HEALTH ALLIANCE MIDWEST INDEMNITY

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MEMBERS' RIGHTS AND RESPONSIBILITIES

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

- A 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 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 Subscription Certificate or 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 PLAN

INTRODUCTION

The Health Alliance Midwest Indemnity Policy is established as a fully insured health insurance product of **Health Alliance Medical Midwest Plans, Inc.** (Health Alliance). The main office of Health Alliance 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 Summary of Benefits (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 PLAN WORKS

The Health Alliance Indemnity Policy allows you and your covered Dependents to choose where you receive healthcare services. Healthcare services are paid according to the POS Indemnity Plan, 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 paid its portion of the bill.

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

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 the 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.

Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims)
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.

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 15 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." If your Preauthorization request is denied based on 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 to 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 72 hours of the request. Health Alliance will try to reach you or your authorized representative by telephone as soon as a decision has been made. You or your authorized representative will be notified in writing or electronically within three days of the coverage decision.

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

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 timeframe 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 "External Review of Appeals," and "Expedited Medical Necessity Review."

To determine which 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. You can also contact 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 in order 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 timeframe 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 Medical Necessity Review."

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 based on 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 in 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 must live or work in the Service Area of the Employer Group's Plan and 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 Legal Spouse
- Your natural-born child or legally adopted child or stepchild
- A child for whom you or your Legal Spouse are the court-appointed legal guardian
- A child placed in foster care or placed for adoption with you or your Legal Spouse. Placement or placed for adoption means you assume and retain total or partial support of the child in anticipation of an adoption. If the child's placement for adoption 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.

Coverage for a Dependent child will terminate the last day of the month in which the Dependent child reaches the Limiting Age as stated in this Policy.

For a Dependent to continue being covered by this Plan after his or her 26th birthday, the Dependent:

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

Health Alliance will request documentary proof of the disability and dependency at reasonable intervals during the two years following the Dependent's attainment of the Limiting Age. You will have up to 120 day to provide proof of the disability and dependency.

For Dependents currently on this Plan that were added prior to reaching their Limiting Age:
If documentation is not sent within 120 days, the Dependent's coverage will terminate on the last day of the month.

For Dependents older than the Limiting Age who are not currently on this Plan and are requesting coverage:
If documentation is not sent within 120 days, the Dependent's coverage will not be effectuated.

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

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 Plan.

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

Newborns, Adopted Children, Children Placed for Adoption or Children Placed in Foster Care
If you are the birth mother paying premiums for individual coverage (Employee only), your Newborn child is covered from the moment of birth only if you submit an Employer Group application form to your employer within 31 days of the birth.

If you are paying premiums for Family Coverage, your Newborn child is covered from the moment of birth for the first 31 days of life. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed Group application form to your employer within 31 days following the birth. For the Newborn to be continually covered past the initial 31-day time frame, the Member must submit an Employer Group application form to your employer to add the child within 31 days of birth. Employer Group application forms are available through your employer.

Newborn coverage will include Medically Necessary care for illness, Injury, congenital defects, birth abnormalities and premature birth.

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, including the signature of the judge on a final order of adoption, guardianship or placement for adoption whichever occurs first, accompanied by a completed Employer Group application form within 31 days from the date of the order. Examples of accepted written documentation includes an interim court order or a final order of adoption, guardianship or 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 31 days from the date your request for coverage is received. Employer Group application forms 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 and/or, SBC, reimbursement for claims, Explanation of Benefits 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, or;
- For reasons otherwise specified in the "Termination section" of this Policy.

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 Group application form 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, whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in 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. This Plan will remain in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Employer Group or Health Alliance.

Open Enrollment
An Employer Group may have an Open Enrollment period in which eligible Employees and their eligible Dependents may enroll in, or make other enrollment changes on, the Plan by submitting a completed Group application form to their 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. See "Terms," "Late Entrant." Eligible Employees and their Dependents may enroll by submitting a completed Employer Group application form to your employer within 31 days of the Employer Group's eligibility date. Coverage is effective the first of the month following the receipt of the Employer Group application form.

Special Enrollment
Federal law and this Policy describe special enrollment provisions which establish a period of time in which you have the option to enroll in an Employer Group Plan when you or your Dependents experience a qualifying event. Members may be required to provide verification of their qualifying event to Health Alliance.

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

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

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

- If you acquire a new Dependent through marriage, you may enroll yourself and/or your new Spouse and eligible Dependents in the Plan. The Effective Date of coverage of 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 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 within days 1-15 of the month, the Effective date is the first of the month following the date of the qualifying event. If the date of the qualifying event is within days 16 through the end of the month, the Effective Date is the first of the second month following the date of the qualifying event.

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

- If you or your eligible Dependents' enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, Employee or agent of the Health Insurance Marketplace for Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction. The Effective Date of coverage 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 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.

- 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 death, legal separation or divorce, the Effective Date is the date of the qualifying event.

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

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

- If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Spouse, and 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 qualifying 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, 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.

- 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 would be the first day of the second following month after the qualifying event.

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

- If you 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 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 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), as amended, 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 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 his or her 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 in a position satisfying the Employer group's eligibility requirements 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 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 are specified on the Description of Coverage and/or the SBC. These are the maximum amounts you are required to pay in Copayments, Coinsurance and Deductibles for medical services during the Benefit Year.

Any Copayments, Coinsurance or Deductible amount exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Benefit Year. If you have paid any Deductible, Copayment or Coinsurance amounts after you have reached your Out-of-Pocket Maximum, you may request a refund. Requests for refunds must be submitted to Health Alliance prior to the end of the Plan Year or as soon as reasonably possible. Health Alliance is not responsible for refund requests more than one year after any overpayment.

