SCHEDULE OF BENEFITS

Subject to the exclusions, conditions and limitations of this Plan, a Covered Person is entitled to benefits for the Covered Services described in this ***Schedule of Benefits*** during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. The percentages for Coinsurance and Covered Services shown in this ***Schedule of Benefits*** are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the Covered Expense definition in the ***Defined Terms*** section.

Covered Services may be provided "In-Network" by a Preferred Provider or "Out-of-Network" by a Non-Preferred Provider. However, the Covered Person will maximize the benefits available when Covered Services are provided In-Network by a Provider that belongs to the Preferred Provider Organization Network (a Preferred Provider) and has a contract with the Claims Administrator to provide services and supplies to the Covered Person. The ***Your Closed Panel Preferred Provider Organization (PPO) Benefits*** section provides more detail regarding Preferred and Non-Preferred Providers and the Preferred Provider Organization Network.

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Appropriateness/Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the ***Your Closed Panel Preferred Provider Organization (PPO) Plan*** and the ***Managed Care*** sections. Covered Services that require Precertification, and any Penalty for failure to obtain a Precertification, are specified on the ***Schedule of Benefits***.

BENEFIT PERIOD	Calendar Year

PROGRAM DEDUCTIBLE

Individual Deductible

Preferred Care*	The Individual Deductible amount is equal to $2,000 in each Benefit Period. * The Preferred (In-Network) Care Individual Deductible amount may be subject to an annual cost of living adjustment for high deductible health plans offered with health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Covered Persons will be notified in advance of any changes to the Preferred (In-Network) Care Individual Deductible amount.

COINSURANCE
(Covered Person's Responsibility)

Preferred Care	20% for Covered Services, except as otherwise specified in the ***Schedule of Benefits***. Coinsurance described above applies to all Preferred Covered Services except as may otherwise be indicated by the coverage percentages set forth in the following pages.

OUT-OF-POCKET LIMIT

INDIVIDUAL OUT-OF-POCKET LIMIT

Preferred Care	After $3,000* of Copayment, Deductible and Coinsurance expense has been Incurred by the Covered Person for Preferred Covered Services in each Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that Benefit Period. * The amount of the Preferred (In-Network) Care Individual Out-of-Pocket Limit may be subject to an annual cost of living adjustment for high deductible health plans offered with health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Covered Persons will be notified in advance of any changes to the Preferred (In-Network) Care Individual Out-of-Pocket Limit amount.

LIFETIME MAXIMUM

Preferred Care	Unlimited

REINSTATEMENT	Amounts applied to a Covered Person's Lifetime Maximum are not restorable.

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
OFFICE VISITS	80%	0%
PEDIATRIC IMMUNIZATIONS Deductible does not apply	100%	0%
ADULT PREVENTIVE CARE Deductible does not apply	100%, after a Copayment of $20 per visit.	0%
ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR Deductible does not apply	100%, after a Copayment of $20 (one examination per Benefit Period).	0%
MAMMOGRAMS Deductible does not apply	100%	0%
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT Maximum of six (6) visits per Benefit Period Preferred Deductible does not apply	100%	0%

INPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
HOSPITAL SERVICES Precertification required for all Inpatient admissions other than an admission for Emergency Care or Maternity Care.	100% Benefit Period Maximum: 365 Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
MEDICAL CARE	80%	0%
SKILLED NURSING CARE FACILITY Maximum of 120 Inpatient days per Benefit Period. Precertification required for all Skilled Nursing Care Facility Inpatient admissions.	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
BLOOD	80%	0%
HOSPICE SERVICES	80%	0%
Respite Care: Maximum of 7 days every 6 months. Precertification required for all Hospice Services.	Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	
MATERNITY/OB-GYN/FAMILY SERVICES		
Maternity/Obstetrical Care		
Professional Service	80%	0%
Facility Service	100%	0%
Elective Abortions Services		
Professional Service	80%	0%
Outpatient Facility Charges	80%	0%
Newborn Care	80%	0%
Artificial Insemination	80%	0%

INPATIENT/OUTPATIENT BENEFITS *(Continued)*	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
MENTAL HEALTH/PSYCHIATRIC CARE		
Inpatient Treatment	100% Benefit Period Maximum: 365 Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Outpatient Treatment Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Inpatient Treatment for Serious Mental Illness	100% Benefit Period Maximum: 365 Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Outpatient Treatment for Serious Mental Illness Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%

INPATIENT/OUTPATIENT BENEFITS *(Continued)*	If the Covered Person uses a **Preferred Provider**, the Plan will pay:	If the Covered Person uses a **Non-Preferred Provider**, the Plan will pay:
SURGICAL SERVICES	80%	0%
Outpatient Anesthesia	80%	0%
Second Surgical Opinion	80%	0%
	Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	

If more than 1 surgical procedure is performed by the same Professional Provider during the same operative session, the Claims Administrator will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.

