q: What if a covered member has an emergency?

A: An emergency is described as a recent onset of a medical condition of sufficient severity, including but not limited to severe pain, that would lead a layperson with an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is such that not obtaining 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.

If a covered member needs true emergency care, he/she should go right away to the nearest medical facility. Members who get emergency treatment at an out-of-network facility should call QualChoice within 48 hours after getting care to make sure the emergency room claim is handled the right way.

Members are required to pay their emergency room cost share (i.e., deductible, coinsurance, or copayment) at the time of service. This is waived if the member is admitted to the hospital. When possible, follow-up care for emergency treatment must be received from an in-network provider in order for benefits to be paid at the highest level.

Q: What if a covered member is out of town and needs medically-necessary emergency care?

A: When a covered member is out of town and has a life-threatening or serious emergency, they should call 911 or go to the nearest hospital emergency room for treatment.

Q: What if a covered member has an urgent problem, but it doesn't meet the definition of emergency?

A: During normal business hours, the member should call their primary care physician (PCP). The PCP may send the member to an urgent care center or the emergency room. A referral is NOT required to visit an urgent care facility (even if it is not in-network).

D. Network

Q: How can a covered member find out if a certain doctor or facility is in-network?

A: The member can search for providers on our website or call Customer Service.

- ▶ Customer Service, 501.228.7111 or 800.235.7111
- ▶ QualChoice.com → Already a Member? → Find a Doctor or Hospital

Q: What about emergency care received at an out-of-network hospital?

A: See Emergency Care, page 25 .

Follow-up care for emergency treatment is not covered if done at the emergency room. Follow-up care must be received from an in-network doctor for the highest level of benefits to be paid.

XIII. Forms

All forms are available at QualChoice.com. You can also call Customer Service at 501.228.7111 or 800.235.7111 to ask for a form by fax or mail.

MEMBER FORMS	
Designation of Beneficiary Form The member uses this form to choose a group term life beneficiary. The employer must keep beneficiary designations on file to be sent to QualChoice at the time of a claim.	Medical Claim Form The member uses this form for reimbursement when medical charges for benefits were not filed by a doctor or other healthcare expert.
Designation of Personal Representative This form allows the member to authorize another individual to access their personal health information from QualChoice.	Member Appeal Request Form This form is used by a member who is officially appealing a ruling made by QualChoice to not cover or pay for an item or service (in whole or in part).
Disabled Dependent Request for Extension of Coverage This form is used by a member to request an extension of coverage for a dependent who is over age 26. Dependent must be incapable of self-support due to a physical or mental handicap.	Prescription Reimbursement Claim Form The member uses this form to request reimbursement when prescription drugs are paid out-of-pocket.
EMPLOYER FORMS	
Arkansas State Continuation Coverage Election Form This form is for a group that is not eligible for COBRA and the covered employee's employment terminates or dependency status changes.	Change Form This form is used by the Group Plan Administrator to make additions or changes on currently enrolled members.
Authorization for Automatic Payments This form is for the group to use to request their premium payments be auto-drafted.	Termination Form This form is used by the Group Plan Administrator to terminate (end) a member's coverage because of change in employment, dependent status or death.

XIV. Sample Billing Statement



ABC Group
 P.O. Box 1234
 North Little Rock AR 72119

1

2

3

4

Date Prepared: 11/5/2017
 Date Due: 12/1/2018
 Group Number: 00012345

5 For the Month of December 2017

Thank you for being a QualChoice client. Your current amount due for December 2013 is **\$2,396.87**. If you have any question concerning this invoice or other billing inquiries, please contact our Finance Department at 1-501-228-7111.

Below is a list of all your subgroups and the total amount of premium due for all QualChoice products.

6 InvoiceNumber	7 Subgroup Number - Description	8 Outstanding Balance	9 Current Premium Amount	10 Please Pay This Amount
123456	1000 - Description	\$0.00	\$1,596.68	\$1,596.68
678910	1002 - Description	\$0.00	\$800.19	\$800.19
	Summary	\$0.00	\$2,396.87	\$2,396.87