Any Copayment, Coinsurance or Deductible that is not applied to your Out-of-Pocket Maximum is specified on the Description of Coverage and/or the SBC. Payments for non-covered items or services and amounts over 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 the specified medical services during the Benefit 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 Plan Year renewal date. Rates may also be subject to change during a Plan Year due to a change in, 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.

Unpaid Premiums
Any premium due and unpaid or covered by any note or written order 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 are healthcare services covered under this Policy are subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum benefits specified on the Description of Coverage and/or the 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. 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 to be met before coverage is provided for some healthcare services covered under this Policy. Medical policies are available on the Health Alliance website. To view these policies, log in at HealthAlliance.org and click on the “Authorization” 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 visit limitations are subject to the limitations listed on the Description of Coverage and/or the SBC.

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

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 distance up to 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 are covered when prescribed by a Physician as Medically Necessary; see “Durable Medical Equipment and orthopedic Appliances” and “Home Infusion Services.”

Autism Spectrum Disorders
The Medically Necessary diagnosis and treatment of Autism Spectrum Disorders is covered. “Autism Spectrum Disorders” means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association, including Autism, Asperger’s syndrome and Pervasive Developmental Disorder.

Treatment includes Medically Necessary direct, consultative or diagnostic psychiatric care, direct or consultative psychological care, habilitative or rehabilitative care and therapeutic care:

- Habilitative or rehabilitative care includes counseling and treatment programs intended to develop, maintain, and restore the functioning of a Member under the age of 21 who has been diagnosed with Autism Spectrum Disorder.
- Therapeutic care for Autism Spectrum Disorders includes behavioral, speech, occupational, and physical therapies addressing self-care and feeding, pragmatic, receptive, and expressive language, cognitive functioning, applied behavioral analysis, intervention, and modification, motor planning, and sensory processing.

Services must be provided by either a Physician, clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or healthcare professional with expertise in treating effects of Autism Spectrum Disorders, when the care is determined to be Medically Necessary and ordered by a Physician. To be eligible for coverage, Medically Necessary early intervention services must be delivered by a certified early intervention specialist. Benefits are limited to healthcare services prescribed by your physician in accordance with a treatment plan. Coverage for healthcare services will be provided as prescribed by your treating physician in accordance with the treatment plan.

Coverage for Autism Spectrum Disorders will not be subject to limits, deductibles, copayment or coinsurance provisions that are less favorable than those that apply to physical illness under the Plan.

The Outpatient Rehabilitation Services Plan Year Benefit limit does not apply to the Autism Spectrum Disorders benefit.

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, 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.

Patient under the age of 21 must have two Physicians determine that the surgery is necessary to save the life of the patient or restore the patient's ability to maintain a major life activity. Each Physician must document in the patient's medical record the reason for the physician's determination. Coverage is limited to individuals age 18 and older at the time of 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.

Blood
Blood, blood products and blood transfusions are covered when determined to be Medically Necessary by a Physician. Costs related to the administration and procurement of blood and blood components are 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 phase III is not covered. Cardiac Rehabilitation services are covered at the "Other Covered Services" benefit as listed on your Description of Coverage and/or the SBC.

Chemotherapy and Radiation
Charges for chemotherapy and radiation therapy for Medically Necessary treatment are covered.

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

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

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 to be Medically Necessary. An initial office visit iscovered 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.

Clinical Trials
During an Approved Clinical Trial, routine patient care that is administered to the Member, as defined in this Policy, is covered unless the service or item is covered by the clinical trial directly. Each covered service is subject to the Deductible, Copayment or Coinsurance amounts specified on the Description of Coverage and/or SBC.

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

- Medically Necessary

- Approved by one of the following agencies: the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the U.S. Department of Defense, the U.S. Department of Veterans Affairs or the U.S. Department of Energy; and/or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; 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 with a medical diagnosis and are not used for Contraceptive purposes or for unintended pregnancy for females are not considered Wellness and are subject to the medical 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 with a medical diagnosis are subject to the appropriate Deductible, Copayment and/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 with a medical diagnosis are subject to the appropriate Deductible, Copayment and/or Coinsurance as specified on the Description of Coverage and/or the SBC.

Elective sterilization procedures, such as tubal ligations and vasectomies intended for Contraceptive purposes are covered under the Wellness benefit.

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

Prescription Contraceptives, including but not limited to, Contraceptive pills, patches and rings are not covered unless otherwise specified in a Rider attached to this Policy.

Dental Services
Hospitalization and anesthesia for dental services are covered, when Medically Necessary= for the following:

- For children less than 19, and under;
- Individuals with a medical condition that requires Hospitalization or general anesthesia for dental care; and
- Or for individuals who are disabled.

Also, 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. The diabetic equipment listed in this subsection must be obtained from a Participating Provider or podiatrist and prescribed in writing by a Participating Provider or podiatrist. Diabetic equipment not listed in this subsection are covered when Medically Necessary.

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

Diagnostic Testing
Diagnostic testing, including but not limited to, x-ray examinations, laboratory tests and pathology services are covered when ordered by a Physician and Preauthorized by Health Alliance, when Preauthorization is required.

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 and Orthopedic Appliances
Corrective and orthopedic appliances, such as leg braces and knee sleeves, and durable medical equipment (such as wheelchairs, surgical beds, insulin pumps and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. 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. A maximum benefit limit may apply. Costs associated with the repair of covered equipment are covered if the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered. The rental or purchase of an electric breast pump is covered during pregnancy and through the postpartum period. The rental or purchase of a manual breast pump is covered during pregnancy and through the postpartum period under the Plan’s Wellness benefits; see “Wellness” 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 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 and/or Coinsurance is waived if you are admitted to a Hospital when your Plan requires an inpatient Hospital Deductible, Copayment and/or Coinsurance. Unexpected hospitalization due to complications from pregnancy is covered.

