POLICY

Iowa Small Group HMO Policy

Health Alliance™

Health Alliance Midwest complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex. Health Alliance Midwest does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity or sex. Health Alliance Midwest:

- 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.

If you believe that Health Alliance Midwest has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity or sex, you can file a grievance with: Health Alliance Midwest, Customer Service, 3310 Fields South Drive, Champaign, Illinois 61822, telephone: 1-800-851-3379, TTY: 711, fax: 217-902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service 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, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For Language Access Services:

English:
If you, or someone you're helping, have questions about Health Alliance Midwest, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-851-3379.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-851-3379 (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-851-3379 (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 1-800-851-3379（TTY：711）。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-851-3379 (TTY: 711) 번으로 전화해 주십시오.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-851-3379 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم711 (رقم هاتف الصم والبكم: 3379-
1 -800 -8 51

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-851-3379 (телетайп: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન1-800-851-3379 (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 1-800-851-3379 (TTY: 711).

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-851-3379 (TTY: 711).

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-851-3379 (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。
1-800-851-3379（TTY:711）まで、お電話にてご連絡ください。

Pennsylvanian Dutch:
LET OP: Services Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-851-3379 (TTY: 711).

Ukrainian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-851-3379 (телетайп: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-851-3379 (TTY: 711).

HEALTH ALLIANCE MIDWEST HMO

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MEMBERS' RIGHTS AND RESPONSIBILITIES

- A right to receive information about Health Alliance, the services Health Alliance provides, the doctors and other healthcare professionals that Health Alliance contracts with and the Member's rights and responsibilities
- A right to be treated with respect and dignity and to be given a right to privacy
- A right to participate with contracted Providers in making decisions about your healthcare
- A right to have a candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Health Alliance or the care provided
- A right to make recommendations regarding Health Alliance Members' rights and responsibilities Policy
- A right to have reasonable access to healthcare
- A right to receive information in a way that works for you (in languages other than English, in Braille, in large print or other alternate formats, etc.)

- A responsibility to supply, to the extent possible, information Health Alliance and its contracted practitioners and Providers need to provide care
- A responsibility to follow the Plans and instructions for care you have agreed on with your Providers
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- A responsibility to read and understand your Policy and follow the rules of membership
- A responsibility to know the Providers in your network
- A responsibility to notify Health Alliance in a timely manner of any changes in your status as a Member or that of any of your covered Dependents

HEALTH ALLIANCE MIDWEST HMO

INTRODUCTION

The Health Alliance Midwest HMO is a Health Maintenance Organization Plan established as a fully insured product of Health Alliance Midwest, Inc. (Health Alliance), an Illinois health maintenance organization that is authorized and certified to do business in the state of Iowa. Health Alliance administers all aspects of Health Alliance Midwest HMO, which is located at 3310 Fields South Drive, Champaign, Illinois 61822.

This Policy, along with the Description of Coverage and the Summary of Benefits and Coverage (SBC), describes the healthcare Plan chosen by your Employer Group. It is important for you to read this Policy as it explains your rights, benefits and responsibilities as a Health Alliance HMO Member. As a Member, you are subject to all terms and conditions of this Policy and payment of Copayments, Coinsurance and Deductible amounts, as specified on the Description of Coverage and/or the SBC.

Health Alliance Customer Service Representatives are available to help you understand your healthcare Plan. We encourage you to call the number on the back of your Health Alliance Identification Card to speak with one of our representatives about your benefits.

HOW THE HEALTH ALLIANCE MIDWEST HMO PLAN WORKS

The Health Alliance Midwest HMO Plan provides coverage for Medically Necessary healthcare services in exchange for your agreement to certain limitations. You are required to receive all your covered medical care from the Physicians, Hospitals and other Providers within your Health Alliance Provider Network, also referred to as Participating Providers. You are also required to have all your medical care coordinated by your Primary Care Physician whom you select from a list of available Primary Care Physicians in your Provider Network.

A Provider Directory listing Participating Providers by specialty with addresses and telephone numbers is available at HealthAlliance.org. Click on “Finding Care” in the site’s directory. We encourage you to create a login to view your Plan-specific Providers and other Plan information. If you do not have access to the internet or prefer to have a printed copy of the Provider Directory, a paper directory can be provided upon request. If your Primary Care Physician believes you require care from a specialist or other Provider, your Primary Care Physician may refer you to the appropriate Provider. In addition, Preauthorization from Health Alliance is required for some types of care.

Your Relationship with Your Primary Care Physician
Our health maintenance organization (HMO) plan gives you access to a large statewide network that continues to grow with virtual healthcare options. We recommend choosing a Primary Care Physician to support your health and make sure you get the care you need. We want you to have an open and honest relationship with your Primary Care Physician because this Physician will help direct all your healthcare needs. You may change your Primary Care Physician by calling Health Alliance at the number on the back of your Health Alliance Identification Card or by writing to Health Alliance. Please note that a change in Primary Care Physician may change your Provider Network.

In addition to their Primary Care Physician, female Members may select a Women’s Principal Healthcare Provider to provide covered services within the scope of his or her license without a referral from a Primary Care Physician. A Women’s Principal Healthcare Provider must be selected from among the list of Participating Providers in your Provider Network.

A Primary Care Physician (allopathic or osteopathic) who specializes in pediatrics may be selected for your Dependent children on this Plan.

You don't need a referral to see in-network specialists. You will also have coverage for out-of-network emergency and urgent care.

Health Alliance requires Primary Care Physicians to provide access or direction to patients when they are unavailable or after hours. Health Alliance Members also have access to the Patient Advisory line. This phone number is listed on the back of your Health Alliance Identification Card.

The Relationship Between Health Alliance and Participating Providers
Participating Providers are responsible for providing you with the services covered by this Policy. Health Alliance has contracted with Participating Providers to provide you with covered services. Health Alliance does not provide medical services or make medical treatment decisions. Participating Providers are independent contractors and are not agents of Health Alliance. We have not given the Participating Providers the authority to act on behalf of Health Alliance in any manner or to make any promises or representations to you on its behalf. Participating Providers are responsible for the services they provide to you, including the healthcare services covered under this Policy. They are responsible for the manner and skill with which those services are provided or rendered.

Specialty Care from Participating Providers
If your Primary Care Physician believes specialty care is Medically Necessary, he or she may refer you to a Participating Provider in your Provider Network. Physicians, Hospitals, Mental Health and other healthcare Providers are listed in the Provider Directory for your Provider Network by specialty with addresses and telephone numbers. Your Primary Care Physician will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, your Primary Care Physician may give you a standing referral. A standing referral will be effective for either the time period or number of visits specified by your Primary Care Physician.

If the specialty services needed are not available from a Participating Provider in your Provider Network, a referral from your Primary Care Physician and Preauthorization from Health Alliance are required for coverage of the specialty services. Non-Participating Provider services are covered only when a Participating Provider cannot provide the requested Medically Necessary services, except Emergency Services. Female Members may obtain services from a Participating Women's Principal Healthcare Provider without a referral from a Primary Care Physician.

Non-Participating Providers or Out-of-Network Coverage
Health Alliance will not cover services rendered by a Non-Participating Provider, except for Emergency Services, or otherwise specified in this Policy, unless your Primary Care Physician or Women's Principal Healthcare Provider refers you and you receive Preauthorization from Health Alliance.

Termination or Non-Renewal of Participating Providers
In the event that Health Alliance chooses to terminate or not renew a Participating Provider's contract, the Policyholder and Provider will be notified within 60 days. If a Provider notifies us of their intent to terminate their relationship with Health Alliance, we will notify you within 60 days or as soon as possible after Health Alliance receives notice. In the event that the Provider's license has been disciplined by a state licensing board, immediate written notice may be provided.

Continued Care Coverage with Terminating Physicians
If your treating Physician's contract terminates, you may be eligible for coverage of continued treatment by that Physician during a transitional period if you are in an ongoing course of treatment or if you are pregnant. The following conditions must be met: the Physician termination did not involve potential harm to a patient or disciplinary action by a state licensing board; the Physician remains in your Service Area; and the Physician agrees to abide by the terms and conditions of the terminating contract or unless otherwise approved by Health Alliance. You must contact Health Alliance at the number on the back of your Health Alliance Identification Card within 30 days of receiving the termination notice if you want coverage of continued care with a terminating Physician.

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, including but not limited to, serious or complex health conditions, institutional or inpatient care, non-elective surgery, pregnancy and/or treatment for a terminal illness, Health Alliance will cover continued treatment with your Physician for a period of 90 days at their previous level of coverage. The 90-day period starts on the date you receive notice from Health Alliance that your Physician's contract with Health Alliance is terminating.

- **Maternity Care**
  If you are pregnant and have entered the second or third trimester of your pregnancy by the date of your Provider's termination, Health Alliance will cover continued care with that Provider at their previous level of coverage through postpartum care.

Continued Care Coverage for New Members
If your treating Physician is not a Participating Provider in your Service Area, you may be eligible for coverage of continued treatment during a transitional period with that Physician if you are in an ongoing course of treatment or if you are pregnant. Your Physician must agree to accept reimbursement rates similar to other Participating Providers in the Provider Network and comply with Health Alliance quality assurance requirements and policies and procedures. You must contact Health Alliance within 15 days of your Effective Date of coverage if you want coverage of continued care with your Non-Participating Physician.

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, including but not limited to, serious or complex health conditions, institutional or inpatient care, non-elective surgery, pregnancy and/or treatment for a terminal illness, Health Alliance will cover continued treatment with your treating Physician for a period of 90 days from your Effective Date of coverage.

- **Maternity Care**
  If you are pregnant and have entered your second or third trimester of your pregnancy on your Effective Date of coverage, Health Alliance will cover continued care with your treating Physician through postpartum care.

Notice of Member's Right to Appeal a Surprise Bill
When you receive services from an in-network Hospital or ambulatory surgical center, certain Providers may be out-of-network. In these cases, the most those Providers may bill you is your Plan's applicable in-network cost-share. This applies to Emergency Services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network Providers can't balance bill you, unless you give written consent and give up your protections.

PREAUTHORIZATION

Participating Provider Preauthorization Procedure
Health Alliance maintains a list of services that require Preauthorization for Medical Necessity. Your Primary Care Physician or, Participating Provider is responsible for obtaining Preauthorization from Health Alliance on your behalf. If the Preauthorization request is approved, you and your Provider will be notified of the Effective Dates and the kind of care and services you are authorized to receive. If the Preauthorization request is denied, your Provider will be notified in writing. If the Preauthorization request is denied, the Plan will not provide coverage for the requested services.

Non-Participating Provider or Extended Network Preauthorization Procedure
When using Non-Participating Providers or Extended Network Providers, you are responsible for ensuring that all services listed are Preauthorized before you receive the service. If the Preauthorization request is approved, both you and your Provider will be notified of the Effective Dates and the kind of care and services you are authorized

to receive. Once your Preauthorization approval expires, it is your responsibility to notify your Provider so he/she can determine whether further care is needed, and if so, submit another Preauthorization request to Health Alliance.

If your Preauthorization request is denied, Health Alliance will not provide coverage for the requested services. Health Alliance maintains a list of services that require Preauthorization for Medical Necessity. Preauthorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims)
Health Alliance maintains a list of services that require Preauthorization for Medical Necessity. Preauthorization must be obtained prior to a scheduled hospitalization, procedure or purchase of a supply requiring Preauthorization, as described on HealthAlliance.org. Health Alliance will make a coverage decision and notify you or your authorized representative in writing within 15 days of receipt of the request for Preauthorization but no later than 30 days after receiving all of the requested information.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within five days of the request for Preauthorization. You will have 45 days to provide the requested information. Health Alliance will make a coverage decision within 15 days of receipt of the additional information or within 15 days after the end of the period given to provide the additional information, whichever is earlier.

The determination period may be extended one time for 15 days due to circumstances beyond the control of Health Alliance. Health Alliance will notify you or your authorized representative in writing of the reason for the extension.

If your Preauthorization request is denied, you may request an appeal of the denial; see "Appeal Procedures for Non-Urgent Care Decisions (Pre-Service Claims)." If your Preauthorization request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness and you have exhausted the internal appeals process, you also have the right to request that decision be reviewed by an independent review organization; see "External Review of Appeals."

Preauthorization Procedures for Urgent Care (Pre-Service Claims)
Health Alliance maintains a list of services that require Preauthorization for Medical Necessity. Health Alliance will make a coverage decision for Urgent Care within 72 hours of the request. Health Alliance will try to reach you or your authorized representative by telephone as soon as a decision has been made. You or your authorized representative will be notified in writing or electronically within three days of the coverage decision.

If additional information is needed, Health Alliance will notify you or your authorized representative within 24 hours of the request specifying what information is needed to make a decision. You will have 48 hours to provide the requested information. Health Alliance will make a decision as soon as possible after receipt to the requested information, but no later than 48 hours after receipt.

If your Preauthorization request for Urgent Care is denied, you have the right to request an expedited internal appeal of the denial; see "Appeal Procedures for Urgent Care Decisions." If your Physician or other healthcare Provider believes that the denial of coverage of healthcare services or the time frame for completion of an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization. If your Preauthorization request is denied due to treatment being experimental or investigational and your Physician certifies in writing that treatment would be significantly less effective if not promptly initiated, you may request an expedited external review of the denial at the same time you request an expedited internal appeal of the denial; see "Expedited External Review of Appeals."

To determine which medical procedures or durable medical supplies require Preauthorization, log in to your account at HealthAlliance.org, and click on the Authorizations tab. In the section titled "Do I Need a

Preauthorization?" select either "Medical" or "Durable Medical Supplies" on the right, or call Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Notification of Emergency Services
If you are treated or are admitted as an inpatient for an Emergency Medical Condition, you must notify Health Alliance at the number listed on the back of your Health Alliance Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

COVERAGE DECISIONS

Concurrent Care Decisions
Any reduction or termination before the end of an approved period of time, length of stay or number of treatments is considered a denial of coverage. You will be notified in writing at a time sufficiently in advance of the reduction or termination to allow you or your authorized representative to request an internal appeal of the concurrent care decision and to obtain a determination on review before the coverage is reduced or terminated; see "Appeal Procedures for Concurrent Care Decisions."

You, your authorized representative, Physician or other healthcare Provider may request an internal appeal when coverage will be reduced or terminated for ongoing treatment or for Urgent Care. The appeal must be made at least 24 hours before the scheduled reduction or termination of coverage for treatment. For Urgent Care, the appeal must be made within 24 hours after the claim is sent to Health Alliance. Health Alliance will make a decision and notify you, your authorized representative, Physician and any healthcare Provider who recommended services by telephone within 24 hours of the request for an appeal. You, your authorized representative, Physician and any healthcare Provider who recommended services will receive written notice within three days of the decision.

If your Physician or other healthcare Provider believes that the denial of coverage of healthcare services or the time frame for an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization. If the denial of coverage is based on the determination that the requested treatment is experimental or investigational and your healthcare Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited review by an independent review organization; see "Expedited External Review of Appeals."

Coverage Decisions (Post-Service Claims)
Health Alliance will make a coverage decision within 30 days of receipt of a claim for payment or reimbursement of healthcare services that have already been provided. When any services are denied, you or your authorized representative will be notified in writing.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within 30 days of receipt of the claim. You will have 45 days to provide the requested information. Health Alliance will make a decision within 15 days of receipt of the additional information or within 15 days after the end of the period given to provide the additional information, whichever is earlier.

The determination period may be extended one time for 15 days due to circumstances beyond the control of your Plan. You or your authorized representative will be notified in writing of the reason for the extension.

If your claim for coverage is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, you have the right to request an internal review of the denial; see "Appeal Procedures for Coverage Decisions (Post-Service Claims)." If you have exhausted the internal appeals process, you have the right to request an external review by an independent review organization; see "External Review of Appeals."

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Individuals must meet the following requirements to be eligible for enrollment under the Plan:

Policyholder
The Policyholder must be a bona fide Employee, regularly employed on a permanent basis by the Employer Group, who enrolls under his or her Employer Group's health Plan with Health Alliance. A Policyholder is subject to all terms and conditions of the Group Enrollment Agreement.

Dependent
Your Dependent may be eligible to enroll under the Employer Group's Health Alliance Plan for coverage if he or she has one of the following relationships to the Policyholder:

- Your Spouse or legally recognized Spouse.
- Your natural-born, legally adopted child or stepchild.
- A child for whom you or your Spouse are the court-appointed legal guardian.
- A child placed in foster care or placed for adoption with you or your Spouse. Placement or placed means you assume and retain total or partial support of the child. If the child's placement terminates, upon termination the child will no longer be eligible for benefits under the Plan.

Examples of Dependents who are not eligible for coverage under the Plan include, but are not limited to, grandchildren (unless you are the legal guardian), parents and other relatives.

A person is not an eligible Dependent if on active duty in the Armed Forces or National Guard of any country or if covered under the Plan as an Employee.

An eligible Dependent child must be under the age of 26. For a Dependent to continue being covered by this Plan after his or her 26th birthday, the Dependent:

- Must have an apparent handicapped condition that does not allow him or her to stay employed
- Be totally Disabled and dependent on his or her parent (or other care Providers) for lifetime care and supervision

To continue coverage for the Dependent, you must submit documentary proof of the disability and dependency within 31 days when requested by Health Alliance or your Employer. These requests will be made no more than once a year from the date when Health Alliance was first notified of the Dependent's disability and dependency.

Student Status
An unmarried Dependent 26 years old or older may remain covered under the Plan only if the Dependent is enrolled as a full-time student at an Educational Institution. In order to qualify as a full-time student, the Dependent must be enrolled in the required number of hours or courses the school considers full-time attendance. Full-time student coverage will continue through normal breaks in periods of study, including summer breaks, as long as the student returns to school when the scheduled break ends.

Coverage for the unmarried full-time student will terminate on or after the date of graduation or cessation of studies or the date the child marries, whichever is earlier. You are responsible for notifying Health Alliance when your Dependent is no longer eligible for coverage as a full-time student.

An otherwise eligible Dependent who lost coverage due to failure to maintain full-time student status may become eligible for coverage again as a full-time student if the otherwise eligible Dependent is unmarried and is enrolled as a full-time student at an Educational Institution.

Coverage may continue for a Dependent full-time student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic illness or Injury, provided the need for part-time

status or medical leave of absence is supported by a clinical certification of need from a Physician. Coverage shall continue for 12 months after notice of the illness or Injury or until the coverage would have otherwise lapsed pursuant to the terms and conditions of the Policy, whichever comes first.

If your Employer Group elects Domestic Partner coverage, the following Dependents are also eligible Dependents on this plan:

- The child of a Domestic Partner that lives with you.
- A child who you, your Domestic Partner or your Legal Spouse are the court-appointed guardian of.
- A child placed for adoption with you, your Domestic Partner or your Legal Spouse. This means that you are partially supporting the child in the anticipation of adopting that child. If the adoption falls through, that child will no longer be eligible for benefits under the Plan.
- A Domestic Partner if:
    - Both you and your Domestic Partner are at least 18 years old.
    - You and your Domestic Partner share a common permanent residence.
    - Neither you nor your Domestic Partner is married, legally separated or a member of another domestic partnership.
    - Both you and your Domestic Partner are capable of consenting to the domestic partnership.
    - You and your Domestic Partner are not related by blood closer than permitted by state law for marriage.
    - Both you and your Domestic Partner agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.
        - *Basic living expenses* are considered shelter, utilities and all costs directly related to the maintenance of their common residence. It also includes any other costs, such as medical care if some or all of the cost is paid as a benefit because a person is another person's domestic partner.
        - *Joint responsibility* means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for him/herself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

Retired Employee Enrolled in Health Alliance Medicare Plans
If a Retired Employee is covered under this Plan, or is covered under a Health Alliance administered Medicare Advantage plan his or her Dependent Spouse and/or covered Dependent child(ren) may remain covered under this Plan if:

- The Spouse and/or Dependent child(ren) were covered under the Employer Group Plan at the time of the Employee's retirement.
- The Spouse and/or Dependent child(ren) continue to meet the eligibility requirements for Dependent coverage.
- Or as otherwise specified in the Group Enrollment Agreement.

