

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)
<p>Annual Deductible</p> <ul style="list-style-type: none"> The Deductible is calculated on a Calendar Year basis. In-Network and Out-of-Network Deductibles are combined. Deductible amounts applied in the last quarter of a calendar year <i>will not</i> carryover to the next calendar year. All Individual Deductible amounts will count toward the satisfaction of the Family Deductible, however benefits subject to the deductible are not payable until the entire Family Deductible has been met. 	<p>Individual: \$1,500 Family: \$3,000</p>	<p>Individual: \$1,500 Family: \$3,000</p>
<p>Maximum Out-of-Pocket Limit</p> <ul style="list-style-type: none"> 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 only includes Deductible and Coinsurance. Benefits will be paid at 100% of the Maximum Allowable Charge once the Individual or Family Out-of-Pocket Limit is satisfied, whichever applies. Applicable coinsurance will apply until the family HDHP Out-of-Pocket Limit is satisfied. Maximum Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. 	<p>Individual: \$3,000 Family: \$6,000</p>	<p>Individual: \$6,500 Family: \$13,000</p>

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Immunizations⁴ (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 Services²		
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	20% after Deductible	50% after Deductible
Routine Care	20% after Deductible	50% after Deductible
Complex Care	20% after Deductible	50% after Deductible
Advanced Care	20% after Deductible	50% after Deductible
Specialist Office Visit		
Evaluation/Management	20% after Deductible	50% after Deductible
Routine Care	20% after Deductible	50% after Deductible
Complex Care	20% after Deductible	50% after Deductible
Advanced Care	20% after Deductible	50% after Deductible
Inpatient Care		
Physician Services	20% after Deductible	50% after Deductible
Room and Board	20% after Deductible	50% after Deductible
Skilled Nursing and Inpatient Rehabilitation - 30 day limit per calendar year	20% after Deductible	50% after Deductible
Neurological Rehabilitation Facility Services 60 days lifetime maximum	20% after Deductible	50% after Deductible
Facility Services	20% after Deductible	50% after Deductible
Outpatient Care		
Physician Services	20% after Deductible	50% after Deductible
Facility Services	20% after Deductible	50% after Deductible
Observation Services	20% after Deductible	50% after Deductible
Diagnostic Services ³	20% after Deductible	50% after Deductible
Hospice Services - Limited to a lifetime maximum of 180 days	20% after Deductible	50% after Deductible
Surgical Services	20% after Deductible	50% after Deductible
Home Health Care - 40 visit limit per calendar year	20% after Deductible	50% after Deductible
Emergency Services		
Emergency Room	20% after Deductible	20% after Deductible
Urgent Care	20% after Deductible	50% after Deductible
Transportation Services⁵		
Ground Ambulance - \$1,000 per trip	20% after Deductible	20% after Deductible
Air Ambulance - \$5,000 per trip	20% after Deductible	20% after Deductible

