HEALTH ALLIANCE MIDWEST INDEMNITY POLICY

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- 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 about Health Alliance or the care provided.
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- A responsibility to supply information, to the extent possible, that Health Alliance and its contracted Providers need in order to provide care.
- A responsibility to follow the plans and instructions for care that 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 any attached Riders and Amendments 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 INDEMNITY POLICY

INTRODUCTION

The Health Alliance Indemnity Policy is established as a fully insured health insurance product of Health Alliance Midwest, Inc. (Health Alliance), an Illinois insurance company that is authorized and certified to do business in the state of Iowa. Health Alliance is licensed to provide both HMO and Indemnity plans. Health Alliance administers all aspects of Health Alliance Midwest, which is located at 3310 Fields South Drive, Champaign, Illinois 61822. Customer Service representatives are available via phone at 800-851-3379. This number is also on the back of your Health Alliance Identification Card.

This Indemnity Policy, along with the Description of Coverage and the Summary of Benefits and Coverage (SBC), Amendments and/or Riders, describes your out-of-network benefits under the Point of Service (POS) 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 Member. As a Member, you are subject to all terms and conditions of this Policy and payment of any 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 INDEMNITY POLICY WORKS

The Health Alliance Midwest Indemnity Policy allows you and your covered Dependents to choose where you receive healthcare services. Healthcare services are paid according to the POS Plan Indemnity Policy Description of Coverage and/or the SBC, up to the Maximum Allowable Charges after the individual or family Deductible has been met. The Provider may bill you for any amount up to the billed charge after the Plan has paid its portion of the bill.

Make sure that claims from Non-Participating Providers are submitted to Health Alliance within 60 days from the date of service. Claims submitted more than one year from the date of service are not covered by the Plan; see "Payment of Claims" section. You are responsible for submitting the claim or bill to Health Alliance if the Provider does not agree to send a claim on your behalf. The Provider will bill the portion you are responsible for directly to you after the Plan has determined its payment.

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 air ambulance services, 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 get 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. 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 the Provider who requested the Preauthorization will be notified of the Effective Dates and the 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 services. 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. Preauthorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

If there is no Preauthorization, a Retrospective Review will be performed. If Medical Necessity criteria are not met, you are responsible for the entire cost of the services received.

Healthcare Services that Require Preauthorization
Preauthorization provides you with assurance that a hospitalization, procedure or supply will be covered by the Plan. Coverage will not be provided for healthcare services that are not Medically Necessary. Services that require Preauthorization will not be covered if you receive those services prior to approval of the Preauthorization request and it is later determined the services were not Medically Necessary.

To determine what procedures or supplies would require Preauthorization, visit the Health Alliance website HealthAlliance.org click on the Authorizations tab. In the section titled Do I Need a Preauthorization?select either Medical (Procedures) or Durable Medical Supplies to view the list of what requires Preauthorization. You can also contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

PLEASE NOTE: You may use Non-Participating Providers and have benefits paid at the Participating Provider level only when services are not available from a Participating Provider and if you have received Preauthorization from Health Alliance, or in a Medical Emergency. In other words, the Plan will pay at the Participating Provider benefit level for Non-Participating services only if you obtain Preauthorization before receiving treatment. The only exception to this rule is in a Medical Emergency. Care required to treat and stabilize a Medical Emergency will be covered at the same level as services received through a Participating Provider.

Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims)
Health Alliance maintains a list of services that require Preauthorization. Preauthorization must be obtained prior to a scheduled hospitalization, procedure or purchase of a supply listed above. 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. Health Alliance will make a coverage decision for Urgent Care within 24 hours of receipt of the requested information, but no later than 48 hours after receipt 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 of 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 (Procedures) or Durable Medical Supplies to view the list of what requires Preauthorization 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 "External Review of Appeals" and "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 Health Alliance. 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.
- Must 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 asks for it. 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.

An unmarried Dependent may remain covered under the Plan if the Dependent is enrolled as a full-time student at an Educational Institution; see "Student Status."