Active Employees Enrolled in Medicare
In addition to this Plan, the Employer Group may offer a Medicare Advantage or Medicare Supplement plan administered by Health Alliance to active Employees who are Medicare eligible and Medicare is the primary payer. If offered, this plan will also be available to the Employee's Legal Spouse and Dependent children. If your Employer offers this option, you may choose to:

- enroll in this Plan
- enroll in the Employer Group's Medicare Advantage plan
- enroll in the Employer Group's Medicare Supplement plan

If enrollment in the Employer Group's Medicare Advantage plan is elected, those eligible individuals who are not enrolled in Medicare may be enrolled in this Health Alliance Group HMO Plan.

Contact your Employer for information concerning your eligibility for the Employer Group Medicare Advantage plan.

Newborns, Adopted Children, Children Placed for Adoption or Children Placed in Foster Care
If you are the birth mother paying premiums for individual coverage (Employee only), your Newborn child is covered only if you submit an application to your Employer within 60 days of the birth. If you are paying premiums for Family Coverage, your Newborn child is covered for the first 60 days of life. For the Newborn to be continually covered past the initial 60-day timeframe, you must submit an application to your Employer to add the child within 60 days of birth. Applications are available through your Employer.

Newborn coverage will include Medically Necessary care for illness, Injury, congenital defects, birth abnormalities and premature birth. A Newborn of a Dependent child is not covered.

If you adopt a child, serve as a child's legal guardian, a child is placed for adoption with you or placed in foster care with you, coverage is subject to the submission of written documentation accompanied by a completed application within 60 days from the date of the order or agreement. Examples of accepted written documentation include an interim court order or a final order of adoption, guardianship or placement for adoption or placed in foster care, signed by a judge.

Premiums for coverage of a Newborn, adopted child, child placed for adoption or placed in foster care will be payable from the date of eligibility and must be paid within 60 days from the date your request for coverage is received. Applications are available through your Employer.

Qualified Medical Child Support Order
The term "Qualified Medical Child Support Order" means an order that creates or recognizes the Dependent's right to receive benefits under this Plan. A support order may be issued by a state court or through a state administrative process. If the Policyholder has a Dependent child and your Employer Group receives a Medical Child Support Order Notice identifying the child's right to enroll in the Plan, your Employer will notify both the Policyholder and the Dependent that the order has been received. The notification will also indicate the procedure for determining whether the Medical Child Support Order is qualified.

Your Employer will notify you whether the Dependent is eligible for coverage within 31 days of receipt of the order. If the Employer Group offers more than one Plan option, the Dependent will be enrolled in the same Plan in which the Policyholder is enrolled. The Dependent's eligibility for enrollment will be under the same terms and conditions as other Dependents of the Plan. Your Employer does not need approval from you to add a Dependent to the Plan.

Children covered under a Qualified Medical Child Support Order and who reside in a Health Alliance Service Area that is different from the Health Alliance Service Area of the Policyholder will receive the same covered benefits as the Policyholder when utilizing contracted Providers in the Dependent's Health Alliance Service Area and following the Plan's requirements.

The Dependent may designate another person, such as a custodial parent or legal guardian, to receive reimbursement for claims, the Policy, Description of Coverage, the SBC, and other Plan materials.

If your Employer decides that the order is not a Qualified Medical Child Support Order, each Dependent specified in the order as entitled to enroll in the Plan may submit a written appeal to the Employer. The Employer is required to respond in writing within 31 days of receiving the appeal.

The Employer Group will not disenroll or discontinue coverage for any Dependent child until:

- Satisfactory written evidence is provided that the order is no longer effective.
- Comparable coverage through another plan will take effect no later than the disenrollment date.
- The Employer Group eliminates Dependent coverage for all Policyholders.
- The Employer Group terminates the Plan for all Members.

Enrollment of a Dependent in response to a Qualified Medical Child Support Order must be made according to the specifications of the order, without regard for normal enrollment dates.

Initial Enrollment
If you meet the requirements stated in the "Policyholder" or "Dependent" subsections and you also meet the Employer Group's eligibility requirements, you may enroll by submitting a completed form to your Employer within 31 days from your eligibility date.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, (which would constitute fraud or intentional misrepresentation of information), whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in the case of a minor, is required to reimburse Health Alliance for any and all sums paid on his or her behalf for healthcare services, along with any reasonable attorneys' fees and expenses incurred in the collection of such sums.

Effective Date
The Effective Date of coverage under this Plan depends on the Employer Group's eligibility requirements. The eligibility requirements are specified in the Group Enrollment Agreement between the Employer Group and Health Alliance. This Plan will remain in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Employer Group or Health Alliance.

Open Enrollment
An Employer Group may have an Open Enrollment Period where eligible Employees and his or her eligible Dependents may enroll in the Plan by submitting a completed application to their Employer within 31 days of the Employer Group's renewal date.

Special Enrollment
Federal law and this Policy describe special enrollment provisions, which establish a period of time in which you have the option to enroll in an Employer Group Plan when you or your Dependents experience a qualifying event.

To be eligible to enroll under one of these qualifying events, you must submit a written request to your Employer requesting changes in your coverage within 31 days of the event. Any request to add yourself or eligible Dependents after the 31-day period will not be granted. You and/or your eligible Dependents may enroll in any benefit package under the plan. You may be required to provide supporting documentation for the change in enrollment to Health Alliance.

You and your Dependents are eligible for a special enrollment period of 31 days when one of the following qualifying events occurs:

- You and/or your Dependents are eligible for a special enrollment period under another Employer-sponsored Group health plan if you are no longer eligible for the Plan because you cease to live or work in the Service Area and there is no other benefit plan option available under the Plan. The Effective Date of coverage is impacted by the date of the qualifying event. If the date of the qualifying event is within days 1–15 of the month, the Effective Date is the first of the month following the date of the qualifying event. If the date of the qualifying event is within days 16 through the end of the month, the Effective Date is the first of the second month following the date of the qualifying event.

- If you and/or your eligible Dependents exhaust COBRA continuation or state continuation coverage or your employer's contribution or government subsidies paying for COBRA ends, you and your eligible Dependents losing coverage may enroll in the Plan. The Effective Date of coverage for you and your eligible Dependents added through this qualifying event is the first day of the month following the qualifying event if applying before this qualifying event. The Effective Date of coverage for you and your eligible Dependents added through this qualifying event is the first day of the second month following the qualifying event. You will have the option to elect coverage to begin on the first of the following month after the qualifying event or other Regular Effective Date.

- If you gain a Dependent through a court order, you may enroll yourself, your eligible Legal Spouse and eligible Dependents in the Plan. The Effective Date of coverage of you and your Dependents added through this qualifying event is the date of the qualifying event, the first of the month after the qualifying event or, upon your request, a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month then the Effective Date is the first day of the following month after the requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after the requested enrollment.

- If you or your eligible Dependents' enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, Employee or agent of the Health Insurance Marketplace for Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction. The Effective Date of coverage for you and your Dependent added through this qualifying event is the date of the qualifying event or, upon your request, a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month then the Effective Date is the first day of the following month after the requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after the requested enrollment.

- If you acquire a new Dependent through marriage, you may enroll yourself and/or your new Spouse and eligible Dependents in the Plan. The Effective Date of coverage for you and your eligible Dependent added through this qualifying event is the date of the qualifying event.

- If you have other coverage (such as a plan offered by your Spouse's Employer) and you lose coverage because of a qualifying event (such as death, legal separation or divorce), you and your eligible Dependents may enroll in the Plan. In the case of a loss of a Dependent or Dependent status due to death, legal separation or divorce, the Effective Date is the date of the qualifying event.

You and your Dependents are eligible for a special enrollment period of 60 days when one of the following qualifying events occurs:

To be eligible to enroll under these qualifying events, you must submit a written request to your Employer requesting changes in your coverage within 60 days of the event. Any request to add yourself or eligible Dependents after the 60-day period will not be granted. You and/or your eligible Dependents may enroll in any benefit package under the plan. You may be required to provide supporting documentation for the change in enrollment.

- If you acquire a new Dependent through birth, foster care placement, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Spouse, the Newborn or newly adopted child and any other eligible Dependent children not currently enrolled in the Plan. The Effective Date of coverage for you and your Dependent when added through one of these qualifying events is the date of the qualifying event or upon your request of a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after

requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after the requested enrollment.

- If you and/or your eligible Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours, termination of Employer contributions, a termination in a class of coverage, or you receive a notice of the loss of minimum essential coverage, you and your eligible Dependents may enroll in the Plan. Your prior coverage must meet minimum essential coverage standards in order for the loss of coverage to be considered a qualifying event. You have 60 days before or 60 days after a loss of coverage to select a Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the day following the qualifying event.

- If you and/or your eligible Dependents did not receive timely notice of a qualifying event, and were otherwise reasonably unaware that a qualifying event occurred, you and your eligible Dependents may enroll in a Plan. You have 60 days after you are made aware or reasonably should have known of the qualifying event to select a Plan. You will have the option to elect coverage to begin on the first of the following month after the qualifying event or other Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

- In the case of a permanent move, you and/or your eligible Dependents must have had qualifying coverage that met minimum essential coverage standards for one or more days in the 60 days preceding the move (or they must have lived in a foreign country or in a United States territory) in order for this to be considered as a qualifying event. You have 60 days before or 60 days after a permanent move to select a Plan. If the Plan is selected before the move, the Effective Date is the first of the month following the qualifying event. If the Plan is selected after the move, the Effective Date is the first day of the second following month after the qualifying event.

- If you are eligible for coverage but not enrolled in this Plan and you or your Dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you and your eligible Dependents may enroll in the Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

- If you and/or your Dependents become eligible or ineligible for a premium assistance subsidy under Medicaid or CHIP, you and your eligible Dependents may enroll in the Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

- If you and/or your eligible Dependent is enrolled in an eligible Employer-sponsored plan that is not considered qualifying coverage, you are allowed to terminate existing coverage, and may enroll in the Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

- If you and/or your eligible Dependents did not receive timely notice of a qualifying event, and were otherwise reasonably unaware that a qualifying event occurred, you and your eligible Dependents may enroll in a plan. You have 60 days after you are made aware or reasonably should have known of the qualifying event to select a Plan. You will have the option to elect coverage to begin on the first of the following month after the qualifying event or other Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

There is no special enrollment opportunity allowable for an individual due to the failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission of coverage.

Coverage During an Approved Family or Medical Leave of Absence
If your Plan meets the Employer Group size criteria and your Employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may, during the continuance of the approved FMLA leave, continue coverage under the Plan for yourself and your eligible Dependents.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contributions and you fail to do so.
- The date the Employer Group determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues.

Coverage for a Dependent will not be continued beyond the date it would otherwise terminate. If your coverage terminates because your approved FMLA leave is deemed terminated by the Employer Group, you may be eligible for continuation coverage under COBRA. If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for continued coverage on the same terms as an active Employee.

If you return to work following the date your Employer Group determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued active employment rather than going on an approved FMLA leave provided you make a request for such coverage within 31 days of the date your Employer Group determines the approved FMLA leave is to be terminated. If you do not make such a request within 31 days, coverage will be effective under this Policy only if and when the Employer Group gives written consent.

Coverage During Qualified Military Service
A Policyholder absent from work due to qualified military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, may elect to continue the type of coverage in effect on the day immediately prior to the start of the leave. This right applies only to Employees and their Dependents covered under the Plan before leaving for military service.

- Such coverage will continue until the earlier of the following occurs:
    - The 24-month period beginning on the date the Policyholder's absence begins, or
    - The day after the date on which the Policyholder was required to apply for or return to a position of employment and fails to do so.

- A Policyholder who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a Policyholder on active duty for 30 days or less cannot be required to pay more than the Policyholder's share of the contribution, if any, for the coverage.

- Any exclusion or any waiting period under the Plan may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If a Policyholder decides to waive coverage during the qualified military service and returns to employment following the leave, prior Plan coverage will be reinstated immediately upon re-employment if the Policyholder

reports to work within the required time frames established under USERRA and appropriate documentation is provided upon request.

OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS

Copayments, Coinsurance and Deductible
All Copayment, Coinsurance and Deductible amounts are specified on the Description of Coverage and/or the SBC. Any Coinsurance for services from Participating Providers is based on the amount the Participating Provider has agreed with Health Alliance to accept as full payment for the service, which is referred to as the discounted or allowed amount.

Any Coinsurance for services from Non-Participating Providers is based on the Maximum Allowable Charge (MAC) for the service, not the billed charge. You are required to pay any charges in excess of the Maximum Allowable Charge amount.

Deductibles, Copayments and Coinsurance applicable to non-Basic Healthcare Services are not subject to this limitation. Basic Healthcare Services are emergency care, inpatient Hospital and Physician care, Outpatient medical services, Mental Health care and Substance Use treatment.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum amount for an individual and family is specified on the Description of Coverage and/or the Summary of Benefits and Coverage (SBC). These are the maximum amounts you are required to pay in Copayments, Coinsurance and/or Deductibles for Basic Healthcare Services during the Benefit Year.

Any Copayment, Coinsurance or Deductible amount for Basic Healthcare Services exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Benefit Year. If you believe you have paid any Deductible, Copayment or Coinsurance amounts after you have reached your Out-of-Pocket Maximum, you may request a review of your claims. Requests for a claim review must be submitted to Health Alliance prior to the end of the Plan Year or as soon as reasonably possible. Health Alliance is not responsible for refund of overpayments, as payment is made to the Provider. Requests for refunds of overpayments should be made to your Provider.

Any Copayment, Coinsurance or Deductibles that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage and/or the SBC. Payments for non-covered items or services and amounts over the Maximum Allowable Charge do not apply to your Out-of-Pocket Maximum.

Plan Year Maximum Benefit
The Plan Year Maximum Benefit is the total benefit amount for an individual on specific non-Essential Health Benefits and is specified on the Description of Coverage and/or the SBC. This is the maximum amount the Plan will pay for the specified medical services during the Benefit Year.

PREMIUMS

Payment of Premiums
Payment of premiums must be made as follows: you, or anyone paying on your behalf, for example your Employer Group, must remit the specified premium to Health Alliance monthly. You are entitled to the benefits of this Policy only if Health Alliance receives the full amount of the premium within the required time period.

Premium Rate Revision
The monthly premium rate will be effective for the balance of the Plan Year and will be subject to change annually upon the Employer Group's renewal date. Rates may also be subject to change during a Plan Year due to a change in age, number of eligible Dependents, or geographic area status. Notice of such change in the premium rate will be provided to the Employer Group not less than 31 days prior to the Effective Date of the change.

Premium Due Date
The first monthly premium must be paid on or before the Effective Date of this Policy and the succeeding premiums must be paid on or before the due date, subject to the grace period and Special Enrollment Period provisions.

Grace Period
If you or anyone paying on your behalf fails to pay the premium within 31 days after it becomes due, this Policy is automatically canceled and you will not be entitled to further benefits. During the grace period, the Employer Group will remain liable for the payment of the premium for the time coverage was in effect. The Policyholder will remain liable for the payment of any applicable share of the premium for the time coverage was in effect, as well as for any Deductible, Copayment or Coinsurance owed because of services received during the grace period.
Providers will be notified after 30 days of the possibility of denied claims due to non-payment.

Unpaid Premiums
Any premium due and unpaid may be deducted from the payment of a claim under this Policy.

Reinstatement
In the event the premiums are not paid within the time granted, including any grace period, and coverage is terminated, reinstatement of coverage under this Policy is subject to approval by Health Alliance and advance payment of any overdue premiums.

WHAT IS COVERED

The following healthcare services covered under this Policy are subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum Benefits specified on the Description of Coverage and/or the Summary of Benefits and Coverage (SBC).

Expenses for healthcare services, including Basic Healthcare Services, are covered only if your Primary Care Physician or a Participating Provider considers the service to be Medically Necessary for the treatment, maintenance or improvement of your health. Some healthcare services are subject to Preauthorization by Health Alliance. Those services are noted under the "Preauthorization" section of this Policy. Health Alliance maintains a list of services that require Preauthorization for Medical Necessity. Preauthorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Medical policies have been developed as a guide for determining Medical Necessity. These medical policies provide the criteria to be met before coverage is provided for some healthcare services covered under this Policy. Medical policies are available on the Health Alliance website. To view these policies, log in at HealthAlliance.org, click on the Authorizations tab and choose "Medical Policies" on the right, or you can request a paper copy of a medical policy by contacting Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Diagnostic and treatment services from Non-Participating Providers are covered only when an in-network Provider refers you and the services are Preauthorized by Health Alliance, except as stated in the "Emergency Services" subsection.

If you are unsure whether a diagnostic test or treatment will be covered, call Health Alliance at the number listed on the back of your Health Alliance Identification Card to verify coverage and Preauthorization requirements prior to receiving services.

Acupuncture
Acupuncture treatment for the diagnosis of low back pain, neck pain and headaches is covered**.** Acupuncture visit limitations are subject to the limitations listed on the Description of Coverage and/or the SBC.

Additional Surgical Opinion
A consultation with a board-certified surgeon is covered after you receive a recommendation for surgery. If a second opinion does not confirm the primary surgeon's opinion, a third opinion is covered. If your Primary Care Physician

or treating specialist recommends a second or third opinion with a Provider outside your Provider Network, a referral and Preauthorization from Health Alliance is required.

Allergy Testing and Treatment
Allergy testing and treatment is covered when determined to be Medically Necessary.

Ambulance

- **Air Transportation** – Emergency transportation by air ambulance is covered for an Emergency Medical Condition when Medically Necessary. Air ambulance services are not covered when you could be safely transported by ground ambulance or by means other than by ambulance, or for stable patients for distances up to twelve (12) hours.
- **Ground Transportation –** Emergency transportation by ground ambulance is covered for an Emergency Medical Condition when Medically Necessary.

Amino Acid-Based Elemental Formulas
Amino acid-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome are covered when prescribed by a Physician as Medically Necessary; see "Durable Medical Equipment, Orthopedic Appliances and Devices" and "Home Infusion Services."

Bariatric Surgery for Severe Obesity
Bariatric surgery for severe obesity is covered for procedures, based on Medical Necessity, that have significant published experience on long-term results for the treatment of severe obesity for patients who meet Medical Necessity criteria and who have documented failure of Physician-supervised, non-surgical weight loss consisting of dietary therapy, appropriate exercise, behavior modification, psychological support. The Physician must have documented the Member's demonstrated knowledge and compliance with lifelong diet, exercise and behavioral changes necessary for successful maintenance of weight-loss surgery.

Subsequent related surgery is covered, when Medically Necessary, to treat complications from a covered surgery. Subsequent surgery because of failure to achieve or maintain long-term weight loss may not be covered. Coverage is limited to individuals age 18 and older at the time of surgery.

Blood
Blood, blood products and blood transfusions are covered when determined to be Medically Necessary by a Participating Physician. Costs related to the administration and procurement of blood and blood components are also covered, including the processing and storage of blood you donate yourself.