TRANSPLANT SERVICES		
Inpatient Facility Charges	100%	0%
Outpatient Facility Charges	80%	0%
	Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	

TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY		
Inpatient Detoxification	100%	0%
	Benefit Period Maximum: 365 Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	

INPATIENT/OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Inpatient Treatment	100% Benefit Period Maximum: 365 Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Outpatient Treatment	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%

OUTPATIENT BENEFITS	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
AMBULANCE SERVICES		
Emergency Services	80%	0%
Non-Emergency Services	80% Failure to Precertify Preferred Non-Emergency Ambulance services will result in a 20% reduction in benefits payable.	0%
DAY REHABILITATION PROGRAM Benefit Period Maximum: Thirty (30) sessions	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
DIABETIC EDUCATION PROGRAM	80%	0%

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a <u>Preferred Provider</u>, the Plan will pay:**	**If the Covered Person uses a <u>Non-Preferred Provider</u>, the Plan will pay:**
DIABETIC EQUIPMENT AND SUPPLIES	80%	0%
DIAGNOSTIC SERVICES		
Routine Diagnostic/Radiology Services	80%	0%
Non-Routine Diagnostic/Radiology Services (including MRI/MRA, CT scans, Nuclear Cardiology Imaging and PET scans)	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Laboratory and Pathology Tests	80%	0%
DURABLE MEDICAL EQUIPMENT	80% Precertification of Preferred supplies is required for items with a billed amount that exceeds $500 (including replacements and repairs). Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
EMERGENCY CARE SERVICES	80%	80%
HOME HEALTH CARE	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
INJECTABLE MEDICATIONS		
Biotech/Specialty Injectables	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Standard Injectables	80%	0%

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
INSULIN AND ORAL AGENTS If this Plan does not provide coverage for prescription drugs, insulin and oral agents are covered	80%	0%
MEDICAL FOODS AND NUTRITIONAL FORMULAS	80%	0%
NON-SURGICAL DENTAL SERVICES	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
ORTHOTICS	80% Precertification of Preferred supplies is required for items with a billed amount that exceeds $500 (including replacements and repairs). Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
PODIATRIC CARE	80%	0%
PRIVATE DUTY NURSING SERVICES Benefit Period Maximum: 360 hours	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
PROSTHETIC DEVICES	80% Precertification of Preferred supplies is required for items with a billed amount that exceeds $500 (including replacements and repairs). Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
SPECIALIST OFFICE VISITS	80%	0%
SPINAL MANIPULATION SERVICES Benefit Period Maximum: 20 visits	80%	0%
THERAPY SERVICES		
Cardiac Rehabilitation Therapy Benefit Period Maximum: 36 sessions	80%	0%
Chemotherapy	80%	0%
Dialysis	80%	0%
Infusion Therapy	80% Failure to Precertify Preferred services will result in a 20% reduction in benefits payable.	0%
Orthoptic/Pleoptic Therapy Lifetime Maximum: 8 sessions	80%	0%
Pulmonary Rehabilitation Therapy Benefit Period Maximum: 36 sessions	80%	0%
Physical Therapy/Occupational Therapy Benefit Period Maximum: 30 sessions of Physical Therapy/Occupational Therapy combined Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.	80%	0%
Radiation Therapy	80%	0%
Speech Therapy Benefit Period Maximum: 20 sessions	80%	0%

AMENDMENT TO YOUR PERSONAL CHOICE/PPO AGREEMENT

QCC INSURANCE COMPANY
(herein called the "Claims Administrator")

PRESCRIPTION DRUG BENEFIT AMENDMENT RIDER

This Amendment is issued to form part of QCC Insurance Company's Personal Choice Health Benefits Program Group Program Document.