If you receive Emergency Services either inside or outside the Service Area 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 no greater expense to you than if the service had been provided by a Participating

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

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 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/Transplants" 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 a Physician and Preauthorized by Health Alliance.

Private Duty Nursing Service is 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 Primary Care Physician or treating specialist. For purposes of this subsection, Hospice Care program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Member and the Member's family, 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 12 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. A private room would be covered (at no greater cost than a semi-private room to the member) if it is the only room available.

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

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

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

If the recipient of the living human organ donation is not a Member, and you (the Member) are the living organ donor and you have no coverage from any other source, then benefits will be provided to you under this Policy. This 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, each will have benefits paid by their own Policy.

Human Organ Transplant
Human organ benefits for organ or tissue transplants and procedures, including "bone marrow transplants" and similar procedures, are covered with Participating Providers only. Organ donor treatment or services for a Member who serves as an organ donor are covered with Participating Providers only. These services are covered when incurred at an approved center of excellence, when utilizing Participating Providers or otherwise Pre-Authorized; see the "Human Organ Donor" and "Human Organ Transplant" sections in the HMO portion of this Policy.

When visiting a Participating Provider or an approved center of excellence coverage includes, but is not limited to:

- Inpatient and Outpatient Medically Necessary services related to the transplant surgery.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor.
    - Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preparing, preserving and transporting the donated organ or tissue.
- The transportation of the donor organ to the location of the transplant Surgery.
    - 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 people who travel

with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

Infertility Services
Infertility services for the diagnosis and treatment of Infertility will be covered subject to the following terms, conditions and limitations. Infertility services are covered that the Member meets all Health Alliance criteria for coverage. Prescribed and approved services must be received at an Infertility center or other provider approved by and under contract with Health Alliance. Any services not covered are described in the "What is Not Covered" section of this Policy.

The following Infertility services are covered:

- Infertility evaluation by a Participating Physician or Mid-Level Provider.
- Office visits related to the initial evaluation or follow-up appointments.
- Lab and X-ray, Huhner test (post-coital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, Artificial Insemination, semen analysis, acrosome reaction test, urological evaluation and testicular biopsy.
- In Vitro Fertilization, Uterine Embryo Lavage, Embryo transfer, Gamete Intrafallopian Tube Transfer, Zygote Intrafallopian Tube Transfer and Low Tubal Ovum Transfer.
- Assisted Reproductive Technologies (ART), meaning the treatments and/or procedures in which the human Oocytes and/or sperm are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART coverage includes prescription drug therapy used during the cycle in which Oocyte Retrieval is performed.
- Outpatient prescription drugs and Specialty Prescription Drugs for the treatment of Infertility as outlined in this Policy.
- Infertility services after reversal of Sterilization are covered if there is a successful reversal of Sterilization and if the Member's diagnosis meets the definition of Infertility.

Benefit Limitation/Oocyte Retrieval Limitation:

- For treatments that include Oocyte Retrievals, coverage for such treatments will be provided only if the Member has been unable to attain a viable pregnancy, maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments. This requirement shall be waived in the event that the Member or partner has a medical condition that renders such treatment useless.
- For treatments that include Oocyte Retrievals, coverage for such treatments is not required if the Member has already undergone four completed Oocyte Retrievals, except if a live birth follows a completed Oocyte Retrieval, then coverage shall be required for a maximum of two additional completed Oocyte Retrievals. Such coverage applies to the individual per Policy.
- Following the final completed Oocyte Retrieval for which coverage is available, coverage for one subsequent procedure used to transfer the Oocytes or sperm to the covered recipient shall be provided
- The maximum number of completed Oocyte Retrievals that shall be eligible for coverage is six per Policy.

Donor Expenses:

- The medical expenses of an Oocyte or sperm Donor for procedures utilized to retrieve Oocytes or sperm, and the subsequent procedure used to transfer the Oocytes or sperm to the covered recipient, is covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening and prescription drugs,are also covered if established as prerequisites to donation by the insurer.
- Coverage for a known donor is provided. In the event the Member does not have arrangements with a known donor, the use of a contracted facility is required. If the Member uses a known donor, use of

contracted Providers by the donor for all medical treatment, including but not limited to testing, prescription drug therapy and ART procedures, is required.
- If an Oocyte Donor is used, then the completed Oocyte Retrieval performed on the donor will count against the Member as one completed Oocyte Retrieval.

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, and/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 and/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 properly enrolled Newborn. Newborn charges are applied to the eligible covered mother's inpatient benefit for the first 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. Coverage for the Newborn would begin at the moment of birth following enrollment requirements as specified in the "Newborns, Adopted Children, Children Placed for Adoption or Children Placed in Foster Care" 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, not covered under the eligible covered mother's inpatient benefits, is provided, subject to any applicable Coinsurance and Plan Year Medical Deductible specified on the Description of Coverage and/or the SBC.

In addition, coverage is provided for an examination given at the earliest time to the Newborn for the detection of the following disorders:

- Galactosemia
- Maple Syrup urine disease
- Homocystinuria
- Inborn errors of metabolism that result in an intellectual disability and that are designated by the state department
- Congenital adrenal hyperplasia
- Biotinidase deficiency
- Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state department determines that the technology is available for use
- Low oxygen levels, pulse oximetry screening examination

Lactation counseling and/or support, and the rental or purchase of a manual breast pump is covered during pregnancy and through the postpartum period under the Plan's Wellness benefit. The rental or purchase of an electric breast pump is covered during pregnancy and through the postpartum period under the Plan's durable medical benefit; see "Durable Medical Equipment,Orthopedic Appliances and Devices" under "What is Covered."

Benefits for Maternity services are available to the same extent as benefits provide 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
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) Complex medical management; or
(4) 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, 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 by logging in at HealthAlliance.org.