CAR T Therapy
Medically Necessary chimeric antigen receptor (CAR) T-cell immunotherapy is covered for Members at Participating facilities.

Cardiac Rehabilitation Services
Cardiac Rehabilitation is covered. Cardiac Rehabilitation services are covered at the Other Covered Services benefit as listed on your Description of Coverage and/or the SBC.

Chemotherapy and Radiation
Charges for chemotherapy and radiation therapy for Medically Necessary treatment are covered; see "Specialty Medical Drugs" under "What is Covered."

Chiropractic Services
Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness, are generally furnished for the diagnosis and/or treatment of a neuromusculoskeletal condition associated with an injury or illness, and that are determined

by Health Alliance Medical Plans to be Medically Necessary. An initial office visit will be covered to establish a plan of care. Any additional charges billed by a Chiropractor (D.C.), including but not limited to office visits, will be subject to the appropriate Deductible, Copayment and/or Coinsurance as listed on your Description of Coverage and/or the SBC.

Chiropractic Services are subject to coverage limitations specified on the Description of Coverage and/or the SBC. Spinal manipulations may be provided by a Doctor of Osteopathy (D.O.), a Chiropractor (D.C.) or other Provider who can provide this service within the scope of their state license. Any services or treatment not outlined in this section are not covered under the Chiropractic Services benefit.

Clinical Trials
During an Approved Clinical Trial, Health Alliance covers routine patient costs for standard of care items and services typically provided absent a Clinical Trial. Costs for investigational item(s) in the clinical trial, such as an investigational drug, procedure, device, and/or service, is not covered, as the item(s) are being investigated and are not standard of care at the time of the trial. Costs paid for, or items and services provided free of charge, by the Approved Clinical Trial Providers or research sponsors are also not covered. Each covered service is subject to the Deductibles, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

For coverage of a phase I, phase II, phase III or phase IV clinical trial, the trial must be:

- Medically Necessary;
- Approved by one of the following agencies: the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the U.S. Department of Defense, the U.S. Department of Veterans Affairs or the U.S. Department of Energy; and/or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application as well as be Preauthorized by Health Alliance.

Contraceptive Drugs, Devices and Services
FDA approved prescription Contraceptive devices, injections, procedures and services, including Natural Family Planning, are covered.

Devices and the medical fitting, insertion and/or removal of devices for Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to IUDs, diaphragms, cervical caps or Implanon®. Additional charges billed will apply to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage and/or the SBC.

Injectables and the injection intended for female Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to DepoProvera®. Additional charges billed will apply to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage and/or the SBC.

Elective sterilization procedures, intended for female Contraceptive purposes are covered under the wellness benefit. All sterilization procedures that have a medical diagnosis or are for non-Contraceptive purposes are subject to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage and/or the SBC; see “Sterilization Procedures” under “What is Covered.”

Prescription Contraceptive Services as specified in this section that are prescribed or recommended to treat medical conditions and are not used for Contraceptive purposes or for unintended pregnancy for females are not considered wellness and are subject to the Prescription Contraceptive Device/Injectable Deductible, Copayment or Coinsurance as specified on Description of Coverage and/or the SBC.

Prescription Contraceptives, including but not limited to Contraceptive pills, patches and the ring, are covered under the "What is Covered/What is Not Covered—Pharmacy Benefits" section as defined in this Policy.

Dental Services
Hospitalization and anesthesia for dental work will be covered when determined to be Medically Necessary by Health Alliance for the following:

- Children age five and under;
- Individuals with a medical condition that requires hospitalization or general anesthesia for dental care; and
- Individuals who are Disabled.

See "Oral Surgery" in this section for other covered services.

Delta Dental administers this Policy's pediatric dental benefits, claims payment and dental Provider network access. You will receive additional materials from Delta Dental for these benefits. Upon request, Delta Dental will provide to the Policyholder any usual and customary fees, how the fees are determined and the frequency with which they are evaluated.

This Policy provides essential coverage for dental services for Members under the age of 19. This section describes what services are covered as well as the limitations. Each covered service is subject to the Deductibles, Copayments or Coinsurance amounts specified on the Description of Coverage.

Preventive Pediatric Dental Services
The following services or treatments are considered preventive services and are only covered for Members under the age of 19.

- **Dental sealants** are covered and are limited to one sealant per tooth in a three-year period.
- **Diagnostic services—**X-rays are covered and includes the following: complete or full-mouth X-rays limited to one set every 36 months. Bitewing films limited to one set per Benefit Year.
- **Diagnostic Services**—Evaluations and examinations are covered. Initial or periodic oral examinations and evaluations are covered. Oral examinations and evaluations are limited to two per Benefit Year. Caries susceptibility testing is also covered.
- **Prophylaxis and fluoride treatments** are covered. Prophylaxis/cleanings are limited to one time per Benefit Year. Fluoride treatments are limited to two times per Benefit Year.
- **Space maintainers** are covered. Fixed or removable space maintainers are covered. The re-cementation and removal of a fixed maintainer is also covered.

Minor Restorative Pediatric Dental Services
The following services or treatments are considered minor restorative services and are only covered for Members under the age of 19.

- **Restorative services (fillings)** are covered as follows: Multiple restorations on one surface will be considered one restoration. This includes: amalgam restorations (primary or permanent) and synthetic restorations using either silicate cement, acrylic, plastic or composite resin; crowns using acrylic, plastic or stainless steel; pins and pin retention exclusive of restorative material; and/or re-cementation with inlay, onlay, crown or bridge.
- **Endodontic services** are covered as follows: Pulp capping (excluding final restoration), pulpotomies—therapeutic and partial (excluding final restoration) and pulpal therapy and pulpal regeneration.
- **Periodontic services** are covered as follows: Periodontal scaling and root planning—four or more teeth per quadrant is limited to once per quadrant every 24 months, one to three teeth per quadrant is limited to once per site every 24 months. Also covered is the localized delivery of antimicrobial agents and periodontal maintenance following active periodontal therapy (limited to twice per Benefit Year). Also

covered is gingivectomy or gingivoplasty (limited to once in a 36-month period), osseous surgery (limited to once in a 36-month period), pedicle, free and subepithelial tissue graft procedures, full-mouth debridement.

- **Oral Surgery** is covered as follows: Extractions, which include extraction of one or more teeth; surgical removal of erupted or impacted teeth, involving tissue flap and bone removal of teeth. Also covered are alveoloplasty procedures, incision and drainage of abscess, and removal of exostosis.

Major Pediatric Dental Services
The following services or treatments are considered major services and are only covered for Members under the age of 19.

- **Restorative services** are covered as follows: Cast restorations and crowns are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with a routine filling material. Restorations can include any of the following: inlays; onlays, in addition to inlay allowance; crowns and posts made of acrylic with metal, porcelain, porcelain with metal full-cast metal (other than stainless steel), 3/4 cast metal (other than stainless steel); cast post and core, in addition to crown (not a thimble coping); steel post and composite or amalgam core, in addition to a crown; cast dowel pin (one-piece cast with crown attachment, including pontics); and simple stress breakers, per unit. Crowns are only covered on posterior teeth.
- **Root Canal Therapy** is covered as follows: Root canals (excluding final restoration services) are covered. Retreatment of previous root canal therapy, apexification/recalcification visits, apicoectomy/periradicular surgery, root amputation and Hemisection (not included in any root therapy) is covered.
- **Periodontic services** are covered as follows: Gingivectomy or gingivoplasty (limited to once in a 36-month period), osseous surgery (limited to once in a 36-month period), pedicle, free and subepithelial tissue graft procedures, full-mouth debridement.
- **Dentures** are covered as follows: Dentures including all adjustments done by the dentist furnishing the denture in the first six months after installation. The following is a list covered under this Plan: full dentures, upper and lower; partial dentures—includes base, all clasps, rests and teeth; repairs of dentures. Rebasing and relining of dentures is not covered within the first six months of placement and is limited to once in a 36-month period. Tissue conditioning is also covered.
- **Implants** are covered as follows: If determined to be a Medical Necessity. If Preauthorization is approved, coverage includes the implant/abutment procedure.
- **Crowns and Pontics** are covered as follows: Crowns and pontics are covered on posterior teeth only.

Orthodontic Pediatric Dental Services
The following services or treatments are considered orthodontic services and are only covered for Members under the age of 19.

- Orthodontic treatment is only covered when determined to be Medically Necessary. Approved orthodontia already in progress will cease to be covered once the Member turns 19.

Diabetic Equipment and Supplies
Blood glucose monitors, cartridges for the legally blind, lancets and lancing devices are covered subject to the durable medical equipment Deductible, Copayment or Coinsurance amount specified on the Description of Coverage and/or the SBC. The diabetic equipment listed in this subsection must be obtained from a Participating Provider and prescribed in writing by a Participating Provider. Diabetic equipment not listed in this subsection are covered when Medically Necessary.

Diabetic Self-Management Training and Education
Outpatient self-management training and education, including but not limited to nutritional training, for the treatment of all types of diabetes and gestational diabetes mellitus are covered when Medically Necessary and provided by a qualified Participating Provider.

Diagnostic Testing
Diagnostic testing, including but not limited to X-ray examinations, genetic tests, laboratory tests and pathology services, are covered when ordered by a Participating Provider and Medically Necessary.

Dialysis Treatment
Medically Necessary dialysis treatment is covered for in-home and outpatient clinic settings. Dialysis services are also covered while provided during an inpatient stay. Each covered service is subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

Dressings and Supplies
Dressings, splints, casts and related supplies are covered when Medically Necessary and when administered by a Participating Provider or by a nurse or other healthcare professional under the direction of a Participating Provider.

Durable Medical Equipment, Orthopedic Appliances and Devices
Corrective and orthopedic appliances (such as leg braces and knee sleeves) and durable medical equipment (such as wheelchairs, surgical beds, insulin pumps and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition; see "Prostheses" under "What is Covered." Items and supplies provided under this subsection must be prescribed by a Participating Provider.

Based on Medical Necessity, the equipment is made available through rental or purchase agreements. A maximum benefit limit may apply. Costs associated with the repair of covered equipment are covered if the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered.
To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount under this benefit. Coverage can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Emergency Services
Emergency Services received inside or outside your Provider Network for an Emergency Medical Condition are covered. In an emergency, seek immediate care or call 911 if it is available in your area. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The Emergency Services Copayment or Coinsurance is waived if you are admitted to the Hospital when your Plan requires an inpatient Hospital Copayment or Coinsurance. Elective care or care required as a result of circumstances that could reasonably have been foreseen prior to leaving your Provider Network is not covered. Unexpected hospitalization due to complications of pregnancy is covered.

Emergency Services Care required to treat and stabilize an Emergency Medical Condition when received from a Non-Participating Provider will be covered at no greater expense to you than if the services had been provided by a Participating Provider.

If you receive Emergency Services either inside or outside the Provider Network for an Emergency Medical Condition, you or someone acting on your behalf must notify Health Alliance at the number listed on the back of your Health Alliance Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

Care required to treat and stabilize an Emergency Medical Condition when received from a Non-Participating Provider will be covered at the same level as services received from a Participating Provider.

Health Alliance will cover Post-Stabilization Medical Services, after an emergency medical treatment, if the services are Medically Necessary.

Erectile Dysfunction
Treatment is covered for Members with documented erectile dysfunction without a correctable cause.

Medications will be excluded from coverage unless they meet one of the following requirements:

- Medication is required by a state regulation
- Medication is used to treat a medical condition not related to lifestyle enhancement or performance

All services and prescription drugs are subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

Gender Affirmation Treatment
Gender affirmation treatment is covered when determined to be Medically Necessary.

Genetic Testing
Genetic testing and molecular diagnostic testing is covered when determined to be Medically Necessary. Testing that is determined to be experimental or investigational is not covered; see "Experimental Treatments/Procedures/Drugs/Devices/Transplants" under "What is Not Covered."

Hearing Evaluations
Hearing evaluations performed by Participating Providers are covered. Cochlear Implants are covered for Members when determined to be Medically Necessary. Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered.

Home Health Services
Intermittent Skilled Nursing and skilled therapeutic home services are covered when you are homebound and the services are given under the direction of and approved by a Participating Provider.

Private Duty Nursing Services are covered under home health services when determined Medically Necessary and provided by a licensed or registered nurse who is a not a resident of your household or an immediate family member. Private Duty Nursing is not meant to provide for long-term supportive care. All Copayment, Coinsurance and Deductible amounts for Home Health Services are specified on the Description of Coverage and/or the SBC.

Home Infusion Services
Home infusion services, including medication and supplies, are covered when given under the direction of a Participating Provider.

Hospice Care
Hospice care program charges are covered when ordered by your Primary Care Physician or treating specialist. For purposes of this subsection, Hospice Care program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Member and the Member's family, which includes respite care, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. Hospice means a program that meets the following requirements:

- It must be licensed by the laws of the jurisdiction where it is located and must be operated as a Hospice as defined by those laws.
- It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a Physician, are expected to live less than 6 months because of that illness.
- It must be administered by a Hospital, home health agency or other licensed facility.

Hospital Care
Hospital services are covered for an unlimited number of days when hospitalization is ordered by and provided by a Participating Provider. Coverage is limited to a semi-private (two-bed) accommodation, unless a medical or

behavioral health condition warrants otherwise. Hospital admissions, including Mental Health and Substance Use Disorder, require notification to Health Alliance within 24 hours of admission, or as soon as reasonably possible, after care begins.

Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient and for a post-discharge Physician office visit or in-home nurse visit within 48 hours after discharge.

If you are hospitalized prior to your Effective Date, coverage begins on your Effective Date. Expenses incurred prior to your Effective Date are not covered under this Plan.

Human Organ Donor
If a Member is the recipient of the living human organ donation, coverage at a Health Alliance-approved facility is provided for the donor beginning with the evaluation and ending one year after surgical removal of the organ even if the donor is not a Member. Coverage includes complications related to the surgical removal of the donated organ. Donor charges are applied to the recipient's benefits.

If the recipient of the living human organ donation is not a Member, and you (the Member) are the living organ donor and you have no coverage from any other source, then benefits will be provided to you under this Policy. This would also include any complications related to the surgical removal of the donated organ.

Human Organ Transplant
Human organ transplants are covered for non-experimental organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, when Medically Necessary and is not excluded from coverage under any other sections of this Policy. Transplants must be performed at a Health Alliance-approved facility. These services are covered when incurred at an approved Center of Excellence, when utilizing Participating Providers or otherwise Preauthorized. Coverage for benefits under this subsection begins with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and ends one year after the transplant. Office visit and Hospital Care Copayments, Coinsurance and/or Deductible apply as specified on the Description of Coverage and/or the SBC.

Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.

The Plan covers transportation, lodging and meals for the transplant recipient and a companion for travel to and from the Health Alliance designated transplant center. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

Infertility Services
Infertility services are covered only to diagnose this condition, including a consultation and diagnostic evaluation. Infertility services are covered when the Member meets all Health Alliance criteria for coverage. Prescribed and approved services must be received at an Infertility center or other Provider approved by and under contract with Health Alliance. Any services not covered are described in the "What is Not Covered" section of this Policy. The following Infertility services are covered:

- Infertility evaluation by a Participating Physician or Mid-Level Provider.
- Office visits related to the initial evaluation or follow-up appointments during the diagnostic evaluation.
- Lab and X-ray, Huhner test (postcoital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, semen analysis, acrosome reaction test, urological evaluation, testicular biopsy.

Mandibular and Maxillary Osteotomy
A mandibular or maxillary osteotomy is covered.

Maternity Care
Services rendered by the attending obstetrician or family practitioner during the course of a pregnancy are covered subject to the Routine Prenatal Care Deductible, Copayment or Coinsurance specified on the Description of Coverage and/or the SBC. Medical care, consultation or services rendered by a specialty care Provider, or a Provider other than the attending Physician during the course of the pregnancy is not considered routine prenatal care and is subject to additional applicable office visit, or specialty care Copayments, Coinsurance and/or Deductible as specified on the Description of Coverage and/or the SBC.

Prenatal HIV testing is covered.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the Newborn. Your Primary Care Physician, Women's Principal Healthcare Provider or attending Physician, may determine after consultation with you that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of your Provider, a post-discharge Provider office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge is also covered.

Coverage for the properly enrolled Newborn is provided subject to any applicable Newborn care Copayment, Coinsurance and Benefit Year Medical Deductible amount specified on the Description of Coverage and/or the SBC.

Lactation counseling and/or support and the rental or purchase of a breast pump is covered during pregnancy and through the postpartum period under the Plan's wellness benefit.

Benefits for Maternity services are available to the same extent as benefits provided for other services.

Medical Social Services
Medical social services, including Hospital discharge planning and assistance in accessing community service agencies and other related services, are covered when you are coping with a medical condition.

Mental Health Care
Mental Health Care services for Medically Necessary treatment and/or crisis intervention are covered, as specified on the Description of Coverage and/or the SBC. Coverage includes diagnosis and treatment of the following biologically based mental illnesses:

- Schizophrenia
- Bipolar disorders
- Major depressive disorders
- Schizo-affective disorders
- Obsessive-compulsive disorders
- Autistic disorders

Inpatient hospitalization and residential care are subject to inpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC. Inpatient mental health services require notification to Health Alliance within 24 hours of admission, or as soon as reasonably possible, after care begins, except in emergencies.

Outpatient Mental Health Care visits, including group Outpatient visits, are subject to any Outpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC.

Care in a day Hospital program, partial care or intensive Outpatient program are subject to Deductibles, Copayments or Coinsurance as specified in the Other Covered Services section of the Description of Coverage.

Mental Health services may be provided by a Participating Physician, a registered clinical psychologist or by an ancillary mental health professional under the supervision of a Physician or registered clinical psychologist.

Inpatient treatment in a Psychiatric Medical Institution for Children (PMIC) is covered for a child diagnosed with a biologically based mental illness who meets the Iowa medical assistance program criteria for admission to a PMIC.

Services not covered include care provided by a Non-Participating Provider or non-licensed mental health professional and marriage or social counseling as well as any treatment or care that is not Medically Necessary.

Oral Surgery
Oral surgical procedures are covered in connection with the following limited conditions:

- Traumatic Injury to sound natural teeth for Medically Necessary non-restorative services within 12 months of Injury.
- Traumatic Injury to the jawbones or surrounding tissue within 30 days of the Injury.
- Correction of a non-dental pathological condition such as cysts and tumors.
- Medical Dental work needed in order to treat cancer.

Orthotics
Specially molded and custom-made orthotics are covered when prescribed by a Provider and Medically Necessary. The durable medical equipment and orthopedic appliance Deductible, Copayment or Coinsurance amount as specified on the Description of Coverage and/or the SBC applies. Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or that may be prescribed to avoid an open surgical procedure are covered.

Other Covered Services
Other covered services may include but are not limited to, facility fees, surgical fees, anesthesia charges and other Medically Necessary services as required. These services are subject to the Other Covered Services Deductible, Copayments and Coinsurance as defined on the Description of Coverage and/or the SBC.

Outpatient Prescription Drugs
Outpatient Prescription Drugs are covered as defined in the "What is Covered/What is Not Covered—Pharmacy Benefits" section of this Policy.

Pain Therapy
Medically Necessary pain therapy is covered as defined in this Policy. This includes, but is not limited to pain therapy treatment of breast cancer. Pain therapy means pain therapy that is medically based and includes reasonably defined goals, including but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Medically Necessary pain medications are covered as defined in the "What is Covered/What is Not Covered—Pharmacy Benefits" section of this Policy.

