

Health Alliance Medical Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance Medical Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medical Plans, Customer Service, 301 South Vine, Urbana, IL 61801, telephone: 1-866-247-3296, TTY: 711, fax: 217-365-7494, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

English:

If you, or someone you're helping, have questions about Health Alliance Medical Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-866-247-3296.

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-247-3296 (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-247-3296 (TTY: 711).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-247-3296 (TTY : 711) 。

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-247-3296 (TTY: 711)번으로 전화해 주십시오.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-247-3296 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 711 (رقم هاتف الصم والبكم).
1 -866 -2 47 -3296

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-247-3296 (телетайп: 711).

Gujarati:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-247-3296 (TTY: 711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-247-3296 (TTY: 711).

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-247-3296 (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-247-3296 (TTY: 711).

Japanese:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-866-247-3296 (TTY:711) まで、お電話にてご連絡ください。

Pennsylvanian Dutch:

Wann du Deutsch schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-247-3296 (TTY: 711).

Ukrainian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-247-3296 (телетайп: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-247-3296 (TTY: 711).

Welcome to Health Alliance POS Individual Plan

The Health Alliance Point of Service (POS) Individual plan is a product of Health Alliance Medical Plans, Inc. (Health Alliance), an Illinois domestic stock insurance company licensed to provide both HMO and Indemnity plans. Health Alliance administers all aspects of this Plan, which is located at 301 S. Vine St., Urbana, Illinois 61801-3347. Customer Service Representatives are available via the phone at 1-866-247-3296; this number is also on the back of your Health Alliance Identification Card.

The Health Alliance Point of Service (POS) Individual plan allows you and your covered Dependents to make a choice on where you wish to receive health care services. Your level of coverage is determined by how you choose to receive services. You may choose to receive services from a Participating Provider and receive the highest level of benefits. A Participating Provider is a Physician or Provider that has entered into a valid contract with Health Alliance to provide health care services to Health Alliance HMO Members. These are called HMO Policy (in-network) benefits.

You may also choose to receive services from a Non-Participating Provider. These are called Indemnity Policy (out-of-network) benefits. Choosing to receive services, other than Emergency Services, from a Non-Participating Provider will result in a lower benefit level and more Out-Of-Pocket expenses.

With the Health Alliance Point of Service (POS) Individual plan, you receive two Policies under one Plan. You receive an HMO Policy that explains your in-network benefits and an Indemnity Policy that explains your out-of-network benefits. In addition, you will be responsible for ensuring that all Preauthorization requirements have been met.

This Policy, the Description of Coverage, Summary of Benefits and Coverage (SBC) and the application, constitute the entire contract between you and Health Alliance. No change in this contract will be valid until approved by an executive officer of Health Alliance. No agent has the authority to change this contract or to waive any of its provisions. Any provision, term, benefit or condition of coverage in this Policy may be amended, revised or deleted by Health Alliance in accordance with changes in State and/or Federal law. This may be done without your consent.

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 Copayments, Coinsurance and Deductible amounts, as specified on the Description of Coverage and SBC.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a Non-Participating Provider for a covered service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your Policy's fee schedule, Maximum Allowable Charge, or other method as defined by the Policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill Members for any amount up to the billed charge after the Plan has paid its portion of the bill as provided in Section 356z.3a of this Code. Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Copayments, Coinsurance and Deductible amounts. You may obtain further information about the Participating status of professional Providers and information on Out-Of-Pocket expenses by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

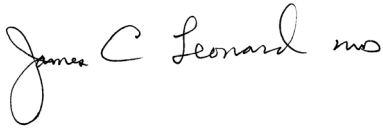
The Effective Date of this Plan is stated on the SBC. This Plan will be automatically renewed from Plan Year to Plan Year, unless canceled or terminated at an earlier date by you or Health Alliance as specified in the "Termination" section of this Policy.

You have the right to examine and return this Policy to Health Alliance within 10 days of receipt and to receive a refund of any premium paid if you are not satisfied with the Policy for any reason. If you return the Policy to Health Alliance, it will be considered void as of the date it was issued to you by Health Alliance. If health care services are

provided to you or any Dependent during the 10-day examination period and prior to the return of the Policy, you will not be entitled to receive a refund of the premium paid for any reason.

Health Alliance Customer Service Representatives are available to help you understand your health care 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.

IN WITNESS WHEREOF, Health Alliance Medical Plan, Inc. has duly executed this Policy.

A handwritten signature in black ink that reads "James C. Leonard" followed by a small flourish.

Dr. James Leonard
President & CEO

HEALTH ALLIANCE INDEMNITY INDIVIDUAL POLICY

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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 health care professionals that Health Alliance contracts with and the Member's rights and responsibilities
 - A right to be treated with respect and dignity and to be given a right to privacy
 - A right to participate with contracted Providers in making decisions regarding your health care
 - 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 the Health Alliance Members' rights and responsibilities Policy
 - A right to have reasonable access to health care
-
- 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 Policy and to 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 INDEMNITY INDIVIDUAL POLICY

INTRODUCTION

This Indemnity Policy is the out of network Policy section of the individual Point of Service (POS) plan that you have chosen.