Cancer specialty drugs, whether oral, intravenous or injected medications are covered at the same financial requirement regardless of the location where 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 are 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 healthcare services for Medically Necessary treatment and/or crisis intervention are covered, as specified on the Description of Coverage and/or the SBC. Inpatient hospitalization and residential care are subject to Inpatient 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 except in emergency situations.

Outpatient mental healthcare visits, including group outpatient visits, are subject to any Outpatient Deductible, Copayment and/or Coinsurance as specified on the Description of Coverage and/or the SBC.

Care in a day Hospital program, or partial or intensive Outpatient program, are subject to Deductible, Copayment 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.

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.

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

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 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.
- Medical dental care required to be performed in order to treat other underlying medical conditions such as malnutrition or digestive disorders.

Orthotics
Specially molded and custom-made orthotics are covered when prescribed by a Physician and Medically Necessary.

The Durable Medical Equipment and Orthopedic Appliance Deductible, Copayment and/or Coinsurance amount applies, as specified on the Description of Coverage and/or the SBC. Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc. of the foot or that may be prescribed to avoid an open surgical procedure are covered.

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.

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

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 determined to be Medically Necessary as specified on Description of Coverage and/or the SBC.

Physician Services
Diagnostic and treatment services and Wellness care for illness or Injury provided by a Physician or under the supervision of a Physician are covered, including 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 of services, Virtual Visits or services received from a Primary Care Physician (including 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, 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 an enrolled Newborn is covered.

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

Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed
- Reconstructive surgery of the other breast to produce a symmetrical appearance
- Prostheses and treatment for all physical complications at all stages of mastectomy, including lymphedemas
- Removal or replacement of an implant 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 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 that are received in the Outpatient or home setting when you are homebound, and are directed at improving your physical functioning are covered, subject to any Outpatient Rehabilitation coverage visit limitations per condition, per Benefit Year specified on the Description of Coverage and/or the SBC. Therapies are counted by type and date of service. Habilitation services are also covered under the Rehabilitation Services benefit.

Sexual Assault or Abuse Victims
Hospital and medical services in connection with sexual abuse or assaults that are of an emergency nature 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 intended for Contraceptive purposes only, are covered under the Wellness benefit listed on the Description of Coverage and/or the SBC. All sterilization procedures with a medical diagnosis or 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 when 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.

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

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

Inpatient benefits include: Medically Necessary Inpatient Hospitalization and residential care and are subject to the Substance Use Disorder Deductible, Copayment or Coinsurance as specified on the Description of Coverage and/or the SBC. Inpatient care requires notification to Health Alliance within 24 hours of admission except in emergency situations.

Outpatient benefits include individual counseling sessions or group Outpatient visits.

Care in a day Hospital program or partial intensive Outpatient treatment program are subject to Deductible, Copayment 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, Copayment or Coinsurance specified on the Description of Coverage and/or the SBC.

Benefits for Substance Use Disorder services are available to the same extent as benefits provided for other services.

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.

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

Tobacco Cessation Program
Tobacco cessation is covered, including Health Alliance's Quit 4 Life® program. Tobacco cessation prescription drug therapy, as defined by the Health Alliance formulary, is covered.

Urgent Care
Services obtained at a Participating Urgent Care centers are covered. These services are intended for immediate Outpatient treatment for an unforeseen illness, Injury or condition to prevent serious deterioration. Urgent Care centers may also 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 is 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 back of your 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 Deductible and/or Copayments or Coinsurance 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 HSAs under federal tax law.

Other preventive health services include:

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 children vaccination schedules as determined by published preventive care guidelines.

For a complete listing of the immunization schedules and immunizations please visit HealthAlliance.org orCDC.gov.

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

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

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

Pap Smear
One cervical smear or Pap smear test every three 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.

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

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/or Coinsurance as specified 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 year(s) for Members ages 20 years and older. Cholesterol screenings 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) for Members 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.

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

Ultrasound for Abdominal Aortic Aneurysm
A one-time ultrasound screening for men ages 65 to75 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 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; see “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 years who have a 20 pack-year smoking history and currently smoke or Members who have quit within the past 15 years, is covered. Screening would be discontinued once a Member has not smoked for 15 years or the Member develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Additional charges or visits are subject to the appropriate Deductibles, Copayments and/or Coinsurance on the Description of Coverage and/or the SBC. Preauthorization is required.

BRCA Counseling and Evaluation
BRCA counseling and evaluation for women whose personal or family history of breast, ovarian, tubal or peritoneal cancer is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes is covered. BRCA counseling and evaluations for reasons other than what is listed here or additional charges, are subject to the appropriate Copayments, Coinsurance and/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 for women at an increased risk for breast cancer and at a low risk for adverse medication effects of risk reducing chemoprevention is covered.

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

Tuberculosis Infections Screening
Screening for latent tuberculosis infection (LTBI) for asymptomatic Members who are at increased risk 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 "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 are at risk for anemia
- Gonorrhea preventive medication for 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 years with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater.
- Select vaccinations administered at pharmacies.
- Bowel Prep Kits, as defined by the Health Alliance formulary, used prior to a colonoscopy for members ages 45 and older once per year.
- Tamoxifen and raloxifene used for breast cancer risk reduction.Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at a 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 a 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 ages 0 to 6 years old is covered
- 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 age 0-6 years old who are at risk for exposure
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in Newborns
- Tuberculin testing for children at a 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
- 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 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 and documented in any Amendments and/or Riders.

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, 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 shall 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 with a diagnosis of 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, ear molds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not covered unless you would be bed or- chair- confined without such equipment. This includes any dispensing fees incurred in obtaining these items.

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

- The medical treatment, procedure, drug, device or transplant is the subject of ongoing phase I, II, III or IV clinical trials, or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the 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, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.
- Organ transplants will be deemed experimental or investigational if the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research, as part of the federal Department of Health &Human Services (HHS) determines that such procedures are either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
- If Health Alliance has made a written request or had one made on its behalf by a national organization, for determination by HHS as to whether a specific organ transplant procedure is clinically acceptable and the organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is regarded as experimental or investigational.