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

- The child of a Domestic Partner who 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 cost, 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 good 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 or Medicare Supplement 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, their Spouse and their Dependent children who are Medicare-Eligible and Medicare is the primary payer. If your Employer offers this option, you may choose to:

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

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

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

Student Status
An unmarried Dependent 26 years of age 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.

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 and pay the applicable premium 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 time frame, the Member 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 includes an interim court order or a final order of adoption, guardianship, placement for adoption or placement 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 the Policy, Description of Coverage, the SBC, reimbursement for claims, Explanation of Benefit forms 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 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 application to your Employer within 31 days of 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, 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 together with any reasonable attorneys' fees and expenses incurred in 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. Coverage under this Policy begins on the Effective Date and remains in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Group or Health Alliance.

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

Late Entrant
An Employer Group may allow Employees and their eligible Dependents to enroll as Late Entrants. Eligible Employees and their Dependents may enroll by submitting a completed application to their Employer within 31 days of the Employer Group's eligibility date. Coverage is effective the first of the month following the receipt of the application.

Special Enrollment
Federal law and this Policy describes 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 special enrollment 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 to Health Alliance for the change in enrollment.

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

- If you and your eligible Dependents are no longer eligible under another Employer Group health 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 for you and your Dependents added through this qualifying event is impacted by the date of the qualifying event. If the date of the qualifying event is between the first and fifteenth 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 between the sixteenth and last day of the month, the Effective Date is the first of the second month following the date of the qualifying event.

- If you acquire a new Dependent through marriage, you may enroll yourself and/or your new Legal 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 or your eligible Dependents exhaust COBRA continuation or state continuation coverage, under another Employer Group health plan, 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 is impacted by the date of the qualifying event. If the date of the qualifying event is between the first and fifteenth 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 between the sixteenth and last day of the month, the Effective Date is the first of the second month following the date of the qualifying event.

- If you gain a Dependent through a court order, you may enroll yourself, your eligible Legal Spouse, the new Dependent or any other eligible Dependent children not currently enrolled in the Plan. The Effective Date of coverage for you and your Dependents 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 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 will be 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, intentional 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, intentional misrepresentation or inaction. The Effective Date of coverage of 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 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 will be the first day of the second following month, after the requested enrollment.

- If you have other coverage (such as a plan offered by your Spouse's Employer) and you lose coverage as a result 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 divorce, 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, 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 of you and your Dependent added through one of these special enrollment events 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, 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 will be the first day of the second following month after the 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 (of they must have lived in a foreign country or United States territory) in order for this to be considered 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 will be the first day of the second following month after the qualifying event.

- If you and/or your Dependents 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 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 are 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 recession 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 that 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 that 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 percent 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 re-employment 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 Plan 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

Copayment, 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 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.

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 SBC. This is the maximum amount you are required to pay in Copayments, Coinsurance and Deductibles for medical services during the Benefit Year.

Any Copayment, Coinsurance or Deductible amount exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Benefit Year. If you believe that you have paid any Copayment or Coinsurance amounts after you have reached your Out-of-Pocket Maximum, you may request a review of your claims. Requests for claim

review must be submitted to Health Alliance prior to the end of the Benefit 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 overpayment will need to 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 for 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 specified medical services during the Plan Year. You must reimburse the Plan for any amounts exceeding the Plan Year Maximum that the Plan pays on your behalf.

PREMIUMS

Payment of Premiums
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 Medicare 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.

Health Alliance reserves the right to change the premium rate for an Employer Group if state or federal laws require a change in benefits or other terms of coverage. Written notice will be provided to the Employer Group not less than 31 days prior to the premium rate 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 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 this 31-day grace period, the Employer Group will remain liable for the payment of the premium for the time that coverage was in effect. The Policyholder will remain liable for the payment of any applicable share of the premium for the time that 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 subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum Benefits specified on the Description of Coverage and/or the SBC.

Expenses for healthcare services are covered only if the services are Medically Necessary for the treatment, maintenance or improvement of your health. Some healthcare services are subject to Preauthorization by Health Alliance and a determination that criteria have been met. Those services are noted under the "Preauthorization" section of this Policy. Health Alliance maintains a list of services that require Preauthorization. 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 that must 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.