Ref No.	Name Field	Description
1	Group Information	The group or subgroup name and billing address
2	Date Prepared	The calendar date that your billing was generated
3	Due Date	The date in which your premium payment is to be received
4	Group Number	The primary group number that consolidates all subgroups under one group number for billing purposes
5	Billing Month	The month you are currently being billed for
6	Invoice No.	A unique invoice number that will appear on your group billing statement each time a bill is issued for your group
7	Subgroup & Description	A listing of all your subgroups and the amount due for each
8	Outstanding Balance	Premium discrepancy amount (debit or credit) after last month's billing was reconciled
9	Current Premium Due	Represents the "net premium total" for the current billing period
10	Total Due – Please pay this amount.	Premium discrepancy amount (debit or credit) after last month's billing was reconciled

Product Listing

Medical – Description of Product				Total:	14 \$0.00
Subgroup #1 – Subgroup Description	11 Subscribers	Rate	12 Retro Adjustments	13 Subgroup Monthly Premium	
Employee Only:	1	\$0.00	\$0.00		\$0.00
Employee & Family:	4	\$0.00	\$0.00		\$0.00
Dental – Description of Product				Total:	\$0.00
Subgroup #1 – Subgroup Description	Contracts	Rate	Retro Adjustments	Subgroup Monthly Premium	
Employee Only:	1	\$0.00	\$0.00		\$0.00
Employee & Family:	4	\$0.00	\$0.00		\$0.00
Vision – Description of Product				Total:	\$0.00
Subgroup #1 – Subgroup Description	Contracts	Rate	Retro Adjustments	Subgroup Monthly Premium	
Employee Only:	1	\$0.00	\$0.00		\$0.00
Employee & Family:	4	\$0.00	\$0.00		\$0.00
COBRA – Description of Product (For One Flat Premium)				Total:	\$0.00
Subgroup #1 – Subgroup Description	Contracts	Rate	Retro Adjustments	Subgroup Monthly Premium	
Employee Only:	1	\$0.00	\$0.00		\$0.00

Please send your remittance to: **15** QualChoice
P.O. Box 677272
Dallas, TX 75267

For billing questions, please call: 501.228.7111 or 800.235.7111

Ref No.	Name Field	Description
11	Subscribers	Subscriber counts within each contract type
12	Adjustment	Premium charges being billed, by contract type, for “retroactive changes” only
13	Current Premium	The premium charges billed, by contract type, for the “current month” only
14	Total	Total of all current months plus the retroactive amounts being billed
15	Please Send Your Remittance To	Address to use when mailing monthly premiums



Date Prepared: 12/5/2017
 Date Due: 12/10/2017
 Group Number: 00012345

16 **Subscriber Listing (Current Billing)**

Subgroup 001 – Description			18					19
17 Subscriber	ID Number	Effective Date	Coverage Tier for Medical	Medical	Dental	Vision	Life	Total Premium
John Smith	123456	1/1/2015	A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Julie Smith	654321	1/1/2015	A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
John Smith	123456	1/1/2015	B	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Subgroup 002 – Description								
Subscriber	ID Number	Effective Date	Coverage Tier for Medical	Medical	Dental	Vision	Life	Total Premium
John Smith	123456	1/1/2015	A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Julie Smith	654321	1/1/2015	A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
John Smith	123456	1/1/2015	B	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Ref No.	Name Field	Description
16	Group Plan Description	The subscriber listing is separated by subgroup
17	Subscriber	The name of the subscriber
18	Coverage Tier for Medical	Current medical contract type for each subscriber A=Subscriber and Family B=Subscriber and Spouse C=Subscriber Only D=Subscriber and Dependents
19	Total Premium	Total premium due for all products for that subscriber



Date Prepared: 12/5/2017
 Date Due: 12/10/2017
 Group Number: 00012345

Retro Subscriber Listing (Should Only Show if Applicable)

Subgroup 001 – Description			20					21	22
Subscriber	ID Number	Effective Date	Coverage Tier for Medical	Medical	Dental	Vision	Life	Total Premium	
John Smith	123456	1/1/2015	A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Total				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

Ref No.	Name Field	Description
20	Effective Date	The effective date of the change for that subscriber
21	Premium Adjustment	Premium adjustments resulting from a membership change Premium amounts charged for current billing period are in "Subscriber Listing" section
22	Total Premium	Total premium adjustment for all products for that subscriber

The Group Administration Guide provides general administrative information related to group health plans offered by QualChoice. It is intended for use by group administrators, who are individuals designated by employers to handle routine administrative matters associated with the employer's group health insurance plan. It is not intended as legal or benefits advice, but only as a convenient reference source for general administrative information.

QCA Health Plan, Inc. and QualChoice Life and Health Insurance Company, Inc. are collectively referred to herein as QualChoice.

