This benefit summary is part of the Evidence of Coverage Certificate (Certificate), Form QCA POS LG NGF EOC (1-2019). It is subject to all benefit terms and conditions, limitations and exclusions included in the *Certificate* . It is meant only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the *Certificate* for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the *Certificate* is different than that in this benefit summary, the *Certificate* prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com. All Covered Services are subject to the Deductible and Coinsurance, unless otherwise specified in this Benefit Summary or *Certificate* .

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in balance billing costs to you as well as higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Maximum Out-of- Pocket limits. See the "Member Financial Responsibility Comparison" section in the *Certificate.*

Medical Benefits and Covered Services	**In-Network** (You Pay)	**Out-of-Network** (You Pay)
Annual Deductible		
• The Deductible is calculated on a Calendar Year basis. • In-Network and Out-of-Network Deductibles apply separately. • Deductible amounts applied in the last quarter of a calendar year *will not* carryover to the next calendar year. • Copayments are not included in the Deductible. • All Individual Deductible amounts will count toward the satisfaction of the Family Deductible, but an individual will not have to pay more than the Individual Deductible amount.	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000
Maximum Out-of-Pocket Limit		
• Out-of-Pocket Limit is calculated on a Calendar Year basis. • Applicable coinsurance will apply until the Maximum Out-of-Pocket is met. • Out-Of-Pocket Limit includes Deductible, Coinsurance and Copayments. • Benefits will be paid at 100% of the Maximum Allowable Charge once the Individual or Family Out-of-Pocket Limit is satisfied, whichever applies. • All individual Out-of-Pocket amounts will count toward the satisfaction of the Family Out-of-Pocket Limit, but an Individual will not have to pay more than the Individual Out-of-Pocket Limit for covered charges. • Maximum Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits.	Individual: $4,500 Family: $9,000	Individual: $9,000 Family: $18,000

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Immunizations[1] *(see QualChoice medical policies for covered immunizations)*		
Adult (age 19 and older)	No Cost to You	Not Covered
Child (age 0-19)	No Cost to You	Not Covered
Preventive Services[2]		
Annual Physical	No Cost to You	Not Covered
Pap Smear (1 per 3 years)	No Cost to You	Not Covered
Screening Mammogram (including breast exam) age 40 and older	No Cost to You	Not Covered
Prostate Screening for men age 40 and older	No Cost to You	Not Covered
Bone Density Screening tests, preventive for women age 65 and older	No Cost to You	Not Covered
Colon Cancer Screening, age 50 and older	No Cost to You	Not Covered
Family Planning		
Tubal Ligation and Associated Services	No Cost to You	Not Covered
Insertion or Implantation of Birth Control Pellets, Capsules or IUDs	No Cost to You	Not Covered
Fitting and Insertion of Diaphragms, Rings or Caps	No Cost to You	Not Covered
Injection of Long Acting Contraceptives	No Cost to You	Not Covered
Primary Care Physician Office Visit		
Evaluation/Management	$30 Copayment	40% after Deductible
Routine Care	No Cost to You	40% after Deductible
Complex Care	20%	40% after Deductible
Advanced Care	20% after Deductible	40% after Deductible
Specialist Office Visit		
Evaluation/Management	$50 Copayment	40% after Deductible
Routine Care	No Cost to You	40% after Deductible
Complex Care	20%	40% after Deductible
Advanced Care	20% after Deductible	40% after Deductible
Inpatient Care		
Physician Services	20% after Deductible	40% after Deductible
Room and Board	20% after Deductible	40% after Deductible
Skilled Nursing and Inpatient Rehabilitation - 30 day limit per calendar year	20% after Deductible	40% after Deductible
Neurological Rehabilitation Facility Services 60 days lifetime maximum	20% after Deductible	40% after Deductible
Facility Services	20% after Deductible	40% after Deductible
Outpatient Care		
Physician Services	20% after Deductible	40% after Deductible
Facility Services	20% after Deductible	40% after Deductible
Observation Services	20% after Deductible	40% after Deductible
Diagnostic Services[3]	20% after Deductible	40% after Deductible
Hospice Services - Limited to a lifetime maximum of 180 days	20% after Deductible	40% after Deductible
Surgical Services	20% after Deductible	40% after Deductible
Home Health Care - 40 visit limit per calendar year	20% after Deductible	40% after Deductible
Emergency Services		
Emergency Room	$200 Copayment	$200 Copayment
Urgent Care	$50 Copayment	40% after Deductible
Transportation Services[5]		
Ground Ambulance - $1,000 per trip	20%	20%
Air Ambulance - $5,000 per trip	20%	20%