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 benefits 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.

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

Bariatric Surgery for Severe Obesity
Bariatric surgery for severe obesity is covered for select 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 and, 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. 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 level as listed on the Description of Coverage and/or the SBC.

Chemotherapy and Radiation
Charges for chemotherapy and radiation therapy for Medically Necessary treatment are 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 is 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 Physician that can provide this service within the scope of their state license. Any services or treatment not outlined in this section would not be 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 and/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 & Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the U.S. Department of Defense, the US. 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.

Contraceptive Drugs, Devices and Services
Food and Drug Administration (FDA) approved prescription Contraceptive devices, injections, procedures and services, including Natural Family Planning, are 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.

Devices and the medical fitting and 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.

Sterilization procedures, intended for female Contraceptive purposes are covered under the wellness benefit. Additional charges billed will apply 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 Contraceptives, including but not limited to, Contraceptive pills, patches and the ring, are not covered unless otherwise specified in a Rider attached to this Policy.

Dental Services
Hospitalization and anesthesia for dental services are covered when determined to be Medically Necessary 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.

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, and/or Coinsurance amount specified on the Description of Coverage and/or the SBC. Test strips for blood glucose monitors are covered subject to the Deductible and/or Copayment or Coinsurance amount specified on the Description of Coverage and/or the SBC. 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 any type of diabetes mellitus and gestational diabetes are covered when Medically Necessary and provided by a qualified 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 Physician 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 in-patient 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 Physician or by a nurse or other healthcare professional under the direction of a Physician.

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

Based on Medical Necessity, the equipment is made available through rental or purchase agreements 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. The rental or purchase of a manual breast pump is covered during pregnancy and through the post-partum period under the Plan's wellness benefits; see "Wellness Care" under "What Is 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 and Preauthorization 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 Deductible, Copayment or Coinsurance is waived if you are admitted to the Hospital when your Plan requires an inpatient Hospital Deductible, Copayment or Coinsurance. Unexpected hospitalization due to complications of pregnancy is covered.

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. Emergency Services are subject to the Participating (In-Network) Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

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. An Outpatient Prescription Drug Rider with an Erectile Dysfunction benefit is attached to this Policy.

Each service 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 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" under "What Is Not Covered."

Hearing Evaluations
Hearing evaluations performed by licensed 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 services are given under the direction of, and approved by, a Physician.

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 and approved by a Physician.

Hospice Care
Hospice care program charges are covered when ordered by your Physician. 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, including respite care, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. Hospice refers to 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 his or her illness and, as estimated by a Physician, are expected to live less than 6 months as a result 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 a Physician. 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 a 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 includes any complications related to the surgical removal of the donated organ.

If both the recipient of the living human organ donation and the living organ donor are Members with Health Alliance policies, the recipient's Policy would cover the living organ donor's expenses, beginning with the evaluation and ending one year after surgical removal of the organ. Coverage includes 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. Coverage for benefits under this subsection begins with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and through one year after transplant. Office visit and Hospital care Deductibles and/or Copayments or Coinsurance 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.

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-specialty care Deductible, Copayment or Coinsurance 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. Coverage for the Newborn would begin at birth following enrollment requirements as specified in the "Newborns, Adopted Children or Children Placed for Adoption" section of this Policy. Your 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 Physician, a post-discharge Physician 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 Coinsurance and Benefit Year Medical Deductible specified on the Description of Coverage and/or the SBC.

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

Lactation counseling and/or support and the rental or purchase of a manual breast pump is covered during pregnancy and through the post-partum 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.

Medical Specialty Prescription Drugs
Medical Specialty Prescription 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 Prescription 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. Medical management; or
4. FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.
5. Complex medical management; or
6. FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.

Examples of Medical Specialty Prescription 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, you can view the prescription Drug Formulary at HealthAlliance.org.

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

Medical Specialty Prescription Drugs are covered under this Policy subject to a prior written order by your Physician and Preauthorization by Health Alliance. Medical Specialty Prescription Drugs are those Specialty Prescription Drugs received in the Physician's office and/or are administered by a healthcare professional in an

office or other healthcare setting. Coverage for Medical Specialty Prescription Drugs is subject to the Deductible, Copayment or Coinsurance specified on the Description of Coverage and/or the SBC.