Pediatric Vision Therapy
Office-based vision therapy is covered for treatment of convergence insufficiency in children under the age of 18 years when Medically Necessary as specified on Description of Coverage and/or the SBC.

Physician Services
Diagnostic and treatment services and wellness services provided by a Physician or under the supervision of a Physician, including the recommended periodic healthcare examinations and well-child care, are covered, as specified on the Description of Coverage and/or the SBC. Physician Services include Medically Necessary treatment, Virtual Visits or services received from a Primary Care Physician, pediatricians and specialists.

Physician services are covered if you are hospitalized and they are subject to the provisions of the "Preauthorization" section and "Hospital Care" subsection of this Policy.

Podiatry Services
Services are covered when determined to be Medically Necessary. This includes but is not limited to services related to diabetes.

Prostate Exam
Prostate exams are covered and are subject to the appropriate Deductible and/or Copayment or Coinsurance listed on the Description of Coverage and/or the SBC.

Prostheses
Prosthetic devices (such as artificial limbs) are covered when Medically Necessary due to an illness or Injury. Devices must be prescribed by a Participating Provider.

To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount. Coverage can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Pulmonary Rehabilitation
Pulmonary Rehabilitation Phase I and Pulmonary Rehabilitation Phase II are covered when Medically Necessary. Other Pulmonary Rehabilitation Phases are not covered.

Reconstructive Surgery
Services are covered to correct a functional defect resulting from an acquired and/or congenital disease or Injury when Medically Necessary. Services are also covered when performed to correct a condition resulting from accidental Injury or incident due to surgery. Correction of a congenital defect or birth abnormality of a Newborn is covered.

Coverage is provided for reconstructive surgery or a prosthetic device following a mastectomy when Preauthorized by Health Alliance for the length of time determined by the attending Physician.

Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed
- Reconstructive surgery of the other breast to produce a symmetrical appearance
- Prostheses and treatment for all physical complications at all stages of mastectomy including lymphedemas
- Removal or replacement of an implant is covered if the original reconstruction qualified for coverage and there is a documented medical problem
- Post-discharge office visits or in-home nurse visits within 48 hours of discharge

Rehabilitation and Skilled Nursing Care—Inpatient
Inpatient services for rehabilitation and Skilled Nursing Care are covered with initial and ongoing documentation of Medical Necessity subject to any inpatient rehabilitation and Skilled Nursing coverage limitations specified on the Description of Coverage and/or the SBC.

Rehabilitative Therapy Services—Outpatient
Speech, physical and occupational therapies as well as hot/cold pack therapies, for medical conditions received in the Outpatient or home setting when you are homebound, and which are directed at improving your physical functioning are covered, subject to any Outpatient rehabilitation coverage visit limitations per Primary Medical Diagnosis per Benefit Year specified on the Description of Coverage and/or the SBC. Therapies are counted by type and date of service. Habilitation services are also covered under the Rehabilitation services benefit. Speech, physical

and occupation therapies for the same Primary Medical Diagnosis are combined toward your coverage limitations, as specified on the Description of Coverage and/or the SBC.

Sexual Assault or Abuse Victims
Hospital and medical services in connection with sexual abuse or assaults are covered. The Copayment, Coinsurance and Deductible amount will be waived.

Specialty Medical Drugs
Specialty Medical Drugs are defined as any prescription drugs, regardless of dosage form, which require at least one of the following in order to provide optimal patient outcomes, and are identified as a Specialty Medical Drug on the Health Alliance Drug Formulary:

(1) Specialized procurement handling, distribution or administered in a specialized fashion;
(2) Complex benefit review to determine coverage;
(3) Complex medical management; or
(4) FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.

Examples of Specialty Medical Drugs include, but are not limited to biological specialty drugs, growth hormones and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription Drug Formulary by logging in at HealthAlliance.org.

Cancer specialty drugs, whether oral, intravenous or injected medications, are covered at the same financial requirement regardless of the location they are administered.

Specialty Medical Drugs are covered under this Policy subject to a prior written order by your Physician and Preauthorization by Health Alliance. Specialty Medical Drugs are those Specialty Medical Drugs received in the Physician's office and/or are administered by a healthcare professional in an office or other healthcare setting. Coverage for Specialty Medical Drugs is subject to the Deductibles, Copayments or Coinsurance specified on the Description of Coverage and/or the SBC.

To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Medical Drugs and the medical conditions for which they are approved for coverage. Coverage can be verified by calling Health Alliance at the phone number listed on the back of your Health Alliance Identification Card or at HealthAlliance.org.

Sterilization Procedures
Elective sterilization procedures, such as tubal ligation are covered. Vasectomies performed as an office procedure are covered. Sterilization procedures for women intended for Contraceptive purposes only are covered under the wellness benefit listed on the Description of Coverage and/or the SBC. All sterilization procedures for men and procedures for women that are medical in nature and for non-Contraceptive purposes are subject to the appropriate Deductible, Copayment and Coinsurance listed on the Description of Coverage and/or the SBC. Surgical procedures performed to reverse voluntary sterilization are not covered.

Substance Use Detoxification
Acute inpatient Substance Use detoxification is covered if determined by your Primary Care Physician or Participating Provider that Outpatient management is not medically appropriate. Treatment is considered medical and does not apply to the Substance Use Disorder Treatment benefit until the patient is discharged from the Hospital or transferred to a Substance Use Disorder unit. Inpatient admissions require notification to Health Alliance within 24 hours of admission or as soon as reasonably possible, after care begins, except in emergencies.

The medical, non-psychiatric treatment of Substance Use Disorder, such as detoxification, is covered and is subject to the Physician/Office Visit and Hospital Care Deductible, Copayments or Coinsurance specified on the Description of Coverage and/or the SBC.

Substance Use Disorder Treatment
Substance Use Disorder rehabilitation services or treatment is covered for Medically Necessary treatment, subject to Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC. These services and treatments include but are not limited to, Acute Treatment Services, and Clinical Stabilization Services.

Inpatient benefits include inpatient Medically Necessary Inpatient hospitalization and residential care, and are subject to the Substance Use Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC. Inpatient admissions require notification to Health Alliance within 24 hours of admission, or as soon as reasonably possible, after care begins, except in emergencies.

Outpatient benefits include individual counseling sessions or group Outpatient visits.

Care in a day Hospital program, partial care or intensive Outpatient treatment program are subject to Deductibles, Copayments or Coinsurance as specified in the Other Covered Services section of the Description of Coverage.

Inpatient and Outpatient Substance Use Disorder treatment coverage does not include family retreats.

Surgical Procedures
Medically Necessary inpatient or Outpatient surgeries and procedures are covered as defined in this Policy. Covered services may include assistant surgeons, surgical assistant, surgical fees, facility fees, anesthesia charges and other Medically Necessary services as required. Elective surgeries and procedures may require Preauthorization. Surgeries and procedures are subject to the Deductible, Copayments and Coinsurance as defined on the Description of Coverage and/or the SBC.

Surveillance Tests for Ovarian Cancer
Surveillance tests for ovarian cancer for female Members who are at risk for ovarian cancer are covered.

"At risk for ovarian cancer" means having a family history:

- with one or more first-degree relatives with ovarian cancer,
- of clusters of female relatives with breast cancer,
- of non-polyposis colorectal cancer, OR
- testing positive for *BRCA1* or *BRCA2* mutations.

"Surveillance tests for ovarian cancer" means annual screening using (i) CA-125 serum tumor marker testing, (ii) transvaginal ultrasound, (iii) pelvic examination.

Telemedicine Services
Medically Necessary Telemedicine services are covered. This includes medical exams and consultations and behavioral health, including substance use disorder evaluations and treatment.

Benefits for Telemedicine services are available to the same extent as benefits provided for other services.

Temporomandibular Joint Syndrome (TMJ)
Temporomandibular joint services and treatment as defined in this Policy are covered. Please refer to the section labeled "Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services," as well as "Laboratory and X-rays" on the Description of Coverage for cost share information. Subject to the limitations listed on the Description of Coverage and/or the SBC.

Tobacco Cessation Program
Tobacco cessation is covered, including Health Alliance's Quit For Life® program. Tobacco cessation pharmacological therapy, as defined by the Health Alliance Formulary, is covered subject to the Pharmacy

Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and/or the SBC and as defined in this Policy.

Urgent Care
Services obtained at an Urgent Care Center are covered. These services are intended for immediate Outpatient treatment of an unforeseen illness, Injury or condition to prevent serious deterioration. Urgent Care Centers also may be referred to as convenient care, prompt care or express care centers. They treat patients on a walk-in basis without a scheduled appointment. Urgent care is subject to the Deductible, Copayment or Coinsurance as listed on the Description of Coverage and/or the SBC and any Plan guidelines as defined in this Policy.

Vision Care
Vision screenings and examinations for prescribing glasses or for determining the refractive state of the eyes are covered once every 12 months, unless otherwise specified on the Description of Coverage and/or the SBC.

One pair of eyeglasses or one contact lens per affected eye is covered following cataract surgery. The maximum allowable benefit for frames and lenses is the standard allowable established by the Centers for Medicare and Medicaid Services (CMS).

One pair of eyeglasses, which includes lenses and frames, is covered once every 12 months for all Members under the age of 19, subject to the limitations listed on the Description of Coverage and/or the SBC.

Frames and lenses for Members under the age of 19 are covered once every 12 months as follows:

- One pair of standard frames as defined by the Centers for Medicare and Medicaid Services (CMS).
- One standard lens per eye as defined by CMS.

Additional charges for upgraded or deluxe frames or additional treatments on lenses that are not Medically Necessary (including but not limited to, anti-glare) are not covered.

Contacts for Members under the age of 19 are covered once every 12 months, for a one-year supply as follows:

- Standard lenses
- Monthly lenses
- Bi-weekly lenses
- Daily lenses

Members under the age of 19 are covered for low vision services. Low vision coverage is coverage for professional services for severe visual problems not correctable with regular lenses, including:

- Supplemental Testing—includes evaluation, diagnosis and prescription of vision aids where indicated.
- Supplemental Vision Aids

Low vision services are subject to the Deductibles, Copayments and/or Coinsurance and limitations specified on the Description of Coverage and/or the SBC.

Health Alliance maintains a list of covered and non-covered items and services and the maximum payable amount under this benefit. Coverage can be verified by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Vision care is covered with an Optometrist, Ophthalmologist or other physician who is licensed to provide vision care services.

Wellness Care
Well-child care, annual physicals and annual well women visits are covered as wellness visits when performed by a Participating Provider. Wellness screenings are covered as wellness for asymptomatic Members. Additional visits are subject to the office visit Copayments or Coinsurance and/or Deductible on the Description of Coverage and/or the SBC. If you are on a Health Alliance Health Savings Account (HSA)-eligible High Deductible Health Plan (HDHP), wellness benefits that are not recognized by federal regulations will only be covered at no cost share when you have satisfied your Plan Year Deductible. This limitation is designed to preserve your eligibility for certain federal tax benefits associated with Health Savings Accounts (HSAs) under federal tax law.

Immunizations
Medically Necessary injections and immunizations are covered, including but not limited to:

- Human papillomavirus vaccine for Members ages 9-26;
- Shingles vaccine for Members 50 years old and older;
- hepatitis A and B;
- Influenza vaccine;
- MMR (measles, mumps and rubella);
- Meningococcal;
- Pneumococcal;
- Tetanus, Diphtheria, Pertussis;
- Haemophilus Influenza Type B;
- Inactivated poliovirus;
- Rotavirus
- Varicella; and
- All routine immunizations that are included as part of adult and child vaccination schedules as determined by published preventive care guidelines.

For a complete listing of the immunization schedules and immunizations, visit HealthAlliance.org or CDC.gov.

Immunizations that can be safely administered without the supervision of healthcare professionals will be administered at the most appropriate level of care. Unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups are not covered.

Clinical Breast Exams
A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer is covered.

Mammograms
A screening mammogram, including but not limited to a screening Breast Tomosynthesis (3D mammogram), is covered annually under the wellness benefit for women ages 35 and older. Mammograms other than screening mammograms are subject to the diagnostic testing and/or office visit Deductible, Copayments and/or Coinsurance listed on the Description of Coverage and/or the SBC.

Pap Smear
One cervical smear or Pap smear test every three years is covered for females ages 21-65. Additional Pap smear tests are subject to the appropriate Copayment, Coinsurance and/or Deductible listed on the Description of Coverage and/or the SBC.

Colorectal Cancer Screening

- A screening for colorectal cancer for asymptomatic, average-risk Members ages 45-75, by means of an at-home DNA stool test every three years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.

- A screening for colorectal cancer, for asymptomatic Members starting at age 45, by means of a fecal occult blood test, including immunoassay (FIT), one to three simultaneous determinations, is covered annually.
- A screening for colorectal cancer for Members ages 45 to 75, by means of a virtual colonoscopy every five years, is covered under the wellness benefit. Preauthorization is required.
- A screening for colorectal cancer for Members ages 45-75, by means of a colonoscopy every 10 years or sigmoidoscopy once every five years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.
- Colonoscopies and sigmoidoscopies done other than what is listed under wellness are subject to the office visit and/or Outpatient Surgery/procedure (when there is an associated facility fee) Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and/or the SBC.

Osteoporosis Screening
Bone mass measurement screening for osteoporosis is covered as wellness for Members. Additional osteoporosis screenings are subject to the office visit and/or diagnostic testing Deductible, Copayments and/or Coinsurance as specified on the Description of Coverage and/or the SBC.

Cholesterol/Lipid Screening
Cholesterol or lipid screenings are covered under the wellness benefit once every five years for Members age 20 and older. Cholesterol testing done, other than the wellness screenings listed here or additional charges, will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage and/or the SBC.

Sexually Transmitted Infection Counseling and Screening
Intensive behavioral counseling for all sexually active Members who are at an increased risk for sexually transmitted infections is covered annually under wellness.

In addition to counseling, the below screenings are covered for Members under wellness:

Human Immunodeficiency Virus (HIV) Screening
Screenings for the human immunodeficiency virus (HIV) are covered annually under wellness.

Syphilis Screening
Screenings for syphilis are covered annually under wellness.

Hepatitis C Virus (HCV) Screening
Screenings for the hepatitis C virus (HCV) are covered annually under wellness.

Chlamydia and Gonorrhea Screening
Screenings for chlamydia and gonorrhea are covered annually under wellness for women up to and including age 24, and in older women at an increased risk for infection.

High-Risk HPV (Human Papillomavirus) Screening
Screening for Human Papillomavirus (HPV) by DNA testing for women ages 30 and older, once every five years, is covered under the wellness benefit.

Additional charges or testing will be subject to the appropriate Deductibles, Copayments and/or Coinsurance on the Description of Coverage and/or the SBC.

Domestic Violence Counseling and Screening
Annual screening and counseling for interpersonal, intimate partner and domestic violence is covered for women under the wellness benefit. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage and/or the SBC.

Ultrasound for Abdominal Aortic Aneurysm
A onetime ultrasound screening for men ages 65-75 who have ever smoked is covered.

Alcohol and Drug Misuse Counseling and Screening
Counseling and screening for alcohol and drug misuse are covered, up to four visits annually.

Fall Prevention
Primary care counseling for exercise or physical therapy to prevent falls in community-dwelling adults ages 65 years or older who are at increased risk for falls is covered.

Blood Pressure Screenings
High blood pressure screenings to obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment, for adults ages 18 and older, are covered.

Behavioral Counseling for Skin Cancer Prevention
Counseling for individuals, ages 6 months to 24 years old with fair skin, regarding minimizing his or her exposure to ultraviolet radiation to reduce risk for and prevent incidence of skin cancer is covered.

Depression Screening
Depression screening for Members as part of a clinical exam to ensure accurate diagnosis and treatment follow-up is covered.

Diabetes Screenings
Annual diabetes screenings for Members is covered.

Healthy Diet and Physical Activity Counseling
Annual healthy diet and physical activity counseling for adults with cardiovascular risk factors is covered.

Obesity Screenings and Counseling
An annual obesity screening as part of a clinical exam for adults and children ages 6 and older is covered. Obesity counseling for adults and children ages 6 and older is covered, up to four visits annually.

Tobacco Use Screening
An annual tobacco use screening as part of a clinical exam is covered. Intervention methods, up to eight visits annually, are covered. See the "Tobacco Cessation Program" section of this Policy regarding the tobacco cessation program that is covered.

Lung Cancer Screening
Annual screening with low-dose computed tomography (LDCT) for Members ages 50-80 who have a 20 pack/year smoking history and currently smoke or Members who have quit within the past 15 years is covered. Screening would be discontinued once a Member has not smoked for 15 years or the Member develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage and/or the SBC. Preauthorization is required.

BRCA Counseling and Evaluation
BRCA counseling and evaluation for women whose personal or family history of breast, ovarian, tubal or peritoneal cancer is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes is covered. BRCA counseling and evaluations for reasons other than what is listed here or additional charges, will be subject to the appropriate Copayments, Coinsurance or Deductibles on the Description of Coverage and/or the SBC. Preauthorization is required for BRCA testing.

Breast Cancer Chemoprevention Counseling
Breast cancer chemoprevention counseling is covered for women at an increased risk for breast cancer and at low risk for adverse medication effects of risk reducing chemoprevention.

Tuberculosis Infections Screening
Screening for latent tuberculosis infection (LTBI) is covered for adults who are at increased risk.

Hepatitis B Virus (HBV) Screening
Screening for Hepatitis B Virus (HBV) infection is covered for Members at high risk for infection.

Contraception Services
For a description of the contraceptive services, supplies, devices and drugs covered under the wellness benefit; see "Contraceptive Drugs, Devices and Services" under "What is Covered" and "Outpatient Prescription Pharmacy Contraceptives" under "What is Covered/What is Not Covered—Pharmacy Benefits."

Preventive Drugs
The following are covered at Participating pharmacies under the wellness benefit:

- Folic acid supplements for women who may become pregnant.
- Iron supplements for children ages 6 months to 12 months who are at risk for anemia.
- Gonorrhea preventive eye medication for Newborns.
- Aspirin for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults ages 50-59 years old who have a 10% or greater CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years and are willing to take low-dose aspirin daily for at least 10 years.
- Aspirin for women as a preventive medication after 12 weeks of gestation in Members who are at high risk for preeclampsia.
- Tobacco cessation products as defined by the Health Alliance formulary.
- Statin preventive medication for adults 40-75 years old with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
- Select vaccinations administered at pharmacies.
- Bowel Prep Kits, as defined by the Health Alliance formulary, used prior to a colonoscopy for Members ages 45 and older once per year.
- Tamoxifen and raloxifene used for breast cancer risk reduction.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection.
    - For Members taking PrEP medication or being considered for this therapy, the following services are covered as preventive:
        - Venipuncture for blood draws for these tests
        - HIV testing prior to the start of PrEP therapy, and then once every three months
        - Hepatitis B and C testing prior to starting PrEP therapy, and then periodically, including after PrEP is concluded
        - Creatinine testing
        - Pregnancy testing before beginning PrEP therapy and during PrEP therapy
        - Sexually Transmitted Infection Screening at baseline, and periodically thereafter while on PrEP therapy
        - Adherence counseling to ensure adherence to the prescribed medication, and to maximize PrEP's effectiveness

See "Preventive Drugs" under "What is Covered/What is Not Covered-Pharmacy Benefits."

Wellness services for children, in addition to any wellness services already listed, include:

- Autism screening for children at 18 and 24 months.
- Behavioral assessments as part of preventive exams.