This Policy, along with the Description of Coverage and Summary of Benefits and Coverage explains to you all the details of the health care plan that you have chosen. It is important for you to read this Policy so you can get to know what your rights are as a Member, what's expected of you and what your benefits are.

If you have questions about your plan or need help understanding your benefits, please call Health Alliance at the number listed on the back of your Health Alliance Identification card.

HOW THE HEALTH ALLIANCE INDEMNITY INDIVIDUAL POLICY WORKS

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

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

PREAUTHORIZATION

Non-Participating Provider or Extended Network Preauthorization Procedure

When using Non-Participating or Extended Network Providers, you are responsible for ensuring that all services listed are Preauthorized before you receive the service. If the Preauthorization request is approved, both you and your Provider will be notified of the effective dates and the kind of care and services you are authorized to receive. Once your Preauthorization approval expires, it is your responsibility to notify your Provider so he/she can determine whether further care is needed, and if so, submit another Preauthorization request to Health Alliance.

If your Preauthorization request is denied, Health Alliance will not provide coverage for the requested services. Preauthorization can be initiated by calling Health Alliance at the number on the Health Alliance Identification Card.

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

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

If your Preauthorization request for urgent care is denied, you have the right to request an expedited internal appeal of the denial, see "Appeals" and "Expedited Medical Necessity Review". If your Physician or other health care Provider believes that the denial of coverage of health care 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 internal 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 what procedures or supplies would require Preauthorization visit the Health Alliance website at HealthAlliance.org, login to your account, click on the Authorizations tab and choose Policies & Procedures in the menu on the right, or contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Preauthorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Health Care Services that Require Preauthorization

Preauthorization provides you with assurance that a Hospitalization, procedure or supply will be covered by the Plan. Coverage will not be provided for health care services that are not Medically Necessary. Services that require Preauthorization will not be covered if you receive those services prior to approval of the Preauthorization request and it is later determined the services were not Medically Necessary. To determine what procedures or supplies would require preauthorization visit the Health Alliance website HealthAlliance.org or contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

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

Non-Participating and Extended Network Provider Preauthorization Penalty

If you or your Physician do not Preauthorize Hospital admissions to a Non-Participating or Extended Network Hospital, the Plan imposes a Preauthorization Penalty. The penalty amount is the lesser of 50% or \$1,000 of the billed charges. The Preauthorization Penalty does not apply to your Out-of-Pocket Maximum limit.

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 appeal the concurrent care decision and obtain a determination on review before the coverage is reduced or terminated.

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 health care 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.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

Policyholder

To be eligible to enroll as a Policyholder under this plan, you must complete an application and meet the following requirements:

- You must be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States
- You must not be incarcerated
- You must not be enrolled under another Health Alliance individual health insurance plan while covered under this Plan
- You must not be eligible for Medicare
- If you are an individual who is 21 or older, you must live in the plan's Service Area
- If you are under the age of 21 and not emancipated, you must live in the plan's Service Area or the parent or guardian you reside with must live in the Service Area

Dependent

Your Dependent may be eligible to enroll for coverage under the Plan if he or she is not enrolled under another Health Alliance individual health insurance plan while covered under this Plan, is not eligible for Medicare and has one of the following relationships to you:

- Your Legal Spouse.
- Your natural-born, legally adopted child or stepchild
- A child for whom you are the court-appointed legal guardian
- A child placed for adoption. 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: foster children, 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.

An eligible Dependent child must be (a) under the age of 26 regardless of student status, or (b) under the age of 30 if a veteran and an Illinois resident who served in the Armed Forces and National Guard of the United States and who has received a release or discharge other than a dishonorable discharge. To be eligible for coverage, the eligible Dependent who is a veteran may be required to submit a form approved by the Illinois Department of Veterans' Affairs stating the date on which the Dependent was released from service to Health Alliance.

A Dependent child may continue coverage as a Dependent under the Plan if, upon reaching the Limiting Age, an apparent disabled condition makes the Dependent child incapable of self-sustaining employment, and they are dependent on his or her parent or other care Providers for lifetime care and supervision. Health Alliance may request documentary proof of the disability and dependency. Requests will be made no more often than annually from the date when Health Alliance was first notified of the child's disability and dependency.

Initial Enrollment

If you meet the eligibility requirements stated in the “Policyholder” or “Dependent” subsections, you will be notified of the receipt of your enrollment application and the amount of premium due. Initial enrollment is completed upon receipt of the initial premium payment by Health Alliance.

If a Member is not eligible for coverage under the Plan and intentional misstatement or fraud has been perpetrated, 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 health care services together with any reasonable attorneys’ fees and expenses incurred in collection of such sums.

