



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.qualchoice.com or by calling 1 (800) 235-7111.


| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | Calendar year fulfillment deductible Out-of-network: Individual \$8,000 /Family \$16,000 Preventive care, prescription drugs, and physician office visits are not subject to deductible Copayments and OON amounts over Allowable do not count toward deductible | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. In Network: Individual \$604 /Family \$1,208 Out-of-network: Individual \$14,300 /Family \$25,000 | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |

Questions: Call 1 (800) 235-7111 or visit us at www.qualchoice.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

at www.cciio.cms.gov or call 1 (800) 235-7111 to request a copy.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| Does this plan use a <u>network of providers</u> ? | Yes. For a list of in-network providers , see provider-search.qualchoice.com or call 1 (800) 235-7111. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a <u>specialist</u> ? | No. You don't need a referral to see an in-network specialist . | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
 - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
 - This plan may encourage you to use in network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|--|--|--|
| | | In-Network Provider | Out-Of-Network Provider | |
| If you visit a health care <u>provider's office</u> or clinic | Primary care visit to treat an injury or illness | \$8 Copayment / visit | 50% Coinsurance | —————none————— |
| | Specialist visit | \$10 Copayment / visit | 50% Coinsurance | —————none————— |
| | Other practitioner office visit | \$8 Copayment / visit for nurse practitioner and \$10 Copayment/visit for chiropractor | 50% Coinsurance for nurse practitioner Not Covered for chiropractor | Coverage is limited to 30 visits per calendar year for Chiropractic combined with PT/OT/ST |
| | Preventive care/screening/immunization | No Cost | Not Covered | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|--|---|-------------------------|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| If you have a test | Diagnostic test (x-ray, blood work) | No Cost to You | 50% Coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | No Cost to You | 50% Coinsurance | Requires pre-auth |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.qualchoice.com/members/drug_for_mulary . | Generic drugs | \$4 Copayment / prescription at retail | Not Covered | Covers up to a 30-day supply (retail prescription); Mail order Not Covered |
| | Preferred brand drugs | \$4 Copayment / prescription at retail | Not Covered | Pre-auth/step-therapy may apply |
| | Non-preferred brand drugs | \$8 Copayment / prescription at retail | Not Covered | Maximum quantity per RX may apply |
| | Specialty drugs | \$8 Copayment / prescription | Not Covered | Your formulary is Essential |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 9% Coinsurance | 50% Coinsurance | —————none————— |
| | Physician/surgeon fees | 9% Coinsurance | 50% Coinsurance | —————none————— |
| If you need immediate medical attention | Emergency room services | No Cost to You | No Cost to You | —————none————— |
| | Emergency medical transportation | No Cost to You | No Cost to You | Coverage is limited to \$1,000/trip for ground ambulance and \$5,000/trip for air ambulance |
| | Urgent care | No Cost to You | 50% Coinsurance | —————none————— |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$140 Copayment / day before Deductible | 50% Coinsurance | Requires pre-auth |
| | Physician/surgeon fee | No Cost to You | 50% Coinsurance | —————none————— |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$4 Copayment / visit and 9% Coinsurance/ other outpatient services | 50% Coinsurance | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|-------------------------|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| | Mental/Behavioral health inpatient services | \$140 Copayment / day before Deductible | 50% Coinsurance | Requires pre-auth |
| | Substance use disorder outpatient services | \$4 Copayment / visit and 9% Coinsurance/ other outpatient services | 50% Coinsurance | —————none————— |
| | Substance use disorder inpatient services | \$140 Copayment / day before Deductible | 50% Coinsurance | Requires pre-auth |
| If you are pregnant | Prenatal and postnatal care | No Cost to You | 50% Coinsurance | —————none————— |
| | Delivery and all inpatient services | \$140 Copayment / day before Deductible | 50% Coinsurance | Requires pre-auth; Coverage is limited to \$2,000 benefit maximum per newborn for the first 90 days after birth for Out of Network services |
| If you need help recovering or have other special health needs | Home health care | No Cost to You | 50% Coinsurance | Requires pre-auth, Coverage is limited to 50 visits per calendar year |
| | Rehabilitation services | \$4 Copayment / visit | Not Covered | Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic |
| | Habilitation services | \$4 Copayment / visit | Not Covered | Requires pre-auth, Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic |
| | Skilled nursing care | \$20 Copayment / day before Deductible | Not Covered | Requires pre-auth, Coverage is limited to 60 days per calendar year for Skilled Nursing combined with Inpatient rehabilitation |
| | Durable medical equipment | No Cost to You | Not Covered | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|-----------------------|------------------------|-------------------------|--|
| | | In-Network Provider | Out-Of-Network Provider | |
| | Hospice service | No Cost to You | 50% Coinsurance | Requires pre-auth; Coverage is limited to individuals with life expectancy of 6 months or less |
| If your child needs dental or eye care | Eye exam | \$10 Copayment / visit | 50% Coinsurance | Coverage is limited to 1 exam every 12 months up to age 19 |
| | Glasses | No Cost to You | 50% Coinsurance | Coverage is limited to 1 pair of standard frames & lenses per calendar year up to age 19 |
| | Dental check-up | Not Covered | Not Covered | —————none————— |

Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care unless related to treatment of diabetes • Weight loss programs |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | |
|---|---|
| <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids, 1 device per ear per CY |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1 (800) 235-7111**. You may also contact your state insurance department at **1-866-645-1790**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at **1-800-852-5494**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-800-852-5494**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-235-7111**.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,040
- Patient pays \$500

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$300 |
| Coinsurance | \$0 |
| Limits or exclusions | \$200 |
| Total | \$500 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,120
- Patient pays \$280

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$200 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$280 |

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different

depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Non-Discrimination and Accessibility Notice

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

QualChoice:

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

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

QualChoice Civil Rights Coordinator

QualChoice

P.O. Box 25610

Little Rock, AR 72221-5610

(501) 228-7111

Fax #: 501-707-6729

QCA_COE@qualchoice.com

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

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

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the “Section 1557 Coordinator”):

QualChoice Civil Rights Coordinator

QualChoice

P.O. Box 25610

Little Rock, AR 72221-5610

(501) 228-7111

Fax #: 501-707-6729

QCA_COE@qualchoice.com

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

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator’s decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal,

which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

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

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government. *ATTENTION: If you speak [insert language], 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 Mājōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelōk wōñāān. Kaalōk 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

1-800-235-7111 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقمهااتف الصم والبكم: 117).

German

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

French

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

Hmong

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

Korean

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

Portuguese

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

Japanese

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

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता 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).