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

Eyeglasses, Contacts and Refractory Treatment
Eyeglasses, contact lenses, contact lens evaluations and fittings are not covered, unless there is a diagnosis of cataract or unless otherwise stated in this Policy; see “Vision Care” under “What is Covered.” Lens tinting, scratch protection coating, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses are not covered. Refractive eye surgery is not covered including, but not limited to, refractive keratectomy, radial keratotomy and laser-assisted in-situ keratomileusis (LASIK) surgery.

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

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

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

Illegal Activities
Charges for any service, supply or treatment which 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
The following services are not covered:

- Reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits will be available if the Member's diagnosis meets the definition of Infertility. Coverage is not provided for the diagnostic services needed to confirm a successful reversal
- Payment for services rendered to a non-Member or Member serving as a Surrogate are not covered. However, costs for procedures to obtain eggs, sperm or Embryos from a Member will be covered if the individual chooses to use a Surrogate
- Costs associated with cryopreservation and storage of sperm, eggs and Embryos. Health Alliance will cover the costs associated with subsequent procedures of a medical nature necessary to make use of the cryopreserved substance if the procedures are not deemed to be experimental and/or investigational
- Selective termination of an Embryo. Health Alliance will cover abortions that are Medically Necessary for the life of the mother
- Non-medical costs of an egg or sperm donor
- Travel costs for travel not Medically Necessary, or not mandated or required by Health Alliance. Health Alliance will cover reasonable travel costs as deemed appropriate
- Health Alliance will not provide coverage for Infertility services that are deemed to be experimental or investigational as supported by the written determination of the American Society for Reproductive Medicine or the American College of Obstetrics. Health Alliance will cover Infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from Infertility treatment considered experimental.
- Infertility treatments rendered to Dependents under the age of 18
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided
- Donor Embryos

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

Medicare Benefits
Subject to the Medicare-Eligible Beneficiaries section, 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; see "Bariatric Surgery for Severe Obesity" under "What is Covered."

Outpatient Prescription Drugs
Outpatient Prescription Drugs are not covered, unless otherwise specified in a 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 services with a diagnosis of marriage counseling are 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 Worker's Compensation or similar law. If your Worker's Compensation claim is denied, you are required to notify us of denial within 90 days.
- Charges for appointments scheduled and not kept (missed appointments).
- Charges incurred before you became covered under the Plan or after you terminate from the Plan.
- Complications arising directly from rightfully excluded conditions.
- Services provided by a non-licensed professional.
- Services furnished or billed by a Provider who has been excluded or debarred by the federal government.
- Any service, supply or treatment received outside of the United States of America, other than Emergency Services or Urgent Care.

GRIEVANCES

If you have a concern regarding a medical treatment or services that you have received, you should discuss your concerns with your Physician. If your concern is not resolved, or if your concern is regarding another matter, you may contact Health Alliance via telephone at **800-500-3373** or write to: **Health Alliance Medical Plans, 3310 Fields South Drive, Champaign, Illinois 61822**.

When filing a Grievance, you have the right to designate a representative, such as your Physician, to file a Grievance on your behalf. Additionally, if you receive an adverse Grievance decision, your representative may represent you, and may file an Appeal or a Grievance on your behalf.

If your Physician files a Grievance with Health Alliance that qualifies for an Expedited Review, the Physician will be deemed your representative. Health Alliance will send all correspondence concerning the Grievance directly to your Physician.

In all other situations when a representative seeks a Grievance or an Appeal on your behalf, Health Alliance must receive a signed Designation of Representation form from you, prior to providing any information to, or working directly with your representative. Health Alliance will forward a Designation of Representation form to you to be completed, signed and returned. If this form is not signed or returned, Health Alliance will continue to review your Grievance but will respond only to you, unless a signed form is received.

Health Alliance will accept information, in verbal or written form, regarding the Grievance from you or your Physician via telephone, fax, mail or other reasonable means. Upon request and free of charge, you have the right to receive copies of all documents and information relevant to your appeal.

For more information on our Grievance procedures, or if you would like to file a Grievance verbally with us, you may contact Health Alliance at the toll-free number listed on the back of your Health Alliance Identification Card. Our representatives are available Monday through Friday from 8am to 5pm CST and are knowledgeable about Grievance procedures. If you would prefer to file your Grievance in writing, you may mail it to: Member Relations Department Health Alliance Medical Plans, 3310 Fields South Drive, Champaign, Illinois 61822. If you would prefer to file your Grievance via fax, our fax number is 217-902-9708.

Once Health Alliance receives your Grievance, you should expect a notification within 3 business days, and you should expect a response in writing once your Grievance is closed. This notification may be via phone for Grievances that were received verbally. Once Health Alliance receives your Grievance, your representative should expect a notification within five (5) business days. You should expect a response in writing within five (5) business once the Grievance is closed. This notification may be via phone for Grievances that were received verbally.

Health Alliance will resolve your Grievance in a reasonable period of time that is appropriate to your medical circumstances, but the resolution will never be later than 20 business days after the Grievance was filed. A Grievance would be considered filed on the day that Health Alliance receives it in writing or verbally, at the address or telephone number provided above.

If Health Alliance cannot resolve your Grievance within 20 business days due to the need for additional information, and if your Grievance does not pertain to the denial of any Prior Authorization required by Health Alliance or an adverse certification decision, we will notify you in writing of a 10-business day extension. We will send this extension notice prior to the 19th business day. This extension may occur when information is requested from you or your Physician, and Health Alliance has not received it within 15 business days from our initial request. In the event that an extension is applied, Health Alliance will resolve your Grievance within 30 business days from the date the Grievance was filed. If all of the requested information has not been received, a determination will be made based on the information in Health Alliance's possession.