Initial Enrollment is limited to the designated open enrollment period(s) each year.

Open Enrollment

There will be an Open Enrollment Period each year in which individuals may initially apply for an individual plan or switch individual plans for the next year. You will receive notification in advance of the Open Enrollment Period each year. Individuals may only apply or switch plans outside of this Open Enrollment Period each year when there is a qualifying event for a Special Enrollment Period.

Effective Date

This Plan’s Effective Date is shown on the SBC and will be automatically renewed from Plan Year to Plan Year, unless canceled or terminated at an earlier date by you or Health Alliance, or if you select to switch plans during the Open Enrollment Period.

Special Enrollment Period

Federal law and this policy describe special enrollment provisions, which establish a period of time in which you have the option to enroll in the Plan or switch your plan when you or your Dependents experience a qualifying event. Members may be required to provide verification of their qualifying event to Health Alliance. In order to enroll in coverage retroactively under a special enrollment period, the premium due for all months of retroactive coverage must be paid in full as detailed in the “Payment of Initial Premiums” section.

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

- If you and/or your 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, being released from incarceration 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. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.
- If you and/or your eligible Dependents exhaust COBRA continuation or state continuation coverage, you and your eligible Dependents losing coverage may enroll in the Plan. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.

- If you and/or your Dependents cease to live or work in the Service Area and there is no other benefit plan option available under the Plan. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.
- If you and/or your Dependents have a loss of eligibility for CHIP, Medicaid and/or low income pregnancy coverage, you and your eligible Dependents may enroll in the Plan. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.
- If you and/or your Dependents lose coverage due to loss of eligibility, which may include loss of coverage resulting from retiring or entitlement to Medicare, you and your eligible Dependents may enroll in the Plan. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.
- If you and/or your Dependents are enrolled in any non-calendar year group or individual Plan, even if you have the option to renew coverage. If you experience this qualifying event, you and your eligible Dependents may enroll in the same metal level Plan as your prior Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a loss of coverage to select a Plan. If the Plan is selected before the loss, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the loss, the Effective date would be the first day of the second following month.
- If you acquire, or become, a new Dependent through marriage or a Civil Union partnership and one Legal Spouse has also had qualifying coverage that met minimum essential coverage standards for one or more days in the 60 days preceding the marriage (or they must have lived in a foreign country or United States territory), you may enroll yourself and/or your new Legal Spouse in the Plan. The Effective Date of coverage will be the first day of the following month after the qualifying event.
- If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Legal Spouse, and the newborn or newly adopted child in the Plan. You will have the option to elect coverage to begin on the date of the qualifying event, 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 or if the event falls between the sixteenth and last day of the month, the Effective Date will be the first day of the second following month.
- If you gain a Dependent through a court order you may enroll yourself, your eligible Legal Spouse, and the new Dependent in the Plan. You will have the option to elect coverage to begin on the date of the order 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 or if the event falls between the sixteenth and last day of the month, the Effective Date will be the first day of the second following month.

- If you experience a loss of a Dependent or dependent status through divorce or legal separation you may be eligible for a Special Enrollment. If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after this qualifying event to select a Plan. If the Plan is selected before the qualifying event, the Effective date is the first of the month following the qualifying event. If the Plan is selected after you are eligible, the Effective date would be the first day of the second following month.
- If you experience a loss of a Dependent or dependent status through death you may be eligible for a Special Enrollment. If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. The Effective date is the first of the month following the qualifying event or other Regular Effective Date, at the request of the Member. 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.
- If you and/or your Dependents are newly eligible for a Plan. If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after you are eligible to select a Plan. If the Plan is selected before you are eligible, the Effective date is the first of the month following the qualifying event. If the Plan is selected after you are eligible, the Effective date would be the first day of the second following month.
- If a qualified individual, who was not previously a citizen, national, or lawfully present individual gains such status. If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. If the application is received between the first and fifteenth of the month then the Effective Date is the first day of the following month or if the application is received between the sixteenth and last day of the month, the Effective Date will be the first day of the second following month.
- If you or your eligible Dependents enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, intentional misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace for Health and Human Services (HHS), or its instrumentalities, or non-Health Alliance Marketplace entity as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, intentional misrepresentation or inaction. If the qualifying event falls 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.
- If you or your eligible Dependents adequately demonstrates to the Health Insurance Marketplace that a qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relations to the enrollee. If you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. If the qualifying event falls 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.