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Rehabilitation Services (Combined 30 visits per calendar year excluding cardiac rehab) *Therapy services provided and billed by a licensed Physical, Occupational or Speech Therapist is a PCP Copayment.*		
Physical therapy	$50 Copayment	40% after Deductible
Occupational therapy	$50 Copayment	40% after Deductible
Speech therapy and Audiology testing	$50 Copayment	40% after Deductible
Chiropractic care	$50 Copayment	40% after Deductible
Cardiac rehab (36 visits per calendar year)	$50 Copayment	40% after Deductible
Maternity Services		
Initial Office Visit *All other services are subject to your inpatient and outpatient benefits*	$30 Copayment	40% after Deductible
Infertility Diagnostic Services only	20% after Deductible	Not Covered
Infertility Treatment (limited to 1 cycle of in vitro fertilization treatment per lifetime)	Not Covered	Not Covered
Mental Health and Substance Abuse Disorder[3]		
Office Visit - Consultation, Evaluation and Psychotherapy	$50 Copayment	40% after Deductible
Outpatient (other services and procedures provided in office or outpatient facility)	20% after Deductible	40% after Deductible
Partial Hospitalization	20% after Deductible	40% after Deductible
Inpatient Hospital Services	20% after Deductible	40% after Deductible
Professional Inpatient Services	20% after Deductible	40% after Deductible
Allergy Services		
Office Visit	$50 Copayment	40% after Deductible
Allergy Testing	No Cost to You	40% after Deductible
Allergy Shots	No Cost to You	40% after Deductible
Allergy Serum	20% after Deductible	40% after Deductible
Medical Supplies		
Provided in a Physician's Office	20% after Deductible	40% after Deductible
Home Infusion Therapy Supplies	20% after Deductible	40% after Deductible
Reconstructive Surgery		
Breast Reconstruction Following Mastectomy	20% after Deductible	40% after Deductible
Restoration due to acute trauma, infection or cancer	20% after Deductible	40% after Deductible
Transplantation Services[7] Lifetime maximum of 2 transplants		
Inpatient Physician Services	20% after Deductible	Not Covered
Inpatient Facility Services	20% after Deductible	Not Covered
Outpatient Care	20% after Deductible	Not Covered
Diabetes Management Services		
Supplies[6] and Equipment	20% after Deductible	Not Covered
Insulin Pump	20% after Deductible	Not Covered
Diabetic Education (1 training per lifetime)	$50 Copayment	40% after Deductible
Other Medical Services		
Durable Medical Equipment and Related Supplies	20% after Deductible	Not Covered
Home Phototherapy Devices	$100 Copayment	Not Covered
Genetic Counseling	20% after Deductible	40% after Deductible
Genetic Testing[3]	20% after Deductible	Not Covered
Prosthetic and Orthotic Devices (1 per 3 years unless medically necessary)	20% after Deductible	40% after Deductible

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Other Medical Services		
Hearing Aids ($1,400 per ear)[4]	Not Covered	Not Covered
Temporomandibular Joint Disorder	Not Covered	Not Covered
Smoking Cessation (two 12-week programs per calendar year)	No Cost to You	Not Covered
Vision		
Routine Vision Exam (1 per 24 months, age 19 and older)	$30 Copayment	Not Covered
Routine Pediatric Vision Exam (1 per 24 months, up to age 19)	$30 Copayment	Not Covered
Glasses (lenses and frames) (1 per 24 months, up to age 19)	Not Covered	Not Covered
Dental		
Accidental Injury (limit $2,000 per accident)[4]	20% after Deductible	40% after Deductible
Cleaning (2 per calendar year, up to age 19)	Not Covered	Not Covered
Exam (2 per calendar year, up to age 19)	Not Covered	Not Covered
Basic Services (up to age 19)	Not Covered	Not Covered
Major Services (up to age 19)	Not Covered	Not Covered
Orthodontic Services (up to age 19)	Not Covered	Not Covered
Prescription Drugs[8]		
Deductible	Not Applicable	Not Applicable
Tier 1	$15 Copayment	Not Covered
Tier 2	$35 Copayment	Not Covered
Tier 3	$50 Copayment	Not Covered
Tier 5	$100 Copayment	Not Covered

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

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

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

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

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

Ambulance is only covered if it is deemed Medical Necessary by QualChoice, and only to the closest appropriate facility. Travel by air ambulance will only be covered if such travel will result in quicker arrival at the closest appropriate facility and if the difference in travel time is likely to improve outcome.