- Dyslipidemia screening for children at higher risk of lipid disorders.
- Fluoride chemoprevention supplements for children 6 months to 5 years without fluoride in their water source.
- Coverage for prescription oral fluoride supplement products, generic single ingredient only, for children ages 0-6 months old.
- Varnish application for children ages 0–6 years old.
- Hearing screening for Newborns and children.
- Height, weight and Body Mass Index as part of preventive exams for children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for Newborns.
- Lead screening is covered for children ages 0-6 years old who are at risk for exposure.
- Oral health risk assessment for young children.
- Phenylketonuria (PKU) screening for this genetic disorder in Newborns.
- Tuberculin testing for children at higher risk of tuberculosis.
- Congenital Hypothyroidism screening for infants ages 0-90 days old.
- Developmental screening for children under age three, and surveillance throughout childhood.
- Vision screening for children..

Wellness services for pregnant women, in addition to any wellness service already listed, include:

- Anemia screenings;
- Preeclampsia screening;
- Urinary tract or other infection screenings;
- Gestational diabetes screening once per pregnancy;
- Hepatitis B Virus screening;
- Sexually Transmitted infections screening;
- Rh Incompatibility screening, which also includes follow-up testing for women at high risk;
- Breastfeeding counseling, breast pumps and breastfeeding supplies. See the "Maternity Care" section in this Policy.

Wellness care coverage includes any preventive services recommended by the United States Preventive Services Task Force (USPSTF) that have in effect a rating of A or B; preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, and immunizations for routine use recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control (CDC), adopted by the Director of the CDC, and listed on the Immunization Schedules of the CDC.

Wellness Brochure
To access the most up-to-date version of our wellness brochure, *Be Healthy*, login to HealthAlliance.org. This brochure includes a detailed listing of services and procedures, and their associated procedure codes, that are covered under wellness care.

WHAT IS COVERED/WHAT IS NOT COVERED—PHARMACY BENEFITS

Benefits
Health Alliance administers pharmacy benefits through a national pharmacy benefit manager. Many independent pharmacies and most national chains are Participating pharmacies. Prescription drugs may be obtained through any in-network retail or mail order pharmacy. To find out if a pharmacy is a Participating pharmacy, call Health Alliance at the number listed on the back of your Health Alliance Identification Card.

You must present your Health Alliance Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Deductible, Copayment and/or Coinsurance at the time it is filled. If you do not present your Health Alliance Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement for payment

made at a Non-Participating pharmacy, you will need to submit your itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager's address noted on the back of your Health Alliance Midwest Identification Card.

Prescription drugs prescribed by a Provider in connection with Medically Necessary services are covered for Members subject to the following terms, conditions and limitations.

Prescription Refill Synchronization
Prescription refill synchronization is the allowance to refill one or more maintenance medications on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications. For a complete listing of the covered medications, you can view the prescription Drug Formulary at HealthAlliance.org.

Member cost share will be adjusted based on the quantity of medication filled for the purpose of synchronization of medications. A daily pro-rated cost share will be charged to accommodate medication synchronization.

Schedule II, III or IV controlled substances, drugs that have special handling or sourcing needs that require a single designated pharmacy to fill or refill the prescription, and drugs that cannot be safely split into short-fill periods to achieve synchronization, are excluded from refill synchronization.

If you have more than one maintenance prescription that you fill each at different times and would like to sync them to be able to fill them at the same time each month, please contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Preauthorization
Some prescription drugs require Preauthorization from Health Alliance and certain criteria to be met by you. Drugs that require Preauthorization are noted on the prescription Drug Formulary.

Newly released prescription drugs require Preauthorization for at least six months from the date of launch until the drugs have undergone review by the Health Alliance Pharmacy and Therapeutics Committee.

Your Physician may obtain a Preauthorization Request Form online at HealthAlliance.org or by contacting Health Alliance directly. Preauthorization can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card. If Preauthorization is not obtained, Health Alliance will not provide coverage, and you will be required to pay the full cost of the drug.

Prescription Drug Formulary
A prescription drug formulary, or "formulary," is a list of covered prescription and over-the-counter drugs. You can use the formulary to determine if a drug requires Preauthorization, step therapy or if it has a quantity limit. The formulary also shows you the tier placement for each drug. These tiers will help you estimate how much you will pay each time you fill a prescription. The formulary is split into six tiers.

Drug Tier	Includes
Preventive	Preventive care drugs
Tier 1	Preferred generics
Tier 2	Non-preferred generics
Tier 3	Preferred brand name
Tier 4	Non-preferred brand name
Tier 5	Preferred specialty pharmacy and medical
Tier 6	Non-preferred specialty pharmacy and medical

This tiered system accomplishes two important goals. First, it provides members and their prescribers with access to a wide variety of treatment options. Second, it allows the Plan to assign drugs a cost-sharing that accurately reflects the drug's benefit and cost when compared to other formulary products that treat the same condition.

The drugs listed in the Health Alliance Formulary are reviewed at least annually by the Health Alliance Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee meets six times per year, or every two months, to determine changes to be made to the formulary. Newly available prescription drugs may be added to the formulary after they are reviewed by the Committee. Prescription drugs may also be moved to a higher or lower cost sharing tier, or removed from the formulary, based on recommendations of the Pharmacy and Therapeutics Committee. If a drug moves to a higher tier, or is removed from the formulary you will be notified at least 60 days prior to the change so that you can discuss with your Physician any lower tier or formulary alternatives available to you.

Some prescription drugs are not included in the Drug Formulary. Non-formulary drugs have covered Formulary alternatives in most instances. Coverage of non-formulary drugs requires a request for medical exception from your Physician. Members may qualify for a medical exception if they meet one of the below requirements:

- The medication provides clinically superior outcomes compared to all currently available agents based upon review of the published literature.
- Documentation of trial and failure of all currently available formulary agents in the same therapeutic class.
- Documentation of allergic reactions or contraindication to all currently available formulary agents in the same therapeutic class.

The medical exception request must explain the reason covered Formulary alternatives cannot be used. A Medical exception can be requested by Members, their authorized representative or a prescriber.
Requests may be made verbally, electronically, via paper form, or some other writing and reviewed by a pharmacist. In the case of a non-urgent exception request, Health Alliance will approve or deny the request within five business days after receipt of the request. Urgent requests follow the same procedure, but Health Alliance will approve or deny the request within 72 hours after receipt of the request. These reviews may take longer if we need additional information from your Physician. In the case of a denial, Health Alliance will provide the Member or their authorized representative and the prescribing Provider with the reason for the denial, an alternative covered medication (if applicable), and information regarding the procedure for submitting an appeal to the denial.

To access the most up-to-date version of our Small Group Formulary, visit the Pharmacy Programs section at HealthAlliance.org or call Health Alliance at the number listed on the back of your Health Alliance Identification Card. Some Plans' pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a prescription drug is included in the Formulary and whether the drug will be covered at the Preferred Generic Tier, Non-Preferred Generic Tier, Preferred Brand Tier, Non-Preferred Brand Tier, Preferred Specialty Tier, or Non-Preferred Specialty Tier Prescription Drug Copayment and/or Coinsurance.

Preventive Drugs
As part of the wellness benefit, preventive drugs are covered under the prescription Drug Formulary. Preventive drugs received out of network are subject to the Prescription Drug Copayments or Coinsurance listed on the Description of Coverage. For additional information; see "Preventive Drugs" in the wellness section of this Policy

For a listing of covered preventive drugs; see "Wellness Care" under the "What is Covered" section and/or the Health Alliance Drug Formulary. In addition to the preventive drugs listed here, coverage will also include any other preventive drugs approved by the United States Preventive Service Task Force (USPSTF) that may be upgraded to Grade A or B during the Benefit year. The drugs listed in the Health Alliance formulary are also reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee.

Outpatient Prescription Drug Coverage and Dispensing Limitations

- Outpatient prescription drugs and diabetic supplies are subject to any applicable limitations specified in the "Maximums/Deductibles/Limitations" section on the Description of Coverage and/or the SBC.

- Copayments or Coinsurance for Outpatient Prescription Drugs and diabetic supplies apply to any applicable Benefit Year Outpatient Out-of-Pocket Maximum limit specified on the Description of Coverage and/or the SBC. Initial prescriptions and prescription refills are limited to the maximum supply specified in the "Outpatient Prescription Drugs" section on the Description of Coverage and/or the SBC.
- You pay the lesser of the pharmacy's regular charge for the drug or the Deductible, Copayment and/or Coinsurance specified in the "Outpatient Prescription Drugs" section on the Description of Coverage and/or the SBC for each initial prescription or prescription refill.
- The following diabetic supplies are covered and will be subject to the Copayment, Coinsurance and/or Deductible specified in the Outpatient Prescription Drugs section on the Description of Coverage: glucagon emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors.
- Prescription inhalants are covered. For a listing of specific drugs, view our Drug Formulary at HealthAlliance.org.
- Coverage is provided for prescription Contraceptives or their substitutable generic equivalent when prescribed for the purpose of preventing conception, and which are approved by the U.S. Food and Drug Administration (FDA).
- Coverage includes Medically Necessary pain medication for the treatment of breast cancer.
- Generic drugs may be placed on any formulary tier. This includes specialty tiers if the drug meets the definition of a specialty drug. The majority of generic drugs are covered under the Tier 1 and Tier 2 benefit when they exist and are available and allowable by applicable state or federal law.
- Preferred brand drugs typically move to a non-preferred brand tier after a generic equivalent becomes available. You may be responsible for the applicable member payment amount plus the difference in cost between the brand and generic equivalent if you or your doctor requests the reference brand rather than the generic. Generic drugs have the lowest member payment amount.
- If a Tier 3 or Tier 4 drug is prescribed and a generic does not exist, you pay the Tier 3 or Tier 4 level of coverage as listed on your Description of Coverage and/or the SBC.
- If a higher-tiered drug is determined to be Medically Necessary by your Physician and Health Alliance, you may qualify to pay a reduced-tier copay. To determine if you qualify, call Health Alliance at the number on the back of your Health Alliance Identification Card.
- Injectable syringes are covered when the injectable drug is covered.
- A limited number of over-the-counter (OTC) medications are covered. A prescription is required from your Physician for covered OTC products and the Deductible, Copayment and/or Coinsurance applies.
- Tobacco cessation pharmacological therapy, as defined by the Health Alliance Formulary, is covered.
- Health Alliance covers Medically Necessary immune gamma globulin therapy for members diagnosed with a primary immunodeficiency. Initial authorization will be for no less than three months; reauthorization may occur every six months thereafter. For Members who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by your Physician.
- For a 30-day supply of medication or less, you pay the applicable Deductible, Copayment and/or Coinsurance as indicated on the Description of Coverage.
- For a 31-90-day supply of medication, you pay two times the copay applicable to a 30-day supply as indicated on the Description of Coverage.

Outpatient Prescription Pharmacy Contraceptives

Medically Necessary, FDA approved prescription pharmacy Contraceptive methods are covered under this section when prescribed by a Physician. This includes Contraceptive pills, patches, injections, ring and over the counter (OTC) methods. Prescription Contraceptives are subject to the Outpatient Prescription Drug Copayments, Coinsurance and/or Deductible as indicated on the Description of Coverage and/or the SBC.

- Most Prescription Contraceptive pills, patches, ring and injection will be covered under this section at a Participating pharmacy with $0 Copayment as part of the wellness benefit.
- Preferred Brand and/or Non-Preferred Brand Prescription Contraceptive pills with a generic formulary alternative are subject to the Preferred Brand or Non-Preferred Brand Deductible, Copayments and/or

Coinsurance listed on the Description of Coverage and/or the SBC, plus the difference in cost between the brand-name drug and the generic drug.

- FDA-approved OTC Contraceptive products (including but not limited to female condoms, sponges, and spermicide) are also covered for women with a prescription at a Participating Pharmacy with $0 Copayment as part of the wellness benefit as described on the Description of Coverage and/or the SBC. Coverage is limited to one package per month.
- One type of Contraceptive product is covered per month under this "What is Covered/What is Not Covered—Pharmacy Benefits" section.

Specialty Pharmacy Drugs

Specialty Pharmacy Drugs are defined as any prescription drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty Pharmacy Drug on the Health Alliance Drug Formulary:

(1) Specialized procurement handling; distribution, or is administered in a specialized fashion;
(2) Complex benefit review to determine coverage;
(3) Complex medical management; or
(4) FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.

Examples of Specialty Pharmacy Drugs include but are not limited to fertility drugs, biological specialty drugs, growth hormones, organ transplant specialty drugs and cancer specialty drugs. For a complete listing of specialty drugs, view the prescription Drug Formulary at HealthAlliance.org.

Specialty Pharmacy Drugs are available from a specialty pharmacy vendor. Coverage is subject to a prior written order by your Physician and Preauthorization by Health Alliance.

Health Alliance maintains a list of covered Tier 5 and Tier 6 Specialty Pharmacy Drugs. Tier 5 Specialty Drugs are the most clinically and cost effective; these are also known as Preferred Specialty Drugs. Tier 6 Specialty Pharmacy Drugs are at a higher cost than Tier 5 and usually have clinically comparable alternatives available at the Tier 5 level. These are also known as Non-Preferred Formulary Specialty Drugs.

This tiered system helps manage costs and provides flexibility and some coverage for Members who choose a higher-tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of Specialty Pharmacy Drugs.

The drugs listed in the Health Alliance Formulary are reviewed at least annually by the Health Alliance Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee meets six times per year, or every two months, to determine changes to be made to the formulary. Newly available Specialty Pharmacy Drugs may be added to the formulary after they are reviewed by the Committee. Specialty Pharmacy Drugs may also be moved to a higher or lower cost sharing tier, or removed from the formulary, based on recommendations of the Pharmacy and Therapeutics Committee. If a Specialty Pharmacy Drug moves to a higher tier, then you will be notified at least 60 days prior to the change so that you can discuss with your Physician any lower-tier alternatives available to you.

To access the most up-to-date version of our Small Group Formulary, go to the Pharmacy Programs section at HealthAlliance.org, or call Health Alliance at the number listed on the back of your Health Alliance Identification Card. Some plan's pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a Specialty Pharmacy Drug is included in the Formulary and whether the drug will be covered at the Tier 5 or Tier 6 specialty drug tier Deductible, Copayment and/or Coinsurance.

Specialty Pharmacy Drugs are subject to any applicable Specialty Pharmacy Drug limitations specified in the "Maximums/Deductibles/Limitations" section on the Description of Coverage and/or the SBC. Deductibles, Copayments and/or Coinsurance for Specialty Pharmacy Drugs apply to any applicable Benefit Year Out-of-

Pocket Maximum limit specified in the "Maximums/Deductibles/Limitations" section on the Description of Coverage and/or the SBC.

Prescription Drugs Not Covered

- Prescription drugs prescribed by a Non-Participating Physician or obtained at a Non-Participating pharmacy, unless obtained for treatment of an Emergency Medical Condition.
- Non-prescription drugs are not covered, except for covered diabetic supplies, injectable syringes for covered injectable drugs and a limited number of over-the-counter (OTC) medications as stated above. This includes non-prescription Infertility drugs.
- When a medication is available both by prescription only (federal legend) and as an OTC product, the prescription drug is not covered unless otherwise stated in this section.
- Prescription drugs that are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by Health Alliance, including but not limited to: BOTOX® Cosmetic, psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiants or weight loss medications, anabolic steroids, oral fluoride preparations and hair removal or hair growth promoting medications.
- Devices of any type, other than prescription Contraceptive devices, even if such devices may require a prescription, including but not limited to therapeutic devices, artificial appliances, support garments, bandages, etc.
- Dermatologic products (oral and topical) that offer no additional clinical benefit over existing covered alternatives, including, but not limited to: Clobex lotion/shampoo, Vanos, Capex, Luxiq, Olux and Solodyn.
- Brand-name formulations that are a combination of two or more existing drugs (prescription or over-the-counter), and that offer no additional clinical benefit compared to taking the individual components (the existing drugs do not have to be commercially available in the same strength as the combination product).
- Prescription-strength benzoyl peroxide and combination products.
- Compounded claims in which one or more ingredient is a bulk powder.
- Compounded products, including compounding kits, of two or more commercially available drugs (prescription or OTC) that offer no additional clinical benefit compared to taking the individual components. (Please note that the existing drugs do not have to be commercially available in the same strengths as the compounded product).
- Any drug labeled "Caution—Limited by Federal Law to Investigational Use," or experimental or other drugs that are prescribed for unapproved uses. Prescription Drugs for cancer treatment are covered if the drug is approved by the FDA and the drugs is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network's Drugs and Biologics Compendium; (3) the Thomson Micromedex's DRUGDEX; (4) the Elsevier Gold Standard's Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services, or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States or Great Britain.
- Prescription drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or any medication furnished by any other Drug or Medical Service for which there is no charge to you.
- Any charge for the administration of a drug.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before seventy-five percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Erectile dysfunction drugs related to lifestyle enhancement or performance.
- Medications used for treatment of decreased sexual desire (Addyi, Vyleesi).
- Products classified as Medical Food or supplements.

- Non-sedating antihistamines and combinations.
- Any charge for administration of a drug.
- Any drug determined by a Physician, pharmacy or through retrospective claims review to be abused or otherwise misused by you.
- Medical marijuana is excluded from coverage because it is classified by the federal government as a Schedule I controlled substance, and therefore cannot be prescribed by a healthcare professional.
- V-Go Insulin Delivery Device is excluded from coverage due to a lack of sufficient evidence and conclusions on its safety and efficacy.
- Ketamine IV when used for all off-label indications.
- Drugs that have not been approved as effective by the FDA, including DESI drugs.
- Infertility prescription drugs that are not approved by the FDA for the treatment of Infertility.
- Any prescription drug purchased or imported from outside of the United States.
- Any prescription drug received outside of the United States, unless received as part of Emergency Services or Urgent Care.

Drug Limitations
Certain Outpatient prescription drugs may be subject to drug limitations based on FDA-approved dosage recommendations and the drug manufacturer's package size. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

WHAT IS NOT COVERED (Exclusions and Limitations)

The following services are excluded from coverage under this Policy unless specifically agreed upon by the Employer Group and Health Alliance.

Care from Physicians or Providers other than Participating Providers or in Hospitals not associated with Health Alliance, other than Emergency Services, is not covered.

Abortion
Services, drugs or supplies related to abortions are not covered, except when the life of the mother would be endangered if the fetus was carried to term or when the fetus has a condition incompatible with life outside the uterus, or if the pregnancy is the result of an act of rape or incest.

Acupressure and Hypnotherapy
Charges for treatment and services related to acupressure and hypnotherapy are not covered.

Blood Processing
Costs related to the processing and storage of blood and its components from a person designated as a donor are not covered.

Circumstances Beyond the Control of Health Alliance
To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Health Alliance results in the facilities, personnel or financial resources of Health Alliance and/or any of its Participating Providers being unavailable to provide or arrange for the provision of a covered service in accordance with the requirements of this subsection, Health Alliance is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event.

Convenience or Comfort Items
Convenience or comfort items are not covered. These items include, but are not limited to grab bars, tub transfers, seat lifts, raised toilet seats, telephones and televisions.

Cosmetic Surgery
Surgery for cosmetic purposes and not primarily for reasons of Medical Necessity is not covered. This includes, but is not limited to rhinoplasties, breast reductions, blepharoplasties, liposuction and removal of skin tags and lipomas when not done primarily because of Medical Necessity.

Counseling
Charges for social counseling or marital counseling are not covered.