- If you and/or your eligible Dependents become newly eligible or ineligible for advance payments of the premium tax credit, change in eligibility for cost sharing reductions, or there is a change to your cost share amount. If you experience this qualifying event and you and your Dependents are not currently enrolled in a silver metal level Plan, you and your eligible Dependents may enroll in a silver metal level Plan. If the application is received between the first and fifteenth of the month then the Effective Date is the first day of the following month or if the application is received between the sixteenth and last day of the month, the Effective Date will be the first day of the second following month.
- If you and/or your eligible Dependents enrolled in an eligible employer-sponsored plan become newly eligible or ineligible for advance payments of the premium tax credit due to being ineligible for qualifying coverage in an employer-sponsored plan, including a plan that discontinues or changes available coverage within the next 60 days, if you are allowed to terminate coverage. If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after this event to select a Plan. If the Plan is selected before the event, the Effective date is the first of the month following the qualifying event. If the Plan is selected after the event, the Effective date would be the first day of the second following month.
- If you and/or Dependents gain access to new qualified health plans as a result of a permanent move and also had qualifying coverage that met minimum essential coverage standards for one or more days in the 60 days preceding the move (or they must have lived in a foreign country or United States territory). If you are currently enrolled in a Plan and you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. You have 60 days before or 60 days after a 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.
- If you and/or your Dependents are a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, and are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. If the qualifying event falls 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.
- If you and/or your Dependents apply for coverage through the Health Insurance Marketplace, during an Open Enrollment period or due to a qualifying event, and you are assessed by the Health Insurance Marketplace as potentially eligible for Medicaid or CHIP but then are determined to be not eligible, by the state agency, outside of the Open Enrollment period or more than 60 days after qualifying event. If you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. If the qualifying event falls 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.
- If you and/or your Dependents apply for Medicaid or CHIP during an Open Enrollment period, and it is determined by the state agency that you are not eligible outside of the Open Enrollment period. If you experience this qualifying event, you and your eligible Dependents may enroll in your current Plan, a Plan with the same metal level as your current Plan, a Plan one metal level higher or lower if no Plan is available at the same metal level, or you and/or your Dependents may choose to enroll in any separate Plan. If the qualifying event falls 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.

The individual has 60 days from the date of the qualifying event to enroll or make additions or other changes to their plan.

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.

Court or Administrative Order

If a parent who is enrolled in this Plan is required by a court or administrative order to provide health care coverage for his or her child, the Plan will:

- (1) Upon receipt of a copy of the order and application, permit the covered parent to enroll the child who is otherwise eligible for coverage under the Plan; or
- (2) Enroll the child in the Plan upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering a program for enforcing child support and establishing paternity under federal law (or another child support enforcement program), if the parent is enrolled in the Plan but fails to apply for enrollment of the child as required by the order.

The Plan may not impose on a state agency that has been assigned the rights of an enrollee in the Plan who receives Medicaid benefits, requirements that are different from requirements applicable to an assignee of any other Member in the Plan.

The Plan may not disenroll (or otherwise eliminate the coverage of) the child unless the Plan is provided satisfactory written evidence of either of the following:

- (1) The court or administrative order is no longer in effect.
- (2) The child is or will be enrolled in a comparable health care plan obtained by the parent under such order and that enrollment is currently in effect or will take effect not later than the date coverage under the Plan is terminated.

Coverage under a court or administrative order is subject to the provisions of the Termination section of this Policy.

Newborns, Adopted Children or Children Placed for Adoption

If you are paying premiums for individual coverage (self only), your newborn child is covered from birth only if you submit an application to Health Alliance and pay the applicable premium within 60 days of the birth. If you are paying premiums for Family Coverage, your newborn child is covered for the first 60 days of birth. If payment of an additional premium is required, coverage after 60 days is contingent upon notification to Health Alliance and payment of the additional premium within 60 days following the birth. Coverage for the newborn will include illness, Injury, congenital defects, birth abnormalities and premature birth. A newborn of a Dependent child is not covered.

If you adopt a child, serve as a child's legal guardian or a child is placed for adoption, coverage may be subject to the submission of written documentation accompanied by a completed application within 60 days from the date of the order or agreement. Written documentation includes, but is not limited to, an interim order, an agreement of placement for adoption or the signature of a judge on a final order of adoption, guardianship or placement for adoption.

Premiums for coverage of a newborn, adopted child or child placed for adoption will be payable from the date of eligibility and must be paid within 60 days from the date your request for coverage is received.

OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS

Copayment, Coinsurance and Deductible

All Copayment, Coinsurance and Deductible amounts are listed on the Description of Coverage and SBC. 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 (MAC) amount.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum amount for an individual and family is specified on the Description of Coverage and SBC. These are the maximum amounts you are required to pay in Copayments, Coinsurance and Deductibles for medical services during the Plan Year.

Any Copayments, Coinsurance or Deductible amount for Basic Health Care Services exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Plan Year. If you have paid any Copayment, Coinsurance or Deductible amounts for Basic Health Care Services 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 Copayments, Coinsurance or Deductible amounts that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage and SBC. Payments for non-covered items or services and amounts over the Maximum Allowable do not apply to your Out-of-Pocket Maximum.