Pharmacy Specialty Prescription Drugs are not covered unless otherwise specified in an Outpatient Prescription Drug Rider attached to this Policy.

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 the SBC.

Inpatient hospitalization and residential care are subject to Inpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and 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 emergency situations.

Outpatient mental healthcare visits including group Outpatient visits are subject to any Outpatient mental health Deductible, Copayment 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 any inpatient mental health Deductible, Copayment and/or Coinsurance as specified in the "Other Covered Services" section of the Description of Coverage and/or the SBC.

Mental health services may be provided by a 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-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 30 days of the Injury.
- Traumatic injury to the jaw bones 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 applies, as specified on the Description of Coverage and/or SBC. Special shoe inserts for arch or foot supports that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure are 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 and Preauthorization can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card.

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 Copayments and Coinsurance as defined on the Description of Coverage and/or the SBC.

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 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 medication drugs are not covered unless otherwise specified in a Prescription Drug Rider attached to 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 for illness and Injury and Wellness Care 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 Physician.

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 is a covered benefit when Medically Necessary.

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 lymphedema.
- 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, used for medical conditions and are received in the Outpatient or home setting when you are homebound, and are directed at improving physical functioning are covered, subject to any Outpatient rehabilitation coverage limitations specified on the Description of Coverage and/or the SBC per Primary Medical Diagnois per Benefit Year. Speech, physical and occupational 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.

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 a 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, after care begins.

Substance Use Disorder Treatment
Substance Use Disorder rehabilitation services or treatment is covered for Medically Necessary treatment, subject to Deductibles, Coinsurance or Copayments specified on the Description of Coverage and/or the SBC.

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.

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 and/or Coinsurance specified on the Description of Coverage and/or the SBC.

Surgical Procedures
Medically Necessary inpatient or outpatient surgeries and procedures are covered as defined in this Policy. Covered services may include assistant surgeons, surgical assistants, surgical fees, facility fees, anesthesia charges and other Medically Necessary services as required. 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 women 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, as well as behavioral health (including Substance Use Disorder evaluations and treatment) and licensed dieticians, nutritionists and certified diabetes educators who counsel senior diabetes patients in their homes to remove the hurdle of transportation for them to receive 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 are covered. Please refer to the sections 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, through Health Alliance's Quit For Life® program. Tobacco cessation pharmacological therapy, as defined by the Health Alliance formulary, is covered.

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. Urgent Care centers treat patients on a walk-in basis without a scheduled appointment. These services are subject to the Deductible, Copayment and/or Coinsurance as listed on the Description of Coverage and/or the SBC.

Vision Care
Vision screenings and examinations for prescribing glasses or for determining the refractive state of the eyes are covered, 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 amount established by the Centers for Medicare & Medicaid Services (CMS).

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 listed on the Health Alliance Identification Card.

Vision care is covered with an Optometrist, Ophthalmologist or other Physician who is licensed to provide care to the eye for vision care services; see "Physician Services" for medical eye care, in addition to the items listed in this section.

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 including but not limited to:

- human papillomavirus vaccine for Members ages 9 to 26;
- shingles vaccine for Members 50 years of age 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, please visit HealthAlliance.org or www.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 but not limited to, a screening Breast Tomosynthesis (3D mammogram) is covered annually under the wellness benefit for women ages 35 and over. Mammograms other than screening mammograms are subject to the diagnostic testing and/or office visit Deductible, Copayments or Coinsurance listed on the Description of Coverage and/or the SBC.

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

High-Risk HPV (human papillomavirus) Testing
DNA testing in women ages 30 and older, once every five year(s) is covered under the wellness benefit. Additional charges or testing will be subject to the appropriate Deductible, Copayment or Coinsurance on the Description of Coverage and/or the SBC.

Cholesterol/Lipid Screening
Cholesterol or lipid screenings for asymptomatic members are covered under the wellness benefit once every five years for Members ages 20 years and older. Cholesterol testing done, other than the wellness screenings listed here or additional charges, are subject to the appropriate Deductible, Copayment 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 increased risk for infection.