All Plan provisions, including, but not limited to. Plan Deductible(s), Coinsurance amount(s), Out-of-Pocket Limit(s) Maximums and Lifetime Maximum amounts, as reflected in the Personal Choice/PPO booklet will apply to Prescription Drugs.

This Amendment changes the provisions, conditions or other terms of said Contract and booklet as follows:

1. The ***Defined Terms*** section is amended:

   A. For the purposes of this notice of change, the definition of "Covered Expense" is expanded to include the following:

      D. For services rendered by Pharmacies, "Covered Expense" means the following:

         1. For Covered Services rendered by a Preferred Pharmacy, the amount that the Claims Administrator has negotiated with the Preferred Pharmacy as total reimbursement for a Covered Prescription Drug.
         2. For Covered Services rendered by a Non-Preferred Pharmacy, the lesser of the Non-Preferred Pharmacy's billed charge for the Covered Prescription Drug, or 150% of the average wholesale price for the same Covered Prescription Drug.

   B. The definitions of "Non-Preferred Provider", "Preferred Provider" and "Provider" are expanded to include "Pharmacy."

   C. The following definitions are added:

      BRAND NAME DRUG - a Prescription Drug produced by a manufacturer awarded the original patent for that specific drug or combination of drugs and satisfying the requirements of the U. S Food and Drug Administration (FDA) and applicable state law and regulation. For purposes of this coverage, "Prescription Drug" shall also mean devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

      DRUG FORMULARY - a list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable Physicians, dentists, and, as appropriate, other practitioners to prescribe all Medically Necessary treatment of a Covered Person's condition.

      GENERIC DRUGS – any form of a particular drug which is sold by a manufacturer other than the original patent holder, approved by the FDA as generically equivalent, and in compliance with applicable state laws and regulations.

      NON-PREFERRED MAIL ORDER PHARMACY - a Mail Order Pharmacy that is not a member of the Personal Choice Network.

      NON-PREFERRED PHARMACY - a Pharmacy that is not a member of the Personal Choice/PPO Network.

      PHARMACIST - an individual who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

      PHARMACY - any establishment which is registered and licensed as a Pharmacy with the appropriate State licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

PREFERRED MAIL ORDER PHARMACY - a Pharmacy that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract to provide Covered Persons with mail order prescription drug services.

PREFERRED PHARMACY - a Pharmacy that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for Prescription Drugs provided to Covered Persons.

PRESCRIPTION DRUG - (a) any medication approved by the Claims Administrator and which by Federal and or state laws may be dispensed with a Prescription Order, and (b) insulin. The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Claims Administrator. For purposes of this coverage, "Prescription Drug" shall also mean devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

PRESCRIPTION ORDER - the request in accordance with applicable laws and regulations for medication issued by a Professional Provider.

2. The ***Schedule of Benefits*** is amended:

The following subsection is added:

	If the Covered Person uses a Preferred Provider, the Plan will pay:	**If the Covered Person uses a Non-Preferred Provider,** the Plan will pay:
PRESCRIPTION DRUGS All Plan provisions, including, but not limited to, Plan Deductible(s), Coinsurance amount(s), Out-of-Pocket Limit(s) Maximums and Lifetime Maximum amounts, as reflected in the Personal Choice/PPO booklet will apply to Prescription Drugs.		
Retail Pharmacy	80%	0%
Mail Order Pharmacy	80%	0%

3. The subsection entitled **"PAYMENT OF PROVIDERS"** in ***Your Personal Choice/PPO Network Plan*** section is expanded:

A. The following is added to "Network Provider Reimbursement":

Pharmacy

A pharmacy benefits management company (PBM), which is affiliated with Independence Blue Cross, administers our Prescription Drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The Claims Administrator anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Prescription Drugs are subject to a Covered Person's cost-sharing, including Copayment, Coinsurance and Deductible, as applicable.

B. The following is added to "Payment Methods":

Pharmacies

Preferred Pharmacies
With respect to Preferred Pharmacies, benefits will be provided as specified in the ***Schedule of Benefits*** (contained in Section 2. of this Notice) for the provision of Preferred services or supplies.
The Claims Administrator will compensate Preferred Pharmacies in accordance with the agreements in effect with respect to services or supplies provided to Covered Persons.