Any Copayment, Coinsurance or Deductible amounts for non-Basic Health Care Services that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage.

Plan Year Maximum Benefit

The Plan Year Maximum Benefit is the total benefit amount for an individual on a specific non-Essential Health Benefits and is specified on the Description of Coverage and SBC. This is the maximum amount the Plan will pay for the specified medical services during the Plan Year. You must reimburse the Plan for any amounts exceeding the Plan Year Maximum that the Plan pays on your behalf.

PREMIUMS

Payment of Initial Premiums

When enrolling for coverage, you, or anyone paying on your behalf, must remit the specified binder payment, which consists of the first month's payment, no earlier than the Plan Effective Date or no later than 30 calendar days from the date the Health Alliance received your request to enroll. Health Alliance will also require the payment of any past due premium amounts in full prior to enrolling you in coverage.

In order to enroll in coverage retroactively under a special enrollment period, as detailed in the "Special Enrollment Period" section, the premium due for all months of retroactive coverage must be paid in full. If only one month of coverage is paid, Health Alliance will enroll you in coverage proactively, as detailed in the "Special Enrollment Period" section.

Payment of Monthly Premiums

You, or anyone paying on your behalf, must remit the specified premium to Health Alliance by the date due. You are entitled to the benefits under this Policy only if Health Alliance receives the full amount of the premium within the required time period.

Premium Rate Revision

Premium rates are subject to change annually upon the Plan Year renewal date. Notice of a change in the annual premium rate will be provided to you not less than 31 days prior to the effective date of the change. Rates may also

be subject to change during a Plan Year due to a change in age, number of eligible Dependents or geographic location. Any rate revision based on changes during the Plan Year will be effective the first of the next month after the change.

Health Alliance reserves the right to change the premium rate if state or federal laws require a change in benefits or other terms of coverage. Written notice will be provided to you not less than 31 days prior to the premium rate change.

Please contact Health Alliance at the number on the back of your Health Alliance Identification Card with any questions about your bill or to confirm any rate changes.

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, claims may be pended and you will not be entitled to further benefits. During the grace period, if you receive any services, you will remain liable for the payment of the premium for the time coverage was in effect, as well as for any Copayment, Coinsurance or Deductible owed because of services received during the grace period. If payment is not received after the grace period and services have been rendered, then your Policy will terminate for non-payment of premium as of the end of the month of the grace period and claims may be pended. If payment is not received after the grace period and no services have been rendered, then your policy will terminate for non-payment of premium as of the end of the month of the grace period. Providers will be notified after 30 days of the possibility of denied claims.

Unpaid Premiums

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

Reinstatement

In the event the premium is not paid within the time granted, including any grace period, and coverage is terminated, reinstatement of coverage under this Policy is subject the Enrollment Periods described in this policy. Health Alliance requires all past due premium amounts to be paid in full prior to reinstatement of coverage.

WHAT IS COVERED

The following health care services are covered under this Policy subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum benefits specified on the Description of Coverage and SBC.

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

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 health care services covered under this Policy. Medical policies are available on the Health Alliance website. To view these policies login at HealthAlliance.org, policies are under "Medical and Pharmacy Policies" 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.

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 or by means other than by ambulance.

Ground Transportation – Emergency transportation by ground ambulance is covered for an Emergency Medical Condition when Medically Necessary.

Amino-Based Elemental Formulas

Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome is covered when prescribed by a Physician as Medically Necessary; see "Home Infusion Services".

Autism Spectrum Disorders

The Medically Necessary diagnosis and treatment of Autism Spectrum Disorders for Members under the age of 21 are covered. "Autism Spectrum Disorders" means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association, including Autism, Asperger's disorder, 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 a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Coverage for Medically Necessary early intervention services must be delivered by a certified early intervention specialist.

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

Bariatric Surgery for Severe Obesity

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

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

Blood

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

Cardiac Rehabilitation Services

Cardiac Rehabilitation Phase I, provided on an inpatient basis for an acute cardiac episode or surgery, is a covered benefit. Cardiac Rehabilitation Phase II, which is initiated immediately following Phase I, is covered. Repeat Phase II rehab for the same acute cardiac episode, surgery or event is a provisionally covered benefit. 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 SBC.

Chemotherapy and Radiation

Charges for chemotherapy and radiation for Medically Necessary treatment are covered.

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 Deductibles, Copayments 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:

- Preauthorized by Health Alliance
- Approved by one of the follow 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 United States Department of Defense, the United States Department of Veterans Affairs or the United States 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 drug trial that is exempt from having such an investigational new drug application as well as be pre-authorized by Health Alliance.

Contraceptive Drugs, Devices and Services

Federal Drug Administration (FDA) approved prescription Contraceptive devices, injections, procedures and services, including Natural Family Planning, are covered.

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 the SBC.