For any Grievance regarding a denial of Prior Authorization required by Health Alliance, or adverse certification decisions, Health Alliance will provide a decision and written response. The written response will be provided no later than 20 business15 calendar days from when the Grievance was filed. There are no extensions permitted without your consent.

APPEALS

If the decision received from Health Alliance under the Grievance process is acceptable to you, then your Grievance is closed. If our Grievance decision is not acceptable to you, an Appeal may be initiated. You, your authorized representative, Physician or other healthcare Provider may request an appeal by contacting Health Alliance's **Member Relations Department** via telephone at **800-500-3373, via fax at 217-902-9708** or by writing to the **Member Relations Department, Health Alliance Medical Plans, 3310 Fields South Drive,**

Champaign, Illinois 61822. Health Alliance will provide acknowledgement of the Appeal within 3 business days of receipt of your Appeal request. This acknowledgment could be verbally for Appeals Health Alliance receives verbally.

An Appeal would be considered filed on the day that Health Alliance receives it in writing or verbally, at the address or telephone number provided above. Health Alliance will resolve your Appeal in a reasonable period of time that is appropriate to your medical circumstances. Appeals concerning the denial of any Prior Authorization required by Health Alliance, or adverse certification decisions, will be resolved no later than 30 calendar days from the date the initial Grievance was received by Health Alliance.

Expedited Review
You or your authorized representative, Physician or other healthcare Provider may initiate an Expedited Review of a Grievance or Appeal, in writing, verbally, or by other reasonable means.

To qualify for an Expedited Review the following requirements must be met:

- The service or procedure has not been performed.
- You, your Physician, other health care Provider or authorized representative involved in the appeal believe that the denial of coverage of healthcare services could significantly increase risk to your health.

We will complete the Expedited Review of your Grievance as soon as possible, considering the medical circumstances, but no later than 48 hours of receipt of sufficient information. Health Alliance will communicate our decision via telephone to your Physician or the ordering Provider. Written notice of our determination will be provided to you, your attending Physician and/or ordering Provider and the facility rendering the service.

Health Alliance will complete the Expedited Review of your Appeal as expeditiously as your medical condition requires. Our decision will be communicated via telephone to your attending Physician and/or the ordering Provider. Written notice of our determination will be provided to you, your attending Physician and/or ordering Provider, and the facility rendering the service.

External Grievance
If our decision was not acceptable to you, you or your authorized representative, Physician or other healthcare Provider may qualify to request an External Grievance.

To request an External Grievance you must meet all of the below requirements:

1. The appeal is pertaining to the following determinations made by Health Alliance,
    - Regarding a service(s) or procedure(s) proposed by your Provider:
        - adverse determination of Medical Necessity; or
        - adverse determination of appropriateness; or
        - determination that a proposed service or procedure is Experimental/Investigational; or
    - The appeal is pertaining to Health Alliance's decision to rescind coverage under this Policy; and
2. You, you or your authorized representative, Physician or other healthcare Provider have requested an External Grievance, in writing. This request must be made within 120 days after you receive notification of our determination regarding your appeal; and
3. The service or procedure is not listed as specifically excluded in this Policy.

When an External Grievance is requested, Health Alliance will forward the Grievance along with any relevant information to an Independent Review Organization. The Independent Review Organization will determine whether to uphold, or reverse Health Alliance's appeal determination. The Independent Review Organization will make the determination within 72 hours if you qualify for an Expedited review, if there is an urgent condition, or within 15 business days for non-urgent conditions. The Independent Review Organization will notify Health Alliance and you of their determination within 24 hours if you qualify for an Expedited review, if there is an urgent condition, or within 72 hours for non-urgent conditions. If the Independent Review Organization makes a

determination to reverse Health Alliance's decision, Health Alliance will send written notification to you and your Physician. We will comply with the Independent Review Organization determination.

Filing Time Limit

Grievances:
Health Alliance will not review Grievances received after the end of the calendar year plus 12 months since the incident leading to your Grievance.

Appeals:
Health Alliance will accept Appeals filed within 180 days after you receive notification of our decision concerning your Grievance. Health Alliance will accept External Grievance requests that are filed within 120 days after you receive notification of our Appeal decision.

Grievances and Appeals for Members of ERISA Plans
If you are covered under a Group plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you are required to file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Health Alliance's response is adverse. Upon your request, we will also provide you with detailed information concerning your Appeal.

Notice to Members

Questions regarding your benefits, plan, or coverage should be directed to:

Health Alliance Medical Plans
1-800-851-3379
3310 Fields South Drive
Champaign, Illinois 61822

If you:

a. Need assistance from the governmental agency that regulates this insurance; or
b. Have a complaint Health Alliance has been unable to resolve you may contact the State of Indiana Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461; 1-317-232-2395
Complaints can also filed electronically at: www.in.gov/idoi

General information on the internal and external grievance processes applicable to health insurance issuers is available from the Indiana Department of Insurance at www.in.gov/idoi/3008.htm.

COMPLAINTS

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

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461; 1-317-232-2395
Complaints can be filed electronically at www.in.gov/idoi.

TERMINATION

In the event the Employer Group terminates, this Policy and all rights to benefits and services will cease on the date of termination. The Employer Group will be responsible for notifying you of termination of this Policy under this subsection.

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.

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

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

When Medicare is the primary payer, coverage of a Dependent of an active Employee, who 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 and/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, had it been purchased for the correct age and/or Tobacco status.

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

Coverage of a Dependent child will terminate on the last day of the month in which the child reaches the Limiting Age as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self-sustaining employment by reason of an apparent disabled 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.

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 service 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 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.