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)		
Physical therapy	20% after Deductible	50% after Deductible
Occupational therapy	20% after Deductible	50% after Deductible
Speech therapy and Audiology testing	20% after Deductible	50% after Deductible
Chiropractic care	20% after Deductible	50% after Deductible
Cardiac rehab (36 visits per calendar year)	20% after Deductible	50% after Deductible
Maternity Services		
Initial Office Visit <i>All other services are subject to your inpatient and outpatient benefits</i>	20% after Deductible	50% 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 Disorder³		
Office Visit - Consultation, Evaluation and Psychotherapy	20% after Deductible	50% after Deductible
Outpatient (other services and procedures provided in office or outpatient facility)	20% after Deductible	50% after Deductible
Partial Hospitalization	20% after Deductible	50% after Deductible
Inpatient Hospital Services	20% after Deductible	50% after Deductible
Professional Inpatient Services	20% after Deductible	50% after Deductible
Allergy Services		
Office Visit	20% after Deductible	50% after Deductible
Allergy Testing	20% after Deductible	50% after Deductible
Allergy Shots	20% after Deductible	50% after Deductible
Allergy Serum	20% after Deductible	50% after Deductible
Medical Supplies		
Provided in a Physician's Office	20% after Deductible	50% after Deductible
Home Infusion Therapy Supplies	20% after Deductible	50% after Deductible
Reconstructive Surgery		
Breast Reconstruction Following Mastectomy	20% after Deductible	50% after Deductible
Restoration due to acute trauma, infection or cancer	20% after Deductible	50% after Deductible
Transplantation Services⁷		
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)	20% after Deductible	50% after Deductible
Other Medical Services		
Durable Medical Equipment and Related Supplies	20% after Deductible	Not Covered
Home Phototherapy Devices	20% after Deductible	Not Covered
Genetic Counseling	20% after Deductible	50% after Deductible
Genetic Testing ³	20% after Deductible	Not Covered
Prosthetic and Orthotic Devices (1 per 3 years unless medically necessary)	20% after Deductible	50% 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)	20% after Deductible	Not Covered
Routine Pediatric Vision Exam (1 per 24 months, up to age 19)	20% after Deductible	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	50% after Deductible
Cleaning (2 per calendar year, up to age 19)	Not Covered	Not Covered
Exam (2 per calendar year, up to age 19)	Not Covered	Not Covered
Basic Services (up to age 19)	Not Covered	Not Covered
Major Services (up to age 19)	Not Covered	Not Covered
Orthodontic Services (up to age 19)	Not Covered	Not Covered
Prescription Drugs⁸		
Deductible	Individual: \$1,500 Family: \$3,000	Not Applicable
Tier 1	20% after Deductible	Not Covered
Tier 2	20% after Deductible	Not Covered
Tier 3	20% after Deductible	Not Covered
Tier 5	20% after Deductible	Not Covered

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

²QualChoice 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

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

⁴This 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.

⁵This 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.

⁶Combinations 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.


⁷All 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.

⁸Prescription 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 <u>deductible</u>?	In-Network: Individual \$1,500/Family \$3,000 Out-of-network: Individual \$1,500/Family \$3,000	Calendar year non-embedded. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> is not subject to <u>deductible</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: Individual \$3,000/Family \$6,000 Out-of-network: Individual \$6,000/Family \$12,000	Calendar year non-embedded. The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See the Complete Network www.qualchoice.com or call 1 (800) 235-7111 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	This <u>plan</u> may pay some or all of the costs to see a <u>specialist</u> 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	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	20% <u>Coinsurance</u> also applies to Routine, Complex, and Advanced Care. Requires <u>pre-authorization</u>
	<u>Specialist</u> visit	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	20% <u>Coinsurance</u> also applies to Routine, Complex, and Advanced Care. Requires <u>pre-authorization</u>
	<u>Preventive care/screening/immunization</u>	No Cost	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> ; Drug testing and genetic testing are not covered out-of-network
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.qualchoice.com	Tier 1 (Generic drugs)	20% <u>Coinsurance</u>	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail/mail order prescription)
	Tier 2 (Preferred brand drugs)	20% <u>Coinsurance</u>	Not Covered	
	Tier 3 (Non-preferred brand drugs)	20% <u>Coinsurance</u>	Not Covered	
	Tier 5 (Specialty drugs)	20% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization/step-therapy</u> may apply Maximum quantity per <u>claim</u> may apply Your <u>formulary</u> is Enhanced
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Coverage is limited to \$1,000/trip for ground ambulance and \$5,000/trip for air ambulance

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)	
	<u>Urgent care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> ; Drug testing is not covered out-of-network
	Inpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u>
If you are pregnant	Office visits	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> for service provided by an out of area provider
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> for service provided by an out of area provider
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> for service provided by an out of area provider
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> , Coverage is limited to 40 visits per calendar year
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> , Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic Care
	<u>Habilitation services</u>	Not Covered	Not Covered	Requires <u>pre-authorization</u> , Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic Care
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> , Coverage is limited to 30 days per calendar year for Inpatient Rehabilitation Services/Skilled Nursing Care
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	Not Covered	Requires <u>pre-authorization</u>
	<u>Hospice services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Requires <u>pre-authorization</u> , Coverage is limited to 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	20% <u>Coinsurance</u>	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? **No.**

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)

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,760

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$90
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

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