Devices and the medical fitting and insertion 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 Copayment, Coinsurance or Deductible as specified on the Description of Coverage and 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 Copayment, Coinsurance or Deductible as specified on the Description of Coverage and SBC.

Sterilization procedures, intended for female Contraceptive purposes are covered under the wellness benefit. Additional charges with a medical diagnosis are subject to the appropriate Copayment, Coinsurance or Deductible as specified on the Description of Coverage and SBC (see “Sterilization Procedures” under “What is Covered”).

Prescription Contraceptives, including but not limited to, Contraceptive pills, patches and the ring are covered as defined in the Pharmacy section of this Policy.

Dental Services

Charges incurred and anesthetics provided in conjunction with Dental work that is provided in a Hospital or ambulatory surgical treatment center will be covered for children age six and under; individuals with a medical condition that requires hospitalization or general anesthesia for Dental care; or individuals who are disabled, see “Oral Surgery” in this section for other covered services.

Delta Dental is administering this Policy’s pediatric dental benefit, claims payment and providing dental provider network access. Upon request, Health Alliance and/or Delta Dental will provide any usual and customary fees, how the fees are determined, and the frequency with which the fees are evaluated to the Policyholders.

Diabetic Equipment and Supplies

Blood glucose monitors, cartridges, insulin infusion devices, lancets and lancing devices are covered subject to the durable medical equipment Deductible, Coinsurance or Copayment amount specified on the Description of Coverage and/or SBC. The diabetic equipment listed in this subsection must be obtained from a Participating Provider, and determined to be Medically Necessary.

Diabetic Self-Management Training and Education

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

Diagnostic Testing

Diagnostic testing, including but not limited to, X-ray examinations, laboratory tests and pathology services are covered when ordered by a Physician.

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 health care 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 Provider.

Based on Medical Necessity the equipment is made available through rental or purchase agreements. A maximum benefit limit may apply. Costs associated with the repair of covered equipment are covered if the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered.

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

Emergency Services

Emergency Services received 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 Coinsurance is waived if you are admitted to a Hospital when your Plan requires an inpatient Hospital Coinsurance. Unexpected hospitalization due to complications from pregnancy is covered.

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

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

End-Stage Renal Treatment

Treatment and services for end-stage renal disease are covered in both outpatient and in-patient settings as defined in this Policy. Each covered service is subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and SBC.

Erectile Dysfunction

Treatment is covered for males with documented erectile dysfunction without a correctable cause. Medications will be excluded from coverage unless they meet one of the following requirements:

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

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

Fibrocystic Breast Condition Services

Treatment and services for fibrocystic breast conditions are covered as defined in this Policy. Each covered service is subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and SBC.

Genetic Testing

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

Habilitative Services

Medically Necessary habilitative services are covered for members who have been diagnosed with a congenital, genetic or early-acquired disorder by a Physician licensed to practice medicine in all its branches.

- Habilitative services include occupational therapy, physical therapy, speech therapy, and other services prescribed by the treating Physician pursuant to a treatment plan to enhance the individual's ability to function.
- Congenital, genetic and early acquired disorders include hereditary disorders, autism or an autism spectrum disorder, cerebral palsy or disorders resulting from illness or Injury, which occurred prior to a child's developing functional life skills, such as walking, speaking or self-care skills.

Treatment must be Medically Necessary and therapeutic. Treatment shall be administered by licensed Providers (speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, nurse, optometrist, nutritionist, social worker, or psychologist) under the direction of the treating Physician.

Treatments that are experimental or investigational are not covered. Services that are solely educational in nature or reimbursed under State or federal law are not covered. Treatment of Mental Health Care or other mandated benefits are not included under this benefit.

Hearing Aids

Hearing Aids are covered for members under age 19 when Medically Necessary. Health Alliance will cover two hearing aids, once every three years. Cochlear Implants and bone anchored hearing aids are covered for members when determined to be Medically Necessary.

Hearing Evaluations

Hearing evaluations performed by licensed Providers are covered. Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered, unless otherwise specified in this policy. Cochlear Implants are covered when determined to be Medically Necessary.

Home Health Services

Intermittent Skilled Nursing and Skilled therapeutic home services are covered when you are homebound and services are given under the direction of and approved by a Physician.

Private Duty Nursing Service is covered under home health services when determined Medically Necessary and provided by a licensed or registered nurse who is 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 Service are specified on the Description of Coverage and SBC.

Home Infusion Services

Home infusion services, including medication and supplies are covered when given under the direction of and approved by a Physician.

Hospice Care

Hospice care program charges are covered when ordered by your Physician. For purposes of this subsection, Hospice Care program benefits include, but are not limited to:

- Coordinated Home Care;
- Medical Supplies and dressings;
- Medication;
- Nursing Services - skilled and non-skilled;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Social and spiritual services; and/or
- Respite care services.