In the event Health Alliance decides to no longer offer a particular type of insurance product and a member is hospitalized for a medical or surgical condition their coverage will continue for the duration of the inpatient covered services. Coverage will continue until one the following occurs:

- The member is discharged from the hospital
- The contract has been terminated for 60 days
- The member obtains health insurance, from another carrier, that includes the coverage provided by the terminating plan
- The Employer Group terminates the contract with Health Alliance
- Termination of the member due to:

- The member knowingly providing false information
- The member's failure to comply with the rules stated within the Policy; or
- The member's failure to pay the required premium under the "Premiums" section of this Policy, subject to the grace period.

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, individual, individual and group closed panel or other forms of Group or Group-type coverage (whether insured or uninsured), 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 a "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 as to one or more of the other health plans and secondary to different health plan(s).

3. "**Allowable Expense**" means a healthcare service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

The following are examples of expenses or services that are not allowable expenses:

- If a Member is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans provides coverage for Hospital private rooms).
- If a person is covered under two or more plans that 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 a negotiated fee 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 Benefit Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. “**Closed Panel Plan**” is a plan that provides health benefits to Members primarily in the form of services through a panel of Providers who have contracted with Health Alliance, and that limits or excludes benefits for services provided by other Providers, except in cases of an Emergency Medical Condition or referral by a 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/Parent not Legally Separated or Divorced**: Except as stated in item 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/Parent 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 Legal Spouse of the parent with custody of the child.
   - The plan 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 Benefit Year when any benefits are actually paid or provided before the entity has the actual knowledge.

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

6. **Dependent Adult:** If a married Dependent has his or her own coverage as a Dependent under a Spouse’s plan and has coverage as a Dependent under either or both parent’s plans, the plans covering the Dependent will follow the order of benefit determination rules outlined (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 outlines in (3) above.

7. **Active/Inactive Employee**: The benefits of a plan that cover 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 cover that person as 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 laws right of continuation is also covered by another plan, the following will be the order of benefit determination:

   - The benefits of the plan covering the person as a member, or as that person’s dependent, will pay first.
   - The benefits of the plan providing continuation coverage will pay second.

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

9. **Longer/Shorter Length of Coverage**: If none of the above rules determine the order of benefits, the benefits of the plan that covered an Employee or member longer are determined before those of the plan that covered that person for the shorter term. Benefits by this Policy will not be increased by virtue of this coordination of benefits limitation. It will be the obligation of any Member claiming benefits by this Policy to notify Health Alliance of the existence of all other Employer Group contracts, as well as the benefits payable by any other Employer Group contract. 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. **Network**: If the primary plan has a network of Providers and the secondary plan does not have such a network, the secondary plan must pay benefits as if it were primary when a covered individual uses a Non-Participating, unless the services are rendered on an emergency basis or are authorized and paid for by the primary plan.

11. 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 Medical Plans 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.

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 will 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 theMember, Member's parents (if the Member is a minor) or Member's legal representative as a result of that sickness or Injury.

You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to exercise its rights under this provision. This provision applies whether or not the third party admits liability.

Subrogation
The Plan is assigned the right to recover from the negligent 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 will 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 Dependents' 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 person's 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, 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 Health Alliance Midwest 3310 Fields South Drive, Champaign, Illinois 61822 or fax to our Recovery Department at 217-907-9786. If no response is received within 45 days from the request, claims will not be considered for payment.

MEDICARE-ELIGIBLE BENEFICIARIES

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

- Members with end-stage renal disease, during the first 30 months of Medicare eligibility or entitlement.
- Members ages 65 and over who are covered under this Plan, due to their or their Legal 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 Plan 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 benefit, 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.
- Assign his or her claim for Medicare benefits to the Provider. For covered 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.

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. Any claim for reimbursement or bills for covered healthcare services must be submitted within 20 days, but no later than 90 days of the services or as soon as reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Health Alliance at the address listed below, via electronic claims billing, or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company.

All claims should be submitted to:

Claims Department
Health Alliance Medical Plans, Inc.
3310 Fields South Drive,

Champaign, Illinois 61822

Upon receipt of a notice of a claim, Health Alliance will furnish to the claimant such claims forms, as requested, within 15 days of this notice or request. If after 15 days, the forms are not furnished then the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting his or her initial notice and as long as proof of notice was within the timeframes listed in this section. Health Alliance also accepts itemized bills in lieu of completed claim forms from Non-Participating Providers.

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 timeframe 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 a Group application form 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, aims to safeguard the confidentiality of private information and protect the integrity of healthcare data.

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

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

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

- To you or your authorized representative
- To another party with your signed authorization

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

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

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

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

GENERAL PROVISIONS

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

Entire Contract and Changes
This Policy, the Description of Coverage and/or the SBC, any Amendments or Riders and other papers attached, if any, in combination with the Group Enrollment Agreement and the Group application form, 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 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
If this Plan is terminated for reasons other than those specified in the "Eligibility," "Termination" and "Guaranteed Renewability" sections of this Policy, this Plan will continue to provide benefits according to the Policy and the benefit levels specified on the Description of Coverage and/or the SBC until the 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.

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

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

Guaranteed Renewability
Health Alliance will renew benefits under this Policy at the option of the Employer Group. Health Alliance reserves the right 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 Card issued to you pursuant to this Policy is 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 age, sex, race, ethnicity, religion, national origin, gender, marital status, sexual preference, public assistance status, a person’s status as a victim of domestic violence, health status, physical or mental disability or whether an advance directive has been executed.

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, Inc., 3310 Fields South Drive, Champaign, Illinois 61822. All notices given in the manner provided for in this section will be deemed to have been received by the party to who 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, 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, later than one year from the time proof is otherwise required.

Time Limit on Certain Defenses
No misstatements, except fraudulent misstatements, made in the Group application form 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.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

This section applies only to Members of an Employer Group with 20 or more Employees.