Non-Preferred Pharmacies
With respect to Non-Preferred Pharmacies, benefits will be provided to the Covered Person at the Non-Preferred Coinsurance level specified in the Schedule of Benefits (contained in Section 2. of this Notice).

Any applicable cost-sharing (such as Deductible and Coinsurance amounts) specified in the ***Schedule of Benefits*** will be applied to the Covered Expense amount. The Covered Person will be penalized by the application of a higher Coinsurance level as detailed in the ***Schedule of Benefits***. A Non-Preferred Pharmacy is entitled to collect from the Covered Person any cost-sharing obligation and the remaining balance due.

4. The ***Description of Benefits*** section is expanded to include the following:

PRESCRIPTION DRUGS/MEDICINES

After each Covered Person satisfies the Deductible amount for the Benefit Period, benefits will be provided for covered Prescription Drugs and medicines prescribed by a Physician and dispensed by a licensed Pharmacy*. Benefits for Prescription Drugs are available for a thirty (30) day supply, or the appropriate therapeutic limit, whichever is less, when dispensed from a retail Pharmacy.

Benefits shall also be provided for covered Prescription Drugs prescribed for a chronic condition and ordered by mail if a Covered Person or the prescribing Physician submits to a Preferred Mail Order Pharmacy a written Prescription Drug Order specifying the amount of the covered Prescription Drug to be supplied. Benefits shall be available for up to a ninety (90) day supply of a covered Prescription Drug, subject to the amount specified in the Prescription Drug Order and applicable law.

Prescription Drug Deductible amounts apply to Prescription Drugs dispensed by a retail or mail order Preferred or Non-Preferred Pharmacy.

* If the Claims Administrator determines Prescription Drug usage by any Covered Person appears to exceed usage generally considered appropriate under the circumstances, the Claims Administrator shall have the right to direct that Covered Person to one Pharmacy for all future Prescription Drug Covered Services.

In certain cases, the Claims Administrator may determine that the use of certain Prescription Drugs for a Covered Person's medical condition requires Precertification for Medical Necessity. The Claims Administrator also reserves the right to establish eligible dosage limits of certain Prescription Drugs covered by the Claims Administrator.

For questions concerning pharmaceutical management procedures such as Precertification requirements, prescription limits, use of generic substitution, therapeutic interchange or step therapy protocols and Deductible and Coinsurance amounts, the Covered Person may call the Member Services telephone number on the back of the Covered Person's Identification Card.

A. **Prescription Drugs shall mean drugs or medications (including insulin)**:

1. Which by law require a Prescription Order to dispense;

2. Which are approved by the Claims Administrator and approved for distribution by the federal government;

3. For which Medical Necessity exists; and

4. Which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

B. **Benefits will not be payable for**:

1. Drugs used for Experimental/Investigative purposes;

2. Health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents;

3. Vitamins, unless they require a prescription and are Medically Necessary for the treatment of a specific illness, as determined by the Claims Administrator;

4. Prescription Drugs for which there is an equivalent that does not require a Prescription Order, (i.e. over-the-counter medicines), whether or not prescribed by a physician. This exclusion does not apply to insulin;

5. Drugs which have no currently accepted medical use for treatment in the United States;

6. Drugs dispensed to a Covered Person while a patient in a Hospital, nursing home or other institution;

7. Administration or injection of drugs;

8. Devices of any type, even though such devices may require a Prescription Order. This includes, but is not limited to contraceptive devices, therapeutic devices or appliances, hypodermic needles, syringes or similar devices. This exclusion does not apply to: (a) devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin, and (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines;

9. Drugs used for cosmetic purposes, such as wrinkle removal or hair growth;

10. Smoking deterrent agents;

11. Injectables used for the treatment of infertility when they are prescribed solely to enhance or facilitate conception;

12. Prescription Drugs not approved by the Claims Administrator or prescribed drug amounts exceeding the eligible dosage limits established by the Claims Administrator.

5. The ***Managed Care*** section is amended:

The subsection entitled "**SERVICES REQUIRING PRECERTIFICATION**" is expanded to include the following:

CERTAIN PRESCRIPTION DRUGS

All other terms of the Group Program Document shall remain in effect.