High-Risk HPV (human papillomavirus) Screening
Screening for human papillomavirus (HPV) by DNA testing for women age 30 and over, once every five years, is covered under the wellness benefit.

Additional charges or testing will be subject to the appropriate Deductible, 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 are covered for women under the wellness benefit. Additional charges or visits are subject to the appropriate Deductible, Copayment or Coinsurance on the Description of Coverage and/or the SBC.

Colorectal Cancer Screening

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

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

Ultrasound for Abdominal Aortic Aneurysm
A one-time ultrasound screening for men ages 65 to 75 years 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.

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 of age 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
Diabetes screenings for Members are covered.

Fall Prevention
Primary care counseling for exercise interventions to prevent falls in community-dwelling adults ages 65 years or older who are at increased risk for falls 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 years and older is covered. Obesity counseling for adults and children ages 6 years 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 is 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 to 80 who have a 20 pack-year smoking history and currently smoke or for 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 are 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 women at increased risk for breast cancer and at low risk for adverse effects of chemoprevention is covered.

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

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

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 the "What is Covered" section.

Preventive Drugs
The following are covered at Participating pharmacies under the wellness benefit when a Prescription Drug Rider is attached to this Policy:

- 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 medication for a Newborn's eyes.
- Aspirin for the prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50-59 years who have a 10% or greater 10 year 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 ages 40 to 75 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 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

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 supplement products generic single ingredient only, for children 6 months to 5 years without fluoride in their water source.
- Varnish application for children age 0 to 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 to 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 to 90 days old.
- Developmental screening for children under age 3, 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 screening.
- Sexually transmitted infection screening.
- Rh Incompatibility screening, which also includes follow up testing for women at high risk.
- Breast feeding counseling and manual breast pumps. See also the Maternity 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 Centers for Disease Control and Prevention, adopted by the Director of the Centers for Disease Control and Prevention (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, log into HealthAlliance.org. This brochure includes a detailed listing of services and procedures, and their associated procedure code, that are covered under Wellness Care.

WHAT IS NOT COVERED (Exclusions & Limitations)

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

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 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. Surgical removal of wisdom teeth and 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; see "Durable Medical Equipment" 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
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 or device that is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug or device is the subject of on-going phase I, II III or phase IV clinical trial, 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 or device 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 Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug or device for the treatment or diagnosis of your condition, disease or illness does not conform 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.
- The medical treatment, procedure, drug or device 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 or device 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 or device 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; 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
Services 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 or attempt to commit a felony are not covered.

Infertility Services
Infertility services are not covered unless otherwise specified in a Rider attached to this Policy.

Institutional Care
Institutional care that is for the primary purpose of controlling or changing your environment, or is maintenance care, Custodial Care, domiciliary care, convalescent care or rest cure 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."

Outpatient Prescription Drugs
Outpatient Prescription Drugs are not covered unless otherwise specified in an Outpatient Prescription Drug Rider attached to this Policy.

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, which 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, registered clinical psychologist, or Mid-Level Provider, 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 disbarred by the federal government.
- Any service, supply or treatment received outside of the United States of America, other than Emergency Services or Urgent Care

APPEALS

Appeals are divided into two categories: administrative decisions or 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 or 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 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 or 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, 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 30 days of 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 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 coverage 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 decision be reviewed by an independent review organization; see "External Review of Appeals." If you have a medical condition for which the time frame 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 "External Review of Appeals" and "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 decision be reviewed by an independent review organization; see "External Review of Appeals." If you have a medical condition where the time frame 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."

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 60 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 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 service. 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 877-955-1212 or 515-281-6348, by facsimile at 515-281-3059 or visit their website 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, 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:

- You have not received our written decision on your Pre-Service Claim appeal within 30 days You have not received our decision on your Urgent Pre-Service Claim appeal within 48 hours; or
- 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 time frame 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 applies.

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

TERMINATION

In the event the Employer Group terminates, this Policy and 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 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 of this Policy.