Hospice means a program that meets the following requirements:

- It must be licensed by the laws of the jurisdiction where it is located and must be operated as a Hospice as defined by those laws.
- It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a Physician, are expected to live less than 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 condition warrants otherwise. 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 would also include 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 persons who travel with

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

Infertility Services

Infertility services for the diagnosis and treatment of Infertility will be covered subject to the following terms, conditions and limitations. Infertility services are covered upon prior order and written referral from a Member's Provider and upon prior written approval of a Medical Director 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 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 includes prescription drug therapy used during the cycle where 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.
 - 1) 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.
 - 2) the maximum number of completed Oocyte Retrievals that shall be eligible for coverage is four per Plan Year.

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 will be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening and prescription drugs, will also be 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 only if you have significant functional problems that have not been corrected with Dental and/or orthodontic treatment.

Maternity Care

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

Prenatal HIV testing is covered.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the newborn. 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 birth following enrollment requirements as specified in the "Newborns, Adopted Children or Children Placed for Adoption" section of this policy. Your Primary Care Physician, Woman's Principal Health Care Provider or attending Physician may determine after consultation with you that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of the attending 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 the newborn Copayment, Coinsurance and Plan Year Medical Deductible amount specified on the Description of Coverage and SBC.

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 and Orthopedic Appliances" under "What is Covered").

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

Medical Social Services

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

Medical Specialty Prescription Drugs

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, fertility drugs, biological specialty drugs, growth hormones, and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription Drug Formulary at HealthAlliance.org.

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

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 Specialty Prescription Drugs is subject to the Deductibles, Copayments or Coinsurance specified on the Description of Coverage and SBC.

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

Mental Health Care

Mental health care services for Medically Necessary treatment and/or crisis intervention are covered as specified on the Description of Coverage and the SBC. Inpatient hospitalization and residential care are subject to the Inpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and SBC. Inpatient mental health services require notification to Health Alliance within 24 hours of admission except in emergency situations.

Outpatient mental health care visits including group Outpatient visits are subject to any Outpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and SBC. Coverage also includes electroconvulsive therapy.

Care in a day Hospital program or partial or intensive Outpatient program are subject to Deductibles, Copayments or Coinsurance as specified in the other covered services section of the Description of Coverage.

The 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, care in lieu of detention or correctional placement, non-Medically Necessary services, and services with a diagnosis of marriage or social counseling unrelated to mental health conditions as well as any treatment or care that is not Medically Necessary.

Oral Surgery

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

- Traumatic Injury to sound natural teeth for Medically Necessary non-restorative services within 30 days of Injury.
- Traumatic Injury to the jaw bones or surrounding tissue within 30 days of the Injury
- Surgical removal of complete bony impacted teeth
- Correction of a non-dental pathological condition such as cysts and tumors.
- Medical Dental work needed in order to treat cancer itself
- Medical Dental care required to be performed in order to treat another underlying medical condition such as malnutrition or digestive disorders

Orthotics

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

Outpatient Prescription Drugs

Outpatient Prescription Drugs are covered as defined in the Pharmacy section of this Policy.

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 Deductibles, 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 pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Medically Necessary pain medications are covered as defined in the Pharmacy section of this Policy.

Pediatric Acute Onset Neuropsychiatric Syndrome

Treatment and services for pediatric acute onset neuropsychiatric syndrome, including but not limited to, the use of intravenous immunoglobulin therapy, are covered when Medically Necessary, and as defined in this Policy. Each covered service is subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage.

Pediatric Autoimmune Neuropsychiatric Disorders

Treatment and services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, including but not limited to, the use of intravenous immunoglobulin therapy, are covered when Medically Necessary, and as defined in this Policy. Each covered service is subject to the Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage.

Physician Services

Diagnostic and treatment services and Wellness Care, for illness or Injury, provided by a Physician or under the supervision of a Physician, including the recommended periodic health care examinations and well child care are covered, as specified on the Description of Coverage and SBC. Physician Services include Medically Necessary treatment 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.

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, gynecology, obstetrics or pediatrics.

Prostheses

Prosthetic devices, such as artificial limbs, are covered when Medically Necessary due to an illness or Injury and prescribed by a Physician. Devices must be prescribed by a Physician and Preauthorized by Health Alliance.

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

Pulmonary Rehabilitation

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

Reconstructive Surgery

Services to correct a functional defect resulting from an acquired and/or congenital disease or Injury are covered when Preauthorized by Health Alliance. Services are also covered when performed to correct a condition resulting from accidental Injury or incident due to surgery. Correction of a congenital defect or birth abnormality of a newborn is covered.

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

Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed.
- Reconstructive surgery of the other breast to produce a symmetrical appearance.
- Prostheses and treatment for all physical complications at all stages of mastectomy, including lymphedemas.
- Removal or replacement of an implant is covered if Medically Necessary.
- 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 Care with ongoing documentation of Medical Necessity are covered, subject to any inpatient rehabilitation and Skilled Care coverage limitations specified on the Description of Coverage and SBC.