Custodial or Convalescent Care
Custodial or convalescent care in an acute general Hospital, Skilled Care Facility or home is not covered.

Dental Services
Dental services are not covered, unless specifically addressed as covered in this Policy. Services related to Injuries caused by or arising out of the act of chewing are also not covered. Hospitalizations for Dental work are not covered unless the hospitalization is necessary due to a medical condition. For covered dental services; see "Dental Services" and "Oral Surgery" under "What is Covered."

Disposable Items
Self-administered dressings and other disposable supplies are not covered. For covered services; see "Durable Medical Equipment, Orthopedic Appliances and Devices" under "What is Covered."

Durable Medical Equipment, Orthopedic Appliances and Devices
The following corrective and orthopedic appliances and devices are not covered: hearing aids, earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not covered unless you would be bed- or-chair-confined without such equipment. This includes any dispensing fees incurred in obtaining these items.

Experimental Treatments/Procedures/Drugs/Devices/Transplants
Unless otherwise stated in this Policy, such as coverage for Approved Clinical Trials, the Plan does not pay benefits for any charges incurred for or related to any medical treatment, procedure, drug, device or transplant that is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug, device or transplant is the subject of ongoing phase I, II or III or phase IV clinical trials or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the FDA, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.

In making their determination that a medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature, discussion with medical experts and other technological assessment bodies designated by Health Alliance. Each review will be on a case-by-case basis regarding coverage of a

requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness.

Eyeglasses, Contacts and Refractory Treatment
Eyeglasses, contact lenses, contact lens evaluations and fittings are not covered, unless there is a diagnosis of cataract or unless otherwise stated in this Policy. For covered items and services; see "Vision Care" under "What is Covered."

Lens tinting, scratch protection coating, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses are not covered. Refractive eye surgery is not covered including, but not limited to, refractive keratectomy, radial keratotomy and laser-assisted in-situ keratomileusis (LASIK) surgery.

Fitness
Any program designed for overall physical fitness or membership to fitness facilities for the same purpose is not covered. Rehabilitative therapy is not included in this exclusion.

Governmental Responsibility
Care for disabilities connected to military service for which you are legally entitled to services and for which facilities are reasonably available to you, or for conditions that state or local laws require be treated in a public facility, unless legal liability exists, are not covered.

Hearing Aids
Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered. Any service, supply or treatment for the rehabilitation of hearing impairment is also not covered.

Illegal Activities
Charges for any service, supply or treatment that arose out of or occurred while you were engaged in an illegal occupation or in the commission of or attempt to commit a felony are not covered.

Infertility Services
The following services are not covered:

- Artificial Insemination.
- In Vitro Fertilization, Uterine Embryo Lavage, Embryo transfer, Gamete Intrafallopian Tube Transfer, Zygote Intrafallopian Tube Transfer and Low Tubal Ovum Transfer.
- Assisted Reproductive Technologies (ART), meaning the treatments and/or procedures in which the human Oocytes and/or sperm are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART coverage includes prescription drug therapy used during the cycle where Oocyte Retrieval is performed.
- Outpatient prescription drugs and Specialty Pharmacy Drugs for the treatment of Infertility.
- Reversal of voluntary sterilization.
- Payment for services rendered to a Surrogate uterine carrier.
- Costs associated with cryopreservation and storage of sperm, eggs and Embryos.
- Selective termination of an Embryo. Health Alliance will cover abortions that are Medically Necessary for the life of the mother.
- Costs of an egg or sperm donor.
- Travel costs from the Member's home address as filed with Health Alliance, and/or travel costs not Medically Necessary, or mandated, or required by Health Alliance. Health Alliance will not provide coverage for Infertility services that are deemed to be experimental or investigational as supported by the written determination of the American Society for Reproductive Medicine or the American College of Obstetrics. Health Alliance will cover diagnostic Infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from Infertility treatment considered experimental.

- Infertility treatments rendered to Dependents under the age of 18.
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- Donor Embryos.

Institutional Care
Institutional care that is for the primary purpose of controlling or changing your environment, or maintenance care, Custodial Care, domiciliary care, convalescent care or rest cures is not covered.

Medicare Benefits
Healthcare items and services furnished to a Medicare-Eligible Beneficiary are not covered to the extent that benefits or payment for items or services are provided by or available from Medicare, whether or not those benefits or payment are received.

Obesity
Charges for special formulas, food supplements, special diets, minerals, vitamins or Physician and non-Physician supervised weight loss programs are not covered. Treatment or products for obesity, food addiction or weight reduction are not covered. For covered services; see "Bariatric Surgery for Severe Obesity" under "What is Covered."

Reversal of Sterilization
A surgical procedure to reverse voluntary sterilization and any resulting infertility services are not covered.

Services that Are Not Medically Necessary
Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.

Vocational rehabilitation services or other services or supplies, other than Basic Healthcare Services, that are not Medically Necessary for the treatment, maintenance or improvement of your health are not covered.

Care ordered or directed by individuals other than a Physician or registered clinical psychologist, including family retreats or marriage counseling, is not covered.

Services that are not primarily medical in nature, including but not limited to traditional mattresses, air filters, whirlpools/spas, swimming pools, exercise equipment, gym memberships, air conditioners, adaptive devices/filters for residential heating and air conditioning systems, car seats, and educational services unless specified elsewhere in the Policy, are not covered.

Skin Lesions
Skin lesion removal primarily for cosmetic reasons rather than for Medical Necessity is not covered.

Supplemental Drinks/Vitamins/Weight Gain Products
Over-the-counter supplies or products taken to supplement caloric intake, not primarily medical in nature and not used as the sole source of nutrition, are not covered.

Other Non-Covered Items

- Any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.
- Any service, supply, treatment, diagnosis or advice for which you are not legally required to pay.
- Any service, supply or treatment prohibited by the laws of the United States or the state where the expense was incurred.
- Any care, treatment, service or supply furnished by a facility owned or operated by a state or national government. Charges are covered if you have a legal obligation to pay for the care or treatment or if the United States has the authority to recover or collect the reasonable cost of such care or service.

- Any Injury or illness arising out of or occurring in the course of your job for wage or profit and which is covered by Workers' Compensation or similar law. If your Worker's Compensation claim is denied, you are required to submit the denial to Health Alliance within 90 days.
- Charges for appointments scheduled and not kept (missed appointments).
- Charges incurred before you became covered under the Plan or after you terminate from the Plan.
- Complications arising directly from rightfully excluded conditions.
- Services provided by a non-licensed professional.
- Services furnished or billed by a Provider who has been excluded or debarred by the federal government.
- Any service, supply or treatment received outside of the United States, other than Emergency Services or Urgent Care.

APPEALS

Appeals are divided into two categories: administrative decisions and denials of coverage based on Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness. You or any person you have chosen as your authorized representative, including your Physician, other healthcare Provider or attorney may request an appeal of either category. The party filing the appeal may send us written comments, documents, records or other information regarding your appeal. All available information relevant to your appeal will be considered when reviewing your appeal. A Clinical Peer not involved in the initial denial will review appeals made on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness appeals. A review committee or an individual not involved in the initial denial and who does not work under the authority of the initial decision maker will review administrative appeals.

You, your authorized representative, Physician or other healthcare Provider may request an appeal within 180 days of receiving the initial denial notice by calling the **Member Relations Department at 1-800-500-3373, via fax at 1-217-902-9708** or by writing to the **Member Relations Department, Health Alliance Midwest, 3310 Fields South Drive, Champaign, Illinois 61822.**

Appeal Procedures for Non-Urgent Care Decisions (Pre-Service Claims)
You or your authorized representative, Physician or other healthcare Provider may request an appeal for denial of requested healthcare services that require Preauthorization. Health Alliance will notify the party filing the appeal within three business days of all information required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any healthcare Provider who recommended services verbally and in writing within 15 days of receipt of all requested information, but no later than 30 calendar days after receipt of the request for an appeal.

If the appeal of your Preauthorization request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness and you have exhausted the internal appeals process, you have the right to request that the decision be reviewed by an independent review organization; see "External Review of Appeals."

Appeal Procedures for Urgent Care Decisions (Pre-Service Claims)
You, your authorized representative, Physician or other healthcare Provider may request an appeal for denial of requested healthcare services that require Preauthorization. Health Alliance will make a decision and notify you, your authorized representative, Physician and any healthcare Provider who recommended services by telephone within 24 hours of receipt of all requested information, but no later than 48 hours after receipt of the request for an appeal. You, your authorized representative, Physician and any healthcare Provider who recommended services will receive written notice within three days of the decision.

If the appeal of your Preauthorization request is denied and you have exhausted the internal appeals process, you have the right to request that the decision be reviewed by an independent review organization; see "External Review of Appeals." If you have a medical condition for which the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the requested healthcare services are denied and the denial concerns an

emergency admission, availability of care, continued stay, or healthcare service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based on the determination that the requested service or treatment is experimental or investigational and your healthcare Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review; see "Expedited External Review of Appeals."

Appeal Procedures for Concurrent Care Decisions
You, your authorized representative, Physician or other healthcare Provider may request an appeal when coverage will be reduced or terminated for ongoing treatment. The appeal must be made at least 24 hours before the scheduled reduction or termination of coverage for treatment. Health Alliance will make a decision and notify you, your authorized representative, Physician and any healthcare Provider who recommended services by telephone within 24 hours of the request for an appeal. You, your authorized representative, Physician and any healthcare Provider who recommended services will receive written notice within three days of the decision.

If the appeal for coverage of healthcare services is denied and you have exhausted the internal appeals process, you have the right to request that the decision be reviewed by an independent review organization; see "External Review of Appeals." If you have a medical condition for which the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the request for healthcare services are denied and the denial concerns an emergency admission, availability of care, continued stay or healthcare service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based on the determination that the requested service or treatment is experimental or investigational and your healthcare Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review; see "Expedited External Review of Appeals."

Health Alliance will not reduce or terminate benefits pending the outcome of an appeal; see "Termination" section of the policy for termination reasons.

Appeal Procedures for Coverage Decisions (Post-Service Claims)
You, your authorized representative, Physician or other healthcare Provider may request an appeal for denial to pay or reimburse healthcare services that have already been provided. Health Alliance will notify the party filing the appeal within three days of all information required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and/or other healthcare Provider verbally and in writing within 15 days of receipt of all requested information, but no later than 60 calendar days after receipt of the request for an appeal.

If your claim for coverage is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness and you have exhausted the internal appeals process, you have the right to request that the decision be reviewed by an independent review organization; see "External Review of Appeals."

Civil Action under ERISA
You may have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if your appeal has not been approved after all reviews have been completed.

External Review of Appeals
For denials made on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, you, your Physician or other healthcare Provider or attorney may request an external review by an independent review organization if you are not satisfied with the Health Alliance resolution of the denial of coverage for healthcare services. You, your authorized representative, your Physician or other healthcare Provider may file a written request for external review of the Coverage Decision to the Iowa Insurance Commissioner, Iowa Division of Insurance, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

The request for external review must be written within four months after:

- the date you receive a denial; or
- if Heath Alliance does not issue a written decision, except to the extent you have requested or agreed to a delay, of an appeal within 30 days after you or your authorized representative filed your appeal; or
- the internal appeal review requirement is waived by Health Alliance.

You may also contact the Iowa Division of Insurance by phone at 1-877-955-1212 or 515-281-6348, via fax at 1-515-281-3059 or online at www.iid.iowa.gov. A copy of the Coverage Decision must accompany the request.

Except in the case of an expedited review at an initial Urgent Care Pre-Service Claim denial; see "Preauthorization Procedures for Urgent Care (Pre-Service Claims)," you must exhaust the internal review process before a request for an external review can be made.

You will also be considered to have exhausted the internal review process if:

(1) You have not received our written decision on your Pre-Service Claim appeal within 30 days;
(2) You have not received our decision on your Urgent Pre-Service Claim appeal within 48 hours; or
(3) Health Alliance agrees to waive the internal review exhaustion requirement.

Once the Commissioner determines whether or not an external review is warranted based on the external review guidelines, they will have two business days from receipt of a request for external review to certify the request. The Commission will notify you, your Physician or other healthcare Provider and Health Alliance in writing of the decision within the two business day period.

If the Commissioner decides an external review is warranted, the Commissioner will select an external review organization from a list of organizations certified by the Iowa Insurance Division within three business days of receipt of notification. The Commissioner will notify you, Health Alliance, your Physician or other healthcare Provider of the external review organization selected and the right to submit additional information.

You, your Physician or other healthcare Provider may object to the external review organization selected by notifying the Commissioner within three business days of receipt of the notification from Health Alliance. The Commissioner will have two business days from receipt of the objection to make a determination and notify you, your Physician or other healthcare Provider and Health Alliance.

Once the external review organization is selected, Health Alliance will provide the external review organization information submitted in support of the request for coverage of a service or treatment under the Health Alliance appeal procedures and any other relevant documentation used in making a determination.

You, your Physician or other healthcare Provider will have 10 business days from the mailing date of the final notification of the selected external review organization to provide any information in support of the internal review and other newly discovered relevant information. Failure to provide the information within 10 business days will be grounds for rejection of consideration of the information by the external review organization.

The external review organization will notify you, your Physician or other healthcare Provider of any medical information needed to conduct the review within five business days of receipt of the documentation. Failure to provide the information will be grounds for rejection of consideration of the information by the external review organization.

The external review organization will make its decision within 30 days from receipt of the request of review. The external review organization will mail the decision to you, your Physician or other healthcare Provider and Health Alliance.

Expedited External Review of Appeals
You or your authorized representative may request an expedited external review:

1. If you have a medical condition with which the timeframe for completion of a standard external review would seriously jeopardize your life or health or the ability to regain maximum function, or;
2. If your denial concerns an admission, the availability of care, a continued stay or healthcare services where Emergency Services were received but you have not yet been discharged from the facility, or;
3. If the final denial concerns services treatment that was denied as experimental or investigational and your Physician or Provider has certified in writing that the requested service or treatment would be significantly less effective if not promptly initiated or;
4. If Health Alliance waives the internal review process.

An expedited external review may not be requested unless the Health Alliance internal appeals process has been exhausted or one of the exceptions listed above apply.

Requests for expedited external review should be requested in either by phone or in writing to the Insurance Commissioner at 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315 or 1-877-955-1212 or 515-281-6348. You may also get information online at www.iid.iowa.gov.

The Commissioner will assign an independent review organization to do the expedited review. The independent review organization will make a decision as quickly as the medical condition or situation requires, within 48 hours if the appeal is initiated via phone call and within 72 hours after written receipt of the expedited review request.

COMPLAINTS

If you have a complaint about any medical or administrative matter connected with Health Alliance services that is not resolved by your Provider, or clinic or Hospital personnel, call Health Alliance at the number listed on the back of your Health Alliance Identification Card, or write to Health Alliance Midwest, Inc., 3310 Fields South Drive, Champaign, Illinois 61822.

If you feel a complaint was not resolved in an equitable manner, you may file a written complaint with the Iowa Division of Insurance, 330 East Maple, Des Moines, Iowa 50319.

TERMINATION

In the event the Employer Group terminates this Policy all rights to benefits and services will cease on the effective date of termination. The Employer Group will be responsible for notifying you of termination of this Policy under this subsection and your right to elect coverage under an individual conversion plan subject to the provision in the "Conversion of Coverage" section of this Policy.

If you terminate employment with your Employer Group, coverage under this Policy will terminate the last day of the month in which employment ends or as otherwise specified in the Group Enrollment Agreement. If you become ineligible for continued membership in the Employer Group while the Group Enrollment Agreement between Health Alliance and the Employer Group is in effect, you may be eligible for continuation of coverage subject to the provisions stated in the "Continuation of Employer Group Coverage" section, or you may convert coverage.

Health Alliance may terminate your benefits and cancel this Policy immediately for any of the following reasons:

- You no longer live or work within the Service Area.
- Failure to pay the required premium under the "Premiums" section of this Policy, subject to the grace period.
- The Health Alliance Identification Card is provided for use by any person not eligible for covered services under this Policy.
- Any other reasons allowed by state or federal law.

When Medicare is the primary payer, coverage of a Dependent of an active Employee who is enrolled in the Employer Group's Medicare Advantage Plan will terminate on the earlier of:

- The date the Employee is no longer covered under any plan offered by the Employer Group.
- The date he or she no longer satisfies the Dependent eligibility requirements as specified in the "Eligibility, Enrollment and Effective Date of Coverage" section.
- The date of the Employee's death.
- The date on which any required contribution for coverage is not made, subject to any applicable grace period.
- The date the Employer Group eliminates Dependent coverage for all Policyholders.
- The date the Plan is terminated.
- Or any other termination reason as stated in the "Termination" section of this Policy.

If the age or tobacco status of the insured has been misstated, premiums will be adjusted back to the Effective Date of the policy and the Member will be responsible for adjusted premiums.

Health Alliance may terminate the Member's rights and the rights of any covered Dependent and cancel this Policy as of his or her initial Effective Date if the Member performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Member's Policy. The Member will be provided at least 30 days written advanced notice before the Member's Policy is rescinded. The Member has the right to appeal any such rescission.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, which would constitute fraud or intentional misrepresentation of information, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member, or responsible parent or guardian in case of a minor, is required to reimburse Health Alliance for any and all sums paid on his or her behalf for healthcare services, along with any reasonable attorneys' fees and expenses incurred in collection of such sums.

Coverage of a Dependent child will terminate on the last day of the policy anniversary date in which the child reaches the Limiting Age as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self-sustaining employment due to an apparent handicapped condition and the child is dependent upon his or her parent or other care Providers for lifetime care and supervision, the child will continue to be covered as a Dependent child for the duration of the disability and dependency.

If your Employer Group elects Domestic Partner coverage, coverage of a Domestic Partner and the child of a Domestic Partner will terminate on the last day of the month if one of the following occurs:

- One of the Domestic Partners marries.
- The Domestic Partners no longer have a common residence.

Coverage for healthcare services under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy. The obligation of Health Alliance under this Policy is limited to arranging for the provision of the healthcare services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered healthcare services after the effective date of termination. "Effective date of termination," for the purposes of this section, will mean that date on which Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date you no longer meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

In the event Health Alliance decides to no longer offer an HMO product the following processes will be followed:

- Health Alliance will notify you and your Employer at least 90 days prior to the date that the insurance product is discontinued.

- Health Alliance will offer your Employer the option to purchase a plan that is currently offered in the insurance marketplace.
- If an insurance product is discontinued, Health Alliance would do so uniformly and without regard to any specific Employer's claims or Member health conditions.

Coverage of a Policyholder who is a Retired Employee will end upon his or her enrollment in Medicare, unless otherwise noted in the Group Enrollment Agreement. The Retired Employee will be given the opportunity to enroll in the Employer Group's Medicare Advantage Plan administered by Health Alliance if one is offered.

Coverage of a Dependent of a Retired Employee will terminate on the earlier of:

- The date the Retired Employee is no longer covered under any Health Alliance-administered plan.
- The date the Dependent no longer satisfies the Dependent eligibility requirements as specified in the "Eligibility, Enrollment and Effective Date of Coverage" section.
- The date the Retired Employee enrolls in Medicare, unless otherwise noted in the Group Enrollment Agreement upon his or enrollment in Medicare (Note: The eligible Spouse/Dependent may be given the opportunity to enroll in the Employer Group's Medicare Advantage plan administered by Health Alliance).
- The date of the Retired Employee's death.
- The date on which any required contribution for coverage is not made, subject to any applicable grace period.
- The date the Employer Group eliminates Dependent coverage for all Policyholders.
- The date the Plan is terminated.