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

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

When Medicare is the primary payer, coverage of a Dependent of an active Employee who is enrolled in the Employer Group's Medicare Advantage or Medicare Supplement 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, all amounts payable under this policy shall be such as the premium paid would have been purchased at the correct age and/or Tobacco status.

Health Alliance may terminate the Member's rights 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.

Coverage of a Dependent child will terminate on the last day of the month in which the child reaches the Limiting Age of 26, unless as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement, unless the child is unmarried and enrolled as a full time student. If the unmarried child is enrolled as a full time student, coverage will terminate on or after the date of graduation or cessation of studies or the date the child marries, whichever is earlier. 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 a particular type of insurance 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 available that is currently offered.
- 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 or Medicare Supplement 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 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 (Note: The eligible Spouse/Dependent may be given the opportunity to enroll in the Employer Group's Medicare Advantage or Medicare Supplement 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 Dependents 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 of the health plans and secondary to a 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, 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 (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 routinely provides coverage for private Hospital rooms) is not an allowable expense.
   - 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 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 Maximum Allowable Charges 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 level because he or she did not use a Participating Provider.

4. "**Claim Determination Period**" means a Plan 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 Participating 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 cover the person as an Employee or member (that is, other than as a Dependent) are determined before those of the plan that cover 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 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 Plan 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 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 plans 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) or (4) 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 determines 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.

You must fill out the requested form in writing and return via mail or fax to Health Alliance Midwest 3310 Fields South Drive, Champaign, Illinois 61822 or 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.

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 may fill out and return the request via mail or contact Health Alliance at the number listed on the back of your Health Alliance Identification Card to respond to these requests. If no response is received within 45 days from the receipt of the request, claims may not be considered for payment.

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 the 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 or fax to Health Alliance Midwest 3310 Fields South Drive, Champaign, Illinois 61822 or 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 and authorize and direct his and/or her attorney, personal representative or any insurance company to directly reimburse 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 attorneys' 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 or fax to Health Alliance Midwest, 3310 Fields South Drive, Champaign, Illinois 61822 or 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 Plan for the following Medicare-Eligible Beneficiaries:

- Members with End-Stage Renal disease, during the first 30 months of Medicare eligibility or entitlement.
- Members age 65 and over 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.

Medicare is the primary coverage for those Medicare-Eligible Beneficiaries to whom the MSP laws do not apply (for example, Retired Employees and their Legal Spouses who are ages 65 or older). Benefits for such Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available if the Medicare-Eligible Member enrolled in Medicare and made a proper claim for Medicare payment.

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 Providers, 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.

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 thereafter 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, Illinois 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 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 include:

- 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 is 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: Carle and their 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, the SBC, Amendments, Riders and other papers attached, if any, 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), you should 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
In the event 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, and replacement coverage is not available, then 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 first one of the following occurs: twelve months following the Effective Date of Termination; the date the maximum benefit is reached; or the end of total disability.

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 to not 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 intentional 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 does 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 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, 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.

Proof of Loss
Written proof of loss must be furnished to Health Alliance when there is a claim for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which Health Alliance is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence or legal capacity, late than one year from the time proof is otherwise required.

Time Limit on Certain Defenses
No misstatements, except fraudulent 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.

Through the Group Enrollment Agreement, the Employer Group makes the Health Alliance Indemnity Plan coverage available to people who are eligible under the provisions of this Policy. However, the Group Enrollment Agreement is subject to amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between Health Alliance and the Employer Group without the consent of the Members. By electing medical or Hospital coverage under the Group Enrollment Agreement or accepting benefits of this Policy, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

CONTINUATION OF EMPLOYER GROUP COVERAGE

This is a summary of your rights under the Iowa and the federally mandated continuation coverage laws, then 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

To elect continuation coverage, you must submit a completed application and applicable premium payment to Health Alliance within 30 days after the date coverage under this Policy is terminated.

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.
- Your Employer terminates the Employer Group Policy with Health Alliance.
- If the Member is a former Spouse, upon the former Spouse's remarriage.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families Dependents covered under the Plan will be entitled to elect a temporary extension of health coverage (called "COBRA continuation coverage") where 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:

1. 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.