Continuation Coverage Rights Under COBRA
Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their Dependents covered under the Plan will be entitled to elect a temporary extension of 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:

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

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

(iii) A covered retired Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the Legal Spouse, surviving Legal Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Legal Spouse, surviving Legal 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 Legal Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Dependent 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, Civil Union partners may be eligible for COBRA.

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:

(i) The death of a covered Employee.

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

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

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

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

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

If the Qualifying Event causes the covered Employee, or the covered Legal 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 Legal 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 Legal 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 the Family and Medical Leave Act of 1993 (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 Legal 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 Legal Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify your employer in writing 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 in writing to your employer during the 60-day notice period, any Legal Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to your employer.

NOTICE PROCEDURES:

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

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

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

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"Duration of COBRA Coverage."* That explanation describes other situations where notice from you or the Qualified Beneficiary is required in order to gain the right to COBRA coverage.

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 Legal 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, your Legal Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

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

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

(i) 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.

(ii) 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).

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

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

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

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

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

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

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

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

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

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

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

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

(v) In the case of any 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 website at www.dol.gov/ebsa.

KEEP YOUR EMPLOYER INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep your employer informed of any changes in addresses 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 issues by the National Institutes of Health for center support grants.

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

Benefit Year
The year on which the plan's annual benefits are calculated. The Benefit year for this plan runs on a Calendar year and is the same as the Plan Year unless otherwise defined in the Group Enrollment Agreement.

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

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

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

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

Civil Union
A legally recognized relationship between two adults, either of the same of different sex, which provides the benefits and protection under the laws of the state where the covered Employee lives.

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 that are used, with intention, to prevent pregnancy or conception.

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

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

- An Employer Group health plan
- Health Insurance Coverage
- Part A or Part B of Title XVIII of the Social Security Act (Medicare)
- Title XIX of the Social Security Act (Public Aid/Medicaid)
- Chapter 55 of Title 10, United States Code (Armed Forces personnel)
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefit risk pool
- A health plan offered under Chapter 89 of Title 5, United States Code (government organization and Employees)
- A public health plan
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))
- 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.

Customized Orthotic Device
A supportive device for the body or a part of the body, such as the head, neck, or extremities, that includes the repair or replacement of the device based on the patient's physical condition as medically necessary, excluding foot orthotics defined as an "in shoe" device designed to support the structural components of the foot during weight-bearing activities.

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

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

Dependent
A child or Legal Spouse of a Policyholder who meets the eligibility requirements of the Employer Group.

Description of Coverage
A document attached to this Policy that includes, but is not limited to Deductible, 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.

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 that regulates the majority of private pension and welfare Employer Group benefit plans in the United States.

Essential Health Benefits
Benefits covered under the Policy in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and Newborn care, Mental Health and Substance Use Disorder services, (including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices), laboratory services, preventive and Wellness services, chronic disease management and pediatric services, (including oral and vision care). Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any federal and/or state regulations issued pursuant thereto.

Extended Network Provider
Physician or Provider who has entered into a valid contract with Health Alliance through a leased network arrangement to provide healthcare services to Members.

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 Test
An analysis of human DNA, RNA, chromosomes, proteins or metabolites, if the analysis detects genotypes, mutations or chromosomal changes. Genetic test does not include an analysis of proteins or metabolites that is 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.

Habilitative Services
Healthcare services, including occupational therapy, physical therapy, speech therapy, speech-language pathology, and other inpatient and Outpatient services, prescribed by a treating Physician pursuant to a treatment plan to enhance the patient's ability to function by helping them learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Health Alliance Identification Card
A card that is provided by Health Alliance to each Member upon enrollment. Replacement cards may be requested by contacting Health Alliance at 1-800-851-3379 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)
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 or in a legally recognized civil union partnership with under the laws of the state where the covered Employee lives.

Life-Threatening Disease or Condition
Life-Threatening Disease or Condition means 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 Dependent coverage on his/her parent's plan.

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

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

- Is appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or Injury.
- Is 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 with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Is not mainly for the convenience of you, a Physician or other Provider.
- Is 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" or "your" within this Policy)
A Policyholder or a covered family 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 (DMS)* published by the American Psychiatric Association.

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

Newborn
An infant under 28 days of age.

Open Enrollment
A period of time determined by the Employer Group during which eligible Employees and their Dependents may enroll in, or make enrollment changes on the Plan.

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

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

Participating Provider (Participating)
A Physician, Provider or pharmacy that has entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance Members.

Pervasive Developmental Disorders
The diagnostic category of Pervasive Developmental Disorders (PDD) refers to a group of disorders characterized by delays in the development of socialization and communication skills, such as Autism, Asperger's Syndrome, Childhood Disintegrative Disorder and Rett's Syndrome.

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 Benefit Year for each Member.

Policy
This booklet and any attached Amendments and Riders issued to a Policyholder and that describe the coverage provided under the Plan.

Policyholder (also referred to as "you," "your" or "Member" 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 the practice of family practice, internal medicine or pediatrics. These Physicians are designated in the Provider Directory.

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 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Prosthetic Device
An artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as Medically Necessary.

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

Provider
A healthcare Provider, healthcare facility and/or corporation licensed under the applicable laws of the state within the United States where the services are provided.

Provider Directory
A list of Providers or Provider Networks for your Plan, and the area they serve.

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 or if the qualifying event falls between the sixteenth and last day of the month the Effective Date will be the first day of the second following month.

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 or a physical, occupational or speech therapist.

Skilled Nursing Facility
A facility that is primarily engaged in providing to its resident's 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.

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, and/or 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.

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

Virtual Visits
Physician services delivered by use of a web-based portal or other electronic media, Services, include medical exams and consultations.

Woman's Principal Health Care 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, Gynecology or Family Practice.