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

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

[8]Prescription Benefit Limitations

· Retail Pharmacy - One (1) monthly cost sharing amount per 30 day supply
· Mail Order Pharmacy - Three (3) monthly cost sharing amount per 90 day supply

Additional Information regarding your Prescription Benefit:

· Non-maintenance medications are limited to a 30 day supply. Maintenance medications, retail or mail order, available up to a 90 day supply.
· Insulin and syringes will be covered with one (1) monthly cost sharing amount for each 30 day supply, if filled at the same time.
· Test strips and lancets will be covered with one (1) monthly cost sharing amount for each 30 day supply, if filled at the same time.
· Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.
· Step Therapy - Certain medication may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other therapy is the first line medication fails. Contact Customer Service at 1-800-235-7111 for more details.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1 (800) 235-7111 or visit us at www.qualchoice.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms 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:
What is the overall deductible?	In-Network: Individual $1,500/Family $3,000 Out-of-network: Individual $3,000/Family $6,000	Calendar year embedded. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prescription drugs, and physician office visits are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $4,500/Family $9,000 Out-of-network: Individual $9,000/Family $18,000	Calendar year embedded. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	Yes. See the Complete Network www.qualchoice.com or call 1 (800) 235-7111 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan may pay some or all of the costs to see a specialist for covered services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copayment / visit; Deductible does not apply	40% Coinsurance	Copayment is for Evaluation/Management & Routine Care. 20% Coinsurance for Complex Care, Deductible does not apply. 20% Coinsurance for Advanced Care
	Specialist visit	$50 Copayment / visit; Deductible does not apply	40% Coinsurance	Copayment is for Evaluation/Management & Routine Care. 20% Coinsurance for Complex Care, Deductible does not apply. 20% Coinsurance for Advanced Care
	Preventive care/screening/ immunization	No Cost	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	Requires pre-authorization; Drug testing and genetic testing are not covered out-of-network
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Requires pre-authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.qualchoice.com	Tier 1 (Generic drugs)	$15 Copayment / prescription at retail; $45 Copayment / prescription at mail	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail/mail order prescription) Pre-authorization/step-therapy may apply Maximum quantity per claim may apply Your formulary is Enhanced Deductible does not apply
	Tier 2 (Preferred brand drugs)	$35 Copayment / prescription at retail, $105 Copayment / prescription at mail	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$50 Copayment / prescription at retail, $150 Copayment / prescription at mail	Not Covered	
	Tier 5 (Specialty drugs)	$100 Copayment / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Requires pre-authorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Requires pre-authorization
If you need immediate medical attention	Emergency room care	$200 Copayment / visit; Deductible does not apply	$200 Copayment / visit; Deductible does not apply	None
	Emergency medical transportation	20% Coinsurance Deductible does not apply	20% Coinsurance Deductible does not apply	Coverage is limited to $1,000/trip for ground ambulance and $5,000/trip for air ambulance
	Urgent care	$50 Copayment / visit; Deductible does not apply	40% Coinsurance	Requires pre-authorization
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Requires pre-authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Requires pre-authorization
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copayment / visit; Deductible does not apply	40% Coinsurance	Copayment is for Consultation, Evaluation and Psychotherapy only. 20% Coinsurance for all other outpatient services and procedures; requires pre-authorization; Drug testing is not covered out-of-network
	Inpatient services	20% Coinsurance	40% Coinsurance	Requires pre-authorization
If you are pregnant	Office visits	$30 Copayment / initial visit; Deductible does not apply	40% Coinsurance	Requires pre-authorization for service provided by an out of area provider
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Requires pre-authorization for service provided by an out of area provider
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	Requires pre-authorization for service provided by an out of area provider
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Requires pre-authorization, Coverage is limited to 40 visits per calendar year
	Rehabilitation services	$50 Copayment / visit; Deductible does not apply	40% Coinsurance	Requires pre-authorization, Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic Care
	Habilitation services	Not Covered	Not Covered	Requires pre-authorization, Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic Care
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Requires pre-authorization, Coverage is limited

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				to 30 days per calendar year for Inpatient Rehabilitation Services/Skilled Nursing Care
	Durable medical equipment	20% Coinsurance	Not Covered	Requires pre-authorization
	Hospice services	20% Coinsurance	40% Coinsurance	Requires pre-authorization, Coverage is limited to 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$30 Copayment / visit; Deductible does not apply	Not Covered	Coverage is limited to 1 exam every 24 months up to age 19.
	Children's glasses	Not Covered	Not Covered	Coverage is limited to 1 pair of standard frames & lenses per calendar year up to age 19.
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids, $1400/ear
- Infertility treatment, Limit 1 cycle of IVF per lifetime
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care unless related to treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: QualChoice phone number 1-800-235-7111; the state insurance department phone number 1-800-852-5494; Department of Labor's Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the state insurance department phone number 1-800-852-5494.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$1,500
■ Specialist copay	$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$60
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$1,500
■ Specialist copay	$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$1,500
■ Specialist copay	$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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, prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

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

Procedure:

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

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department

of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

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

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:

ATTENTION: Language assistance services, free of charge, are available to you.
Call 1-800-235-7111 (TTY: 711).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-235-7111 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711).

Lao
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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

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).