2. 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.

3. A Retired Employee who retired on or before the date of substantial elimination of Plan coverage which 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 Spouse or 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 health 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:

1. The death of a covered Employee.

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

3. The divorce or legal separation of a covered Employee from the Employee's Legal Spouse.

4. A covered Employee's enrollment in any part of the Medicare program.

5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the Limiting Age for dependency under the Plan).

6. 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 notice is provided to the Qualified Beneficiary of her or his 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 health 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 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)***
- 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 children. 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:

1. The last day of the applicable maximum coverage period.

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

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

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

5. 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).

6. 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.

1. 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.

2. 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.

3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered 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.

4. 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.

5. In the case of any Qualifying Event other than those 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 percent 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, you should 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 Web site 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 address for you or your Dependents. 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.

Amendment
A separate document attached to this Policy that adds, modifies or deletes existing provisions of the Policy.

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 on which the plan's annual benefits are calculated.

Clinical Peer
A healthcare professional who 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.

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 which 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 Health Alliance 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).
- An organized delivery system licensed by the Director of Public Health.
- 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 persons 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 Plan Year.

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

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

Disabled
(A member that 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.

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.

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 which 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 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 Providers 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.

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 at 800-851-3379 or by logging in to HealthAlliance.org to print a temporary card and order a new one.

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 such as 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. An 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
Accidental physical harm to the body caused by unexpected external means.

Large Employer
An Employer who employed an average of at least 51 Employees on business days during the preceding calendar year and who employs at least 51 Employees on the first day of the Plan Year.

Late Entrant
An individual who enrolls under Health Alliance at a time other than during the first period in which the individual is eligible to enroll under his or her Employer Group plan. An individual who enrolls under a Special Enrollment Period will not be considered a Late Entrant.

Legal Spouse
The adult person whom the Policyholder is legally married to under the laws of the state where the covered Employee lives

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 at which a child is no longer eligible for coverage for Dependent coverage on their parent's plan.

Maximum Allowable Charge
The Maximum Allowable charge is based on a percentage of Medicare's charges, including use of a Medicare gap-fill fee schedule, or the average discount Health Alliance has negotiated with Participating Providers. This is the maximum amount payable for a covered service. If the amount billed by a Non-Participating Provider is more than the Maximum Allowable Charge, you will be responsible for the difference between the Maximum

Allowable Charge and the actual amount billed in addition to Copayments, Coinsurance and Deductible. Amounts in excess of the Maximum Allowable Charges do not apply to your Plan Year Out-of-Pocket Maximum.

Medical Director
Medical Director means 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 which 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 seq.).

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

Mental Health Care
Care for illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

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

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 Provider's office, the home, the Outpatient department of a Hospital or freestanding surgical center.

Participating Provider
A Provider or pharmacy who has entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance Midwest 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 on January 1 and ending December 31 of the same calendar year unless otherwise defined by the Group Enrollment Agreement.

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

Policy
This booklet and any attached Amendments and Riders 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.

Primary Care Physician
A Physician who spends a majority of clinical time engaged in general practice or in family practice, 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
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 eight hours or greater per day and does not include nursing care of less than eight 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
The listing of Physicians, healthcare facilities and other healthcare professionals that are Participating for your Plan. To obtain a listing of Providers in the Health Alliance Provider Network please log onto HealthAlliance.org or contact Health Alliance at the number on the back of your Health Alliance Identification Card.

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

Regular Effective Date
The Effective Date determined for certain 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 will be 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.

Retrospective Review
A review performed after a claim for benefits is received.

Rider
A separate document that provides specific additional benefits not included in this Policy.

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

Skilled Nursing 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 Skilled Nursing 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.

Specialty Prescription 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 Maximums. 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.

Totally Disabled
The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or in the case of an individual who is blind, the inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he or she has previously engaged with some regularity and over a substantial period of time.

Urgent Care
Care that requires immediate attention for an unforeseen illness, Injury or condition to prevent serious deterioration of a condition. May also be refer 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.

Woman’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.