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when you or your covered Dependent have healthcare coverage under more than one plan. When you are covered by two or more health plans, benefits provided by the other plan will be coordinated with those provided by this Plan.

Definitions

1. A "Plan" is any of the following that provides benefits or services for medical or Dental care or treatment. However, if separate contracts are used to provide coordinated coverage for Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    - "Plan" includes: Group insurance, closed panel or other forms of Group or Group-type coverage (whether insured or uninsured), individual or family insurance, closed panel or other individual coverage, medical care components of Group long-term care contracts, such as Skilled Nursing Care; medical benefits under Group or individual automobile contracts, no-fault automobile insurance (by whatever name it is called) and Medicare or other governmental benefits, as permitted by law.
    - "Plan" does not include Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of Group long-term care policies, and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

    - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
    - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

- When there are more than two health plans covering the person, the Plan may be primary to one or more of the other health plans and secondary to different health plan(s).

3. "Allowable Expense" means a healthcare service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

    - If a Member is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans provides coverage for Hospital private rooms).
    - If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and Reasonable fee for a specific benefit is not an allowable expense.
    - If a person is covered under two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
    - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable fees and another plan that provides its benefits or services on the basis of a negotiated fee, the primary plan's payment arrangement shall be the allowable expense for all plans.
    - The amount a benefit is reduced by the primary plan because a Member does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, Preauthorization or when the Member has a lower benefit because he or she did not use a Participating Provider.

4. "Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date, this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a plan that provides health benefits to Members primarily in the form of services through a panel of Providers who have contracted with Health Alliance, and that limits or excludes benefits for services provided by other Providers, except in cases of an Emergency Medical Condition or referral by a Provider on the panel.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules
This Plan determines its order of benefits using the first of the following rules that applies:

1. A plan with no provision for coordination with other benefits is considered to pay its benefits before a plan that contains such a provision.

2. **Non-Dependent/Dependent**. The benefits of the plan that covers the person as an Employee or Member (that is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent.

3. **Dependent Child/Parents not Legally Separated or Divorced**. Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":

- The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

4. **Dependent Child/Parents Legally Separated or Divorced**. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   - The plan of the parent with custody of the child.
   - The plan of the Spouse of the parent with custody of the child.
   - The plan of the parent who does not have custody of the child.
   - The plan of the Spouse of the parent who does not have custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply to any claim determination period or Benefit Year when any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Dependent Child/Joint Custody**. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plan covering the child will follow the order of benefit determination rules outlined in (3) above.

6. **Dependent Adult.** If a married Dependent has his or her own coverage as a dependent under a Spouse's plan and has coverage as a Dependent under either or both parents' plans, the plans covering the Dependent will follow the order of benefit determination rules outlined in (9) below.

   - In the event that the Dependent's coverage under the Spouse's plan began on the same date as the Dependent's coverage under either or both parents' plans, the plans covering the Dependent will follow the order of benefit determination rules outlined in (3) above.

7. **Active/Inactive Employee**. The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as the Employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this requirement will be ignored.

8. **Continuation Coverage**. If a person whose coverage is provided by a federal or state law right of continuation is also covered by another plan, the following will be the order of benefit determination:

   - The benefits of the plan covering the person as a Member, or as that person's Dependent, will pay first.
   - The benefits of the plan providing continuation coverage will pay second.

   If the other plan does not contain the order of benefits determination described within this subsection, and if, as a result, the plans do not agree on the order of benefits, this requirement will be ignored.

9. **Longer/Shorter Length of Coverage**. If none of the above rules determine the order of benefits, the benefits of the plan that covered an Employee or Member longer are determined before those of the plan that covered that person for the shorter term.

   Health Alliance will have the right to release and obtain from any Physician, other medical professional, insurance company or other person or organization, any claim information (including copies of records) to pay to any other organization any amount determined to be warranted by this Policy. Health Alliance may recover any overpayment, which may have been made to any person, insurance company or

organization under the provisions of this section. Each Member claiming benefits by this Policy must give Health Alliance any information it needs to pay the claim.

10. If none of the previously discussed rules apply, then the plans are to share the allowable expense equally.

Effect on the Benefits of This Plan
When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. Each benefit is reduced in proportion and then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information
Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Health Alliance may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Health Alliance need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Health Alliance any facts it needs to apply those rules and determine benefits payable.

Health Alliance may also request updated information from you annually or when information is received that indicates a change from the information we have on file to verify or update your Coordination of Benefits information. You must fill out the requested form in writing and return via mail to Health Alliance Medical Plans 3310 Fields South Drive, Champaign, Illinois 61822 or by fax to our Recovery Department at 217-902-9786. If no response is received within 45 days from the request, claims may not be considered for payment. If it is not reasonably possible for you to respond within 45 days, please contact Health Alliance as soon as possible to provide an explanation for claims consideration.

Facility of Payment
A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Health Alliance may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. Health Alliance will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF REIMBURSEMENT

If a Member recovers expenses for sickness or Injury that occurred due to the negligence of a third party, the Plan shall have the right to first reimbursement for all benefits paid by the Plan from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Member, Member's parents, if the Member is a minor, or Member's legal representative as a result of that sickness or Injury. You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to exercise its rights under this provision. This provision applies whether or not the third party admits liability.

You must fill out the requested form in writing and return via mail to Health Alliance Medical Plans 3310 Fields South Drive, Champaign, Illinois 61822 or by fax to our Recovery Department at 217-902-9786. If no response is received within 45 days from the request, claims may not be considered for payment. If it is not reasonably possible for you to respond within 45 days, please contact Health Alliance as soon as possible to provide an explanation for claims consideration.

SUBROGATION

The Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Plan for that sickness or Injury. You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to obtain its rights under this provision. This

provision applies whether or not the third party admits liability. Health Alliance may also request information from you based on claims or other information received if a third party is involved. If no response is received within 45 days from the receipt of the request, claims may not be considered for payment.

LIABLE THIRD PARTY

If you and/or any of your covered Dependents incur a claim for medical expenses as a result of Injuries caused by someone else's negligence, wrongful act or omission, this Plan is not responsible to pay these expenses. This Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments including auto or medical expense type coverage. However, this Plan will provide benefits, otherwise payable under this Plan, only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of your and/or your Dependent's rights of recovery against any person or organization to the extent of the benefits provided. Subrogation is a legal right allowing the Plan to recover medical expenses paid by the Plan on behalf of a Member from another party if the Member's Injuries are caused by the other party's negligence. You and/or your covered Dependents agree to do whatever is necessary to secure the rights of the Plan. You and/or your covered Dependents agree not to do anything after loss to prejudice the rights of the Plan. You and/or your covered Dependents agree to cooperate with the Plan and/or any representatives of the Plan in completing forms and in giving information surrounding any accident the Plan or its representatives believe necessary to fully investigate the incident.

2. The Plan is also granted a right of reimbursement from the proceeds of any recovery by settlement, judgment or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

3. The Plan, by payment of any benefits, is granted a lien on the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents. You and/or your covered Dependents consent to the lien and agree to take whatever steps are necessary to assist the Plan to secure a lien.

4. The Plan, by payment of any benefits, is granted an assignment of the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents to the extent of the benefits paid. By accepting benefits, you and/or your covered Dependents consent to assignment, authorize, and direct his and/or her attorney, personal representative or any insurance company to reimburse directly the Plan or its designee to the extent of the benefits paid. This assignment becomes effective and is binding upon any attorney, personal representative or any insurance company upon service of a copy of this provision upon them by the Plan or its designee.

5. The subrogation and reimbursement rights, assignments and liens apply to any recoveries made by or on behalf of you and/or your covered Dependents as a result of the Injuries sustained, including but not limited to the following:

    - Payments made directly by the third party responsible for Injuries or any insurance company on behalf of the third party responsible for Injuries or any other payments on behalf of the third party responsible for Injuries.
    - Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of you and/or your covered Dependents or other person.
    - Any other payments from any source designed or intended to compensate you and/or your covered Dependents for Injuries sustained as the result of negligence or alleged negligence of a third party.
    - Any workers' compensation award or settlement.

6. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents, minors and incompetent or Disabled persons' settlements or recoveries.

7. You and/or your covered Dependents shall not make any settlement that specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by you and/or your covered Dependents, which right shall not be defeated or reduced by the application of any so-called Made-Whole Doctrine, or any other such doctrine that intends to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

9 You and/or your covered Dependents shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, no court costs or attorneys' fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called Fund Doctrine or Common Fund Doctrine, or Attorney's Fund Doctrine.

10. The Plan shall recover the full amount of benefits without regard to any claim of fault on the part of you and/or your covered Dependents, whether under comparative negligence or otherwise.

11. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

12. In the event that you and/or your covered Dependents fail or refuse to comply with the terms of this agreement, you and/or your covered Dependents shall reimburse the Plan for any and all costs and expenses including attorney's fees, incurred by the Plan in enforcing its rights.

Health Alliance may also request information from you based on claims or other information received to verify Third Party Liability information or to verify if a Third Party is involved. You must fill out the requested form in writing and return via mail to Health Alliance Midwest, 3310 Fields South Drive, Champaign, Illinois 61822 or via fax to our Recovery Department at 217-902-9786. If no response is received within 45 days from the request, claims may not be considered for payment.

MEDICARE-ELIGIBLE BENEFICIARIES

The federal "Medicare Secondary Payor" (MSP) laws regulate how certain Employers may offer Employer Group healthcare coverage to Medicare-Eligible Employees and Dependents. Under the MSP laws, Medicare generally pays secondary to the Employer Group healthcare coverage provided under this Policy for the following Medicare-Eligible Beneficiaries:

- Members with end-stage renal disease, during the first 30 months of Medicare eligibility or entitlement.
- Members ages 65 and older who are covered under this Plan due to their or their Spouse's current employment status with the Employer Group, if the Employer Group has 20 or more Employees.
- Disabled Members under age 65 who are covered under this Policy due to their or a family member's current employment status with the Employer Group, if the Employer Group employs more than 100 Employees.

To assist your Employer Group and Health Alliance in complying with the MSP laws, you must notify your Employer Group promptly if you or any of your covered Dependents becomes eligible for Medicare or has Medicare eligibility terminated or changed. You must also promptly and accurately complete any requests for information from your Employer Group or Health Alliance concerning your or any of your covered Dependents' Medicare eligibility.

For a Medicare-Eligible Beneficiary to obtain the greatest level of benefits, a Medicare-eligible Member to whom the MSP laws do not apply should:

- Enroll in Part A and Part B of Medicare.

- Obtain needed healthcare services and items from Providers according to the terms and conditions of this Policy. For services received from a Provider, this Plan will cover any applicable Medicare Deductible and Coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.
- Assign his or her claim for Medicare benefits to the Provider. For services received from a Provider, this Plan will cover any applicable Medicare Deductible and Coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.

If you do not enroll in Part B of Medicare, you will be responsible for the portion of the bills that Medicare would have allowed under Part B coverage.

We encourage you to call Health Alliance at the number on the back of your Health Alliance Identification Card with any questions about the benefits available and how to obtain them. For questions regarding Medicare eligibility or benefits, contact the Centers for Medicare and Medicaid Services.

Members may not be enrolled in Medicare and a qualified High Deductible Health Plan to be paired with a heath savings account (HSA).

PAYMENT OF CLAIMS

The Plan pays benefits or assigns payment of benefits to the healthcare Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. If services are received outside of your network, or outside of the United States, you may be required to pay the Provider at the time services are received, and submit an itemized statement to Health Alliance for reimbursement. You may also be required to submit any payment due by Health Alliance to the Provider. In situations where a monetary conversion is required, conversion will be based on the rate that was in effect on the date of discharge by the Provider or facility. Any claim for reimbursement or bills for covered healthcare services must be submitted within 90 days of the service or as soon as reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Health Alliance at the address listed below, via electronic claims billing, or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company. All claims should be submitted to:

Claims Department
Health Alliance Midwest, Inc.
3310 Fields South Drive
Champaign, IL 61822

The Plan is not responsible for claims or bills submitted more than one year after the provision or initiation of the service to which the claim or bill relates. Health Alliance will notify you and your Provider if additional information is needed to process your claim. You, your authorized representative or Provider have 45 days from the receipt of the notice to provide the requested information. The claim may be denied if the requested information is not received within the time frame given to provide the information.

Unless Health Alliance receives prior written instruction from you, any healthcare benefits unpaid at your death will be paid to the healthcare Provider rendering the service for which benefits are due or reimbursed to your estate. If benefits payable are $1,000 or less, Health Alliance may pay someone related to you by blood or marriage that Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

PRIVACY AND CONFIDENTIALITY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), together with the Standards for Privacy of Individually Identifiable Health Information, aim to safeguard the confidentiality of private information and protect the integrity of healthcare data.

Use of Information
Protected Health Information is used in the normal course of business for underwriting and establishing premiums, processing claims, informing you of your benefits and encouraging participation in health promotion programs. Other ways this information is used includes:

- Providing membership rosters to healthcare Providers
- Corresponding with you
- Participating in accreditation, auditing and quality improvement activities
- Participating in disease management studies to improve healthcare
- Providing you with healthcare reminders
- Conducting utilization review, reporting and other medical management activities
- Investigating complaints and appeals
- Establishing and maintaining proper records
- Billing and collection activities
- Fulfilling requests for information about services and benefits
- Coordination of Benefits with other plans

Disclosure of Information
Nonpublic personal and Protected Health Information are disclosed under the following circumstances:

- To you or your authorized representative
- To another party with your signed authorization
- For Plan administration (healthcare operations and payment)
- To persons or companies that perform healthcare operations on behalf of Health Alliance
- Specific information that you agree to disclose (you will be given the opportunity to object)
- Information that has been de-identified (you cannot be identified in the information disclosed)
- Sharing information with government agencies as required by applicable state and federal laws

Health Alliance has policies and procedures in place to protect the confidentiality of your information. All persons or companies acting with Health Alliance or on the behalf of Health Alliance are contractually obligated to keep the information confidential and use it only to carry out the services they are contracted to provide. Health Alliance participates in organized healthcare arrangements with its affiliates: Carle and its affiliates, OSF, Springfield Clinic and Memorial Hospital.

Your Rights
Under the privacy regulations, you are granted the following rights with respect to your Protected Health Information:

- Right to access your own Protected Health Information
- Right to amend or correct Protected Health Information that is inaccurate or incomplete
- Right to obtain an accounting of disclosures of your Protected Health Information
- Right to request additional restrictions on the use and disclosure of your Protected Health Information
- Right to complain about our privacy practices
- Right to receive a written privacy notice that explains your rights in further detail

GENERAL PROVISIONS

Clerical Error
Clerical error, whether of the Employer Group or Health Alliance, in quoting benefits or in processing or maintaining any record pertaining to the coverage under this Policy, will not invalidate coverage otherwise validly in force or reinstate coverage otherwise validly terminated.

Entire Contract and Changes
This Policy, the Description of Coverage, and/or the SBC, in combination with the Group Enrollment Agreement, and the application, constitute the entire contract between you and Health Alliance. No change in this contract will be valid until approved by an executive officer of Health Alliance. No agent has the authority to change this contract or to waive any of its provisions. Any provision, term, benefit or condition of coverage in this Policy may be amended, revised or deleted in accordance with the terms of the Group Enrollment Agreement between the Employer Group and Health Alliance, or in accordance with changes in state and/or federal law. This may be done without your consent.

ERISA
If you have questions about your rights under the Employee Retirement Income Security Act (ERISA), contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Extension of Benefits in the Case of Total Disability
If this Plan is terminated for reasons other than those specified in the "Eligibility", "Termination of Coverage", and "Guaranteed Renewability" sections of this Policy, this Plan will continue to provide benefits according to the Policy and the benefit levels specified on the Description of Coverage and/or the SBC until the earlier of: 12 months following the effective date of termination, the date the maximum benefit is reached or the end of total disability.

Financial Information
You may request in writing from Health Alliance a statement of the financial arrangements between Health Alliance and a Participating Provider. If requested, Health Alliance will provide the percentage of Deductibles, Copayments, Coinsurance and total premiums spent by Health Alliance HMO on healthcare-related expenses and other expenses including administrative expenses. This description of financial arrangements will not include specific Provider reimbursement levels or premium contributions paid by the Employer Group.

Genetic Information
Health Alliance does not use any information derived from genetic testing, and prohibits the use of such information, to make any delivery, issuance, renewal or claims payment decisions.

Guaranteed Renewability
Health Alliance will renew benefits under this Policy at the option of the Employer Group. Health Alliance reserves the right not to renew or to discontinue coverage under this Policy and under the Group Enrollment Agreement for one or more of the following reasons:

- Non-payment of premium by the Employer Group, which includes payments not made in a timely manner
- Acts of fraud or any material misrepresentation by the Employer Group
- Violation of participation or contribution rules under the Group Enrollment Agreement
- Health Alliance ceases to offer coverage in the market
- Movement outside the Service Area by either the Member, Employer Group or Health Alliance

Health Alliance Identification Card
The Health Alliance Identification Cards issued to you pursuant to this Policy are for identification only. Possession of a Health Alliance Identification Card confers no right to services or other benefits under this Policy. To be entitled

to such services or benefits, the holder of the card must in fact be a Member on whose behalf all applicable premiums under this Policy have actually been paid.

Hospitalized on Effective Date
If on your Effective Date under the Plan, you or any of your covered Dependents are inpatients in a Hospital, you are required to notify the Plan at the number on the back of your Health Alliance Identification Card within 48 hours of the Effective Date or as soon as reasonably possible. Medically Necessary charges incurred on or after your Effective Date will be covered by the Plan. Charges incurred prior to 12:01 a.m. of your Effective Date will not be covered by the Plan.

Legal Action
No legal action shall be brought to recover on this Policy before 60 days after written proof of loss has been furnished. No legal action shall be brought to recover on this Policy more than three years after the time that written proof of loss was furnished.

New Medical Technologies
To keep pace with technology changes and your equitable access to safe and effective care, Health Alliance has established policies and procedures to evaluate new developments in medical technology and its applicability to benefit changes. Professionals with the expertise related to new medical procedures, pharmacological treatments and devices participate in the evaluation of each new technology and the creation of criteria for its applications.

Non-Discrimination
Health Alliance does not make or permit unfair discrimination between Members or potential Members who have like insuring, risk and other factors and elements. Health Alliance will not refuse to issue or cancel any contract, notices of proposed insurance or decline renewal to such contract because of race, color, national origin, age, disability, sex, sexual preference, sexual orientation, gender identity, marital status or health or treatment of the Member or any potential Member.

Notices
Any notice to be given under the terms of this Policy by Health Alliance to the Employer Group will be in writing and may be affected by deposit in any post office in the United States addressed to the Employer Group at the most recent address of the Employer Group shown in the records of Health Alliance. Any notice to be given to you under the terms of this Policy by Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to your most recent address shown in the records of Health Alliance. Any notice to be given under the terms of this Policy to Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to Health Alliance Midwest, Inc., 3310 Fields South Drive, Champaign, Illinois 61822. All notices given in the manner provided for in this section will be deemed to have been received by the party to whom addressed five business days after deposit in said post office.

You may notify us of a change of address by calling Health Alliance at the number on the back of your Health Alliance Identification Card or by sending the change of address information to the Membership Department, Health Alliance Midwest, 3310 Fields South Drive, Champaign, Illinois 61822.

Time Limit on Certain Defenses
No misstatements made in the application for this Policy will be used to void this contract or to deny a claim for loss incurred after two years from the Effective Date of coverage. This provision does not include fraudulent misstatements.

Timely Payment of Claims
All benefits due will be paid upon receipt of proof of loss. We will notify you within 30 days if additional information is needed. If payment is delayed more than 30 days after all necessary information regarding the claim has been received, we will pay interest on benefits due.

Other Provisions
The obligation of Health Alliance is limited to furnishing healthcare coverage to Members through Providers of care. Health Alliance is not liable, in any event, for any act or omission of the professional personnel of any medical group, Hospital or other Provider of services to Members.

The healthcare coverage provided for in this Policy is not transferable to another party by any Member.

CONTINUATION OF EMPLOYER GROUP COVERAGE

This is a summary of your rights under the Iowa and the federally mandated continuation coverage laws, in effect. You may be eligible to continue your healthcare coverage under this Policy provided you meet the requirements stated below and the terms and conditions of the Group Enrollment Agreement. It is the responsibility of your Employer to notify you of your rights to continuation of coverage. You should contact your Employer for more detailed information on your rights to continuation of coverage.

STATE CONTINUATION

Eligibility
You, your covered Spouse, Dependent children and if applicable, Domestic Partner or children of a Domestic Partner may be eligible for nine months of continuation coverage if you are a Member whose coverage under this Policy would otherwise terminate due to termination of the Policyholder's employment (termination of employment cannot be due to misconduct), termination of membership and if you:

- Are not covered under another Employer Group health insurance policy or entitled to Medicare
- Have not moved outside the Service Area

Health Alliance will provide continuation coverage to a Spouse and any covered Dependents whose coverage under this Policy would otherwise terminate due to divorce or annulment from the Policyholder or the death of the Policyholder and if you:

- Are not covered under another Employer Group health insurance policy or entitled to Medicare
- Have not moved outside the Service Area

Election
Your Employer will provide you within ten days from the termination or death, the instructions as to how to apply for this coverage, if eligible.

Termination of Coverage
Continuation coverage under this Policy will terminate if one of the following occurs:

- You have exhausted the maximum nine-month period
- You have failed to make timely premium payments
- The Group Enrollment Agreement is terminated
- You become covered under another Employer Group health insurance policy
- You become eligible for Medicare
- You have moved outside the Service Area
- You convert to an individual or family conversion policy
- Your Employer terminates the Employer Group policy with Health Alliance

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)
This section applies only to Members of an Employer Group with 20 or more Employees.

Continuation Coverage Rights Under COBRA
Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their Dependents covered under the Plan will be entitled to elect a temporary extension of healthcare coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

What is COBRA continuation coverage?
COBRA continuation coverage is the temporary extension of Employer Group health plan coverage that must be offered to certain Policyholders and their eligible Dependents (called "Qualified Beneficiaries") at Employer Group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?
In general, a Qualified Beneficiary can be:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Retired Employee who retired on or before the date of substantial elimination of Plan coverage that is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner who does not qualify as a Policyholder's tax dependent under IRS rules is not considered a Qualified Beneficiary. However, per the Group Enrollment Agreement, Domestic Partners may be eligible for COBRA. A Dependent who does not qualify as a Policyholder's tax Dependent under IRS rules is not considered a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other Employer Group healthcare coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another Employer Group health plan.

What is a Qualifying Event?
A Qualifying Event is any of the following if the Plan provided that the Member would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in any part of the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(vi) The Employer files for bankruptcy under Title 11 of the U.S. Code and you are a Retired Employee.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

If a covered Employee discontinues coverage for his or her Spouse in anticipation of divorce or other Qualifying Event prior to the actual event, when the divorce or other Qualifying Event becomes final, the Employer must be notified so the notification can be sent.

If your Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), the taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). **Note**: The covered Employee and Dependents will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage?
The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?
The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date that notice is provided to the Qualified Beneficiary of their right to elect COBRA continuation coverage.

Qualified Beneficiaries should take into account that a failure to elect COBRA will affect future rights under federal law. Qualified Beneficiaries should take into account the special enrollment rights available under federal law. Qualified Beneficiaries have the right to request special enrollment in another Employer Group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's Employer) within 30 days after your Employer Group healthcare coverage under the Plan ends because of a Qualifying Event. Qualified Beneficiaries will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their Employer Group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Employer for further information.

Is a covered Employee or Qualified Beneficiary responsible for informing the Employer of the occurrence of a Qualifying Event?
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Employer has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date that coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the Employee,
- commencement of a proceeding in bankruptcy with respect to the Employer, or
- enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify your Employer <u>in writing</u> within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided <u>in writing</u> to your Employer during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to your Employer.

NOTICE PROCEDURES

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to your Employer. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the Plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the Employee*** covered under the Plan,
- the ***name(s) and address(es) of the Qualified Beneficiary(ies)***, and
- the ***Qualifying Event*** and the ***date*** it happened.

If the Qualifying Event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts (for example, in order to qualify for a disability extension).

Once your Employer receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their eligible Dependents. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying Event. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any Employer Group health Plan (including a successor plan) to any Employee.

(iv) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(v) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the Disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer Disabled, whichever is earlier; or

(b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?
The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event, if there is not a disability extension and 29 months after the Qualifying Event, if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the Retired Employee ends on the date of the Retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the Retired Employee ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the Retired Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Employer must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Employer.

How does a Qualified Beneficiary become entitled to a disability extension?
A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Employer with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Employer.

Does the Plan require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102 percent of the applicable premium and up to 150 percent of the applicable premium for any expanded period of COBRA continuation coverage covering a Disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?
If a Qualified Beneficiary's COBRA continuation coverage under an Employer Group health Plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the

Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, contact your Employer or COBRA administrator. For more information on ERISA, including COBRA, HIPAA and other laws affecting Employer Group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.DOL.gov/EBSA.

KEEP YOUR EMPLOYER INFORMED OF ADDRESS CHANGES
To protect your family's rights, you should keep your Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

TERMS

Capitalized terms used throughout the Policy are defined in this section.

Acute Treatment Services
24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups and discharge planning.

Approved Clinical Trials
A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is approved or funded by a federally funded trial or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

Basic Healthcare Services
Emergency care, inpatient Hospital and Physician care, Outpatient medical services, Mental Health Care and Substance Use Disorder treatment.

Benefit Year
The year in which the Plan's annual benefits are calculated.

Cardiac Rehabilitation
A medically supervised program that helps improve the health and well-being of people who have heart problems. Rehab programs include exercise training, education on heart-healthy living and counseling to reduce stress and help you return to an active life. There are different phases in cardiac rehabilitation care. See the "Cardiac Rehabilitation" section under the "What is Covered" section of this Policy.

Phase I is part of the inpatient days spent while being treated and recovering from a cardiac condition.

Phase II is a comprehensive, long-term program that includes medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Phase II refers to Outpatient, medically supervised programs that are typically initiated one to three weeks after hospital discharge and that provide appropriate electrocardiographic monitoring.

Phase III involves Members who no longer need medical supervision while exercising. These Members may embark on a long-term program of exercise and health maintenance. Such programs are usually undertaken at home or in a fitness center.

Center of Excellence
A tertiary or healthcare Provider that is identified as having highly skilled experts and produces the best outcomes. Also called a "Center of Quality."

Clinical Peer
A healthcare professional that is in the same profession and the same or similar specialty as the healthcare Provider who typically manages the medical condition, procedures or treatment under review.

Clinical Stabilization Services
24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Coinsurance
A percentage of a charge you must pay directly to the Provider for services rendered to you by the Provider.

Contraceptives
Devices, drugs, procedures or other methods that are used with intention to prevent pregnancy or conception.

Copayment
A specific dollar amount you must pay for certain covered services at the time and place you receive such services.

Creditable Coverage
Coverage you have had prior to enrolling in this Plan under any of the following:

- An Employer Group health plan
- Health insurance coverage
- Part A or Part B of Title XVIII of the Social Security Act (Medicare)
- Title XIX of the Social Security Act (Public Aid/Medicaid)
- Chapter 55 of Title 10, United States Code (armed forces personnel)
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefit risk pool
- A health plan offered under Chapter 89 of Title 5, United States Code (government organization and Employees)
- A public health plan
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))
- S-CHIP (State Children's Health Insurance Program)
- Any health coverage provided by a government entity, whether or not it qualifies as insurance coverage
- Coverage provided under a plan established or maintained by a foreign country or political subdivision

If you or your covered Dependent(s) have a 63-day period where you or your covered Dependent(s) were not covered under any of the above, the period preceding the 63-day period will not count as Creditable Coverage.

Custodial Care
Care furnished for the purpose of meeting Non-Medically Necessary personal needs that could be provided by people without professional skills or training, such as assistance in walking, positioning, dressing, bathing, eating, preparation of special diets and taking medications.

Deductible
The amount you must pay before the Plan benefits begin. A new Deductible will apply each Benefit Year.

Dependent
A child or Spouse of a Policyholder who meets the eligibility requirements of the Employer Group. If your Employer Group elects Domestic Partner coverage, this would include the Domestic Partner of a Policyholder or the child of a Domestic Partner who meets the eligibility requirements of the Group.

Description of Coverage
A Description of Coverage attached to this Policy that includes, but is not limited to, Copayment, Coinsurance, Deductible amounts, benefit limitations and Out-of-Pocket Maximum.

Disabled
A Member who possesses a mental or physical condition that limits senses, movements, or activities.

Domestic Partner
An adult partner with whom the Policyholder lives in an exclusive, emotionally committed and financially responsible relationship.

Drug Formulary
A listing of drugs that your Plan covers.

Educational Institution
A school that maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. The term school includes elementary, junior and senior high schools, colleges, universities and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence courses or schools offering only courses through the Internet.

Effective Date
The date you and your covered Dependents are eligible for benefits under this Policy.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services
Services including, transportation, but not limited to ambulance services, and inpatient and Outpatient services available 24 hours a day, seven days a week, furnished by a Provider qualified to provide such services and needed to evaluate or stabilize an Emergency Medical Condition.

Employee
A person who is an active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer Group
An Employer, association, union or other Employer Group who has contracted with Health Alliance to offer healthcare benefits to its Employees.

ERISA (Employee Retirement Income Security Act of 1974)
A federal law that regulates the majority of private pension and welfare Employer Group benefit plans in the United States.

Essential Health Benefits
Benefits covered under the Policy in at least the following categories: ambulatory patient services, Emergency

Services, hospitalization, maternity and Newborn care, mental health and Substance Use Disorder services, (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any federal and/or state regulations issued pursuant thereto.

E-Visit
Non face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.

Extended Network Provider
A Physician or Provider who has entered into a valid contract with Health Alliance through a leased network arrangement to provide healthcare services to Members. An Extended Network Provider is not responsible for obtaining Preauthorization on your behalf.

Family Coverage
The healthcare services arranged for and provided to you and any of your Dependents under the terms and conditions of this Policy and for which the applicable premium has been paid to and received by Health Alliance.

Formulary Drugs
Drugs that are included in the list of medications your Plan covers.

Genetic Testing
An analysis of human DNA, RNA, chromosomes, proteins or metabolites, if the analysis detects genotypes, mutations or chromosomal changes. Genetic Testing does not include an analysis of proteins or metabolites that are directly related to a manifested disease, disorder or pathological condition.

Group Enrollment Agreement
A contract, which this Policy is a part of, between Health Alliance and the Employer Group to offer Employer Group healthcare benefits to its Employees.

Health Alliance Identification Card
A card that is provided by Health Alliance to each Member upon enrollment. Replacement cards may be requested by contacting the Customer Service Department.

Healthcare Professional
A person who is licensed as a Physician, advanced practice registered nurse or physician assistant.

Health Insurance Marketplace
A resource that helps individuals, families and small businesses learn about health insurance options, compare plans, choose plans and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage.

Health Savings Account (HSA)
A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA), you can pay for Deductibles, Copayments, Coinsurance and some other expenses. An HSA can be used only if you have a High Deductible Health Plan (HDHP).

High Deductible Health Plan (HDHP)
A plan with a higher Deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more healthcare costs yourself before the insurance company starts to pay its share. A High Deductible Health Plan (HDHP) can be combined with a Health Savings Account (HSA), allowing you to pay for certain medical expenses by using untaxed dollars.

Hospital
An institution that meets the following requirements:

- It must provide medical and surgical care and treatment for acutely sick or injured persons on an inpatient basis.
- It must have diagnostic and therapeutic facilities.
- Care and treatment must be given by or supervised by Physicians. Day and night nursing services must also be given and must be supervised by a licensed nurse.
- It must not be operated by a national, provincial or state government.
- It must not be primarily a place of rest, a place for the aged or a nursing home.
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a Hospital as defined by those laws.

Injury
An accidental physical harm to the body caused by unexpected external means.

Life-Threatening Disease or Condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limiting Age
The age a child is no longer eligible for Dependent coverage on their parent's Plan.

Medical Director
A licensed Physician employed or under contract with Health Alliance to provide services including, but not limited to, utilization management and quality assurance reviews.

Medically Necessary (Medical Necessity)
A service or supply that is required to identify or treat your condition and is:

- Appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or Injury.
- Adequate and essential for the evaluation or treatment of a disease, condition or illness.
- Can reasonably be expected to improve your condition or level of functioning.
- Conforms to standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Not mainly for the convenience of you, a Physician or other Provider.
- The most appropriate medical service, supply or level of care that can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an Outpatient.

Medicare-Eligible Beneficiary
A Member who is eligible for Medicare due to age, disability or end-stage renal disease, whether or not the Member enrolls in Medicare. Medicare is the program established by Parts A and B of Title XVIII of the Social Security Act, as amended (42 U.S.C. 1395 et eq.).

Member (also referred to as "you" or "your" within this Policy)
A Policyholder or a covered Dependent who is entitled to benefits under the Plan.

Mid-Level Provider
A healthcare professional, other than a Physician, who provides patient care in a collaborative practice under the supervision of a Physician.

Newborn
An infant under 28 days of age.

Non-Participating Provider (Non-Participating)
A Provider or pharmacy that has not entered into a valid contract with Health Alliance to provide healthcare services to Members.

Non-Formulary Drugs
Drugs that are not included in the list of medications your Plan covers.

Non-Preferred Drugs
Formulary Drugs for which a Member pays a higher cost share; these drugs usually have a lower cost Preferred Formulary alternative.

Open Enrollment
A period of time determined by the Employer Group during which eligible Employees and their Dependents may enroll in the Plan.

Out-of-Pocket Maximum
The maximum dollar amount you and/or your family will pay in accumulated Copayments, Coinsurance and/or Deductible amounts for Healthcare services during a Benefit Year. Amounts paid for non-covered healthcare services and certain other expenses will not apply to the Out-of-Pocket Maximum.

Outpatient
The care you or a Dependent receives in a Physician's office, the home, the Outpatient department of a Hospital or freestanding surgical center.

Participating Provider
A Physician or Provider who has entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance HMO Members.

Physician
A person licensed to practice medicine in all of its branches under the applicable laws of the state within the United States where the services are provided.

Plan
The program of healthcare benefits adopted by the Employer Group for its eligible Employees.

Plan Year
The 12-month period beginning and ending on the dates listed on your Summary of Benefits and Coverage (SBC).

Plan Year Maximum Benefit
The total benefits available for certain covered services during a Benefit Year for each Member.

Policy
This booklet, which is issued to a Policyholder and that describes the coverage provided under the Plan.

Policyholder (also referred to as "you" or "your" within this Policy)
A person who is a bona fide Employee, regularly employed on a permanent basis by the Employer Group and enrolled in Health Alliance. A Policyholder must live or work in the Service Area of the Employer Group's plan and is subject to the terms and conditions of the Group Enrollment Agreement.

Post-Stabilization Medical Services
Services provided after an emergency medical treatment to a stabilized Member with the intent to maintain, improve or resolve his or her condition.

Preauthorization (Preauthorized)
A review by Health Alliance prior to receipt of services to determine and authorize the coverage level of Medically Necessary services for which the Plan will pay.

Preferred Drugs
Formulary Drugs that are considered well suited for most Members.

Prescription Refill Synchronization
The allowance to refill one or more maintenance medications on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications.

Primary Care Physician
A Physician who spends a majority of clinical time engaged in general practice or in the practice of family medicine, internal medicine or pediatrics. These Physicians are designated in the Provider Directory.

Primary Medical Diagnosis
The main condition or disease causing symptoms or requiring treatment. The first listed condition for treatment.

Private Duty Nursing Service
Private Duty Nursing Services are skilled nursing services provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or a licensed practical nurse (L.P.N.). Private Duty Nursing is typically shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Protected Health Information
All individually identifiable health information maintained or transmitted by the Plan.

Provider
A healthcare Provider (such as a Physician or Mid-Level Provider), healthcare facility and/or corporation licensed under the applicable laws of the state within the United States where the services are provided.

Provider Directory
A list of Participating Providers for your Plan and the area they serve.

Provider Network
The Participating Providers that are associated with your Plan.

Regular Effective Date
The Effective Date determined for special enrollment periods. If enrollment is requested between the first and fifteenth of the month then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

Retired Employee
A former active Employee of the Employer who was retired while employed by the Employer and who is covered under the Employer Group's healthcare Plan.

Service Area
The geographic region that contains the counties within which the Plan is authorized to do business.

Skilled Care
Services that can only be performed by or under the supervision of a licensed nurse, physical, occupational or speech therapist.

Skilled Nursing Facility
A facility that is primarily engaged in providing to its residents Skilled Care or rehabilitation (physical, occupational or speech therapy) services. Skilled Nursing Facilities do not include convalescent nursing homes, rest facilities or facilities for the aged that primarily furnish Custodial Care.

Small Employer
An Employer who employed an average of at least one but not more than 50 Employees on business days during the preceding calendar year and who employs at least one Employee on the first day of the Plan Year.

Specialty Pharmacy Drugs
Any agent that is obtained from a specialty drug Provider because of special handling, storage, administration, monitoring and/or financial requirements.

Spouse
The person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. Your Employer may require documentation proving a legal marital relationship.

Substance Use Disorder
The uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency that develops with continued use and for which treatment is Medically Necessary. The addictive substances included under Substance Use are limited to alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

Summary of Benefits and Coverage (SBC)
A brief summary of covered benefits and limits for Members and Dependents covered by this Policy. It includes but is not limited to Copayment, Coinsurance, Deductible amounts, benefit limitations and Out-of-Pocket Maximum. The SBC includes a uniform glossary of terms.

Telemedicine
The delivery of clinical services via synchronous, interactive audio and video communications systems that permit real-time communication between the Provider and the patient. Services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology. Telemedicine provides remote access for face-to-face services such as consultations, office visits, preventative care, and mental health services. Telemedicine, through technology, replicates the interaction of a traditional in-person encounter between a Provider and a patient.

Urgent Care
Care that requires immediate attention for an unforeseen illness, Injury or condition to prevent serious deterioration of a condition. May also be referred to a facility known as convenient care, prompt care or express care.

Virtual Visits
Brief communication technology-based services when the patient checks in with the healthcare Provider via telephone or other telecommunications device to decide whether an office visit or other service is needed. Virtual visits also include the service of remote evaluation of recorded video and/or images submitted by an established patient for reviewing patient-transmitted photo or video information conducted via pre-recorded "store and forward" video or image technology to assess whether an office visit or other service is needed.

Women's Principal Healthcare Provider
A person licensed to practice medicine in all of its branches under the applicable laws of the state where he or she provides services, specializing in Obstetrics and/or Gynecology or Family Practice.