Rehabilitative Therapy Services—Outpatient

Speech, physical and occupational therapies as well as hot/cold pack therapies, for medical conditions received in the Outpatient or home setting when you are homebound, which are directed at improving physical functioning are covered subject to any Outpatient rehabilitation coverage limitations specified on the Description of Coverage and SBC per condition per Plan Year.

Medically Necessary preventive physical therapy for the treatment of multiple sclerosis is covered when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

The Outpatient Rehabilitation and Habilitative Services Plan Year Benefit limits do not apply to the Autism Spectrum Disorders benefit.

Naprapathic services rendered by a licensed Naprapathic practitioner are covered subject to the combined Outpatient Rehabilitation Services visit limitations specified on the Description of Coverage and SBC.

Sexual Assault or Abuse Victims

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

Spinal Manipulation

Spinal manipulation and mobilization is covered for the care of musculoskeletal spinal disorders where significant improvement can be from such treatment. This benefit also includes muscle manipulations when determined to be Medically Necessary. Hot/cold pack therapy used in conjunction with manipulation and mobilization is also covered, see “Rehabilitation Therapy Services-Outpatient.” Spinal manipulation is subject to coverage limitations specified on the Description of Coverage and SBC. Spinal manipulation may be provided by a Participating Doctor of Osteopathy (D.O.), a Chiropractor (D.C.) or other Physician that can provide this service within the scope of their state license.

Sterilization Procedures

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

Substance Use Detoxification

Acute inpatient Substance Use detoxification is covered if determined by your Primary Care Physician 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.

Substance Use Disorder Treatment

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

Inpatient benefits include Medically Necessary inpatient hospitalization and residential care Inpatient services require 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 or intensive Outpatient treatment program are subject to Deductibles, Copayments or Coinsurance as specified in the other covered services section of the Description of Coverage.

Inpatient and Outpatient Substance Use Disorder treatment coverage does not include services in care in lieu of detention or correctional placement or 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 Copayments or Coinsurance specified on the Description of Coverage and 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 BRC1 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 would include medical exams and consultations; and behavioral health, including substance use disorder evaluations and treatment.

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

Temporomandibular Joint Syndrome (TMJ)

Temporomandibular Joint services and treatment as defined in this Policy are covered.

Tobacco Cessation

A tobacco cessation program is covered through Health Alliance's Quit For Life® program. Tobacco cessation pharmacological therapy, as defined by the Health Alliance formulary, is covered subject to the Pharmacy Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and SBC and as defined in this Policy.

Urgent Care

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

Vision Care

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

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

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

Contacts for members under the age of 19 are covered once every 12 months as follows:

- Standard lenses—one contact lens per eye (total two lenses)
- Monthly lenses (six month supply)—six lenses per eye (total 12 lenses)
- Bi-weekly lenses (three month supply)—six lenses per eye (total 12 lenses)
- Daily lenses (one month supply)—30 lenses per eye (total of 60 lenses)

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

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

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

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

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

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

Members under the age of 19 are eligible for a 15% discount off provider's standard pricing or 5% off a provider's promotional pricing towards laser surgery including PRK, Lasik and Custom Lasik. This is an eligible discount on pricing only laser surgery is not covered under this Policy.

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

Wellness Care

Well-child care, annual physicals and annual well women visits are covered as Wellness visits. Additional visits are subject to the office visit Copayments, Coinsurance and/or Deductible on the Description of Coverage and SBC.

- **Immunizations**

Medically Necessary immunizations, including but not limited to:

- human papillomavirus vaccine for Members ages 9-26;
- shingles vaccine for Members 60 years of age and older;
- hepatitis A & B;
- influenza vaccine;
- MMR (Measles, mumps and rubella);
- Meningococcal;
- Pneumococcal;
- Tetanus, Diphtheria, Pertussis;
- Haemophilus influenzae type b;
- Inactivated Poliovirus;
- Rotavirus;
- Varicella; and
- All immunizations that are scheduled 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 or www.cdc.gov.

Immunizations that can be safely administered without the supervision of health care 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 at least every three years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older 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 age 35 and over. Screenings other than what is listed are subject to the diagnostic testing and/or office visit Copayments, Coinsurance or Deductibles listed on the Description of Coverage and SBC.

A comprehensive breast ultrasound and breast MRI may be considered wellness if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a Physician and when specific medical criteria are met. A screening MRI of the breast may be considered wellness when medically necessary as determined by a Physician and when specific medical criteria are met. Breast ultrasounds and MRI's that do not meet wellness or screening medical criteria would be subject to the diagnostic testing and/or office visit Copayments, Coinsurance or Deductibles listed on the Description of Coverage and the SBC.

- **Pap Smear**

One cervical smear or Pap smear test each year is covered for females. Additional Pap smear tests are subject to the appropriate Deductible and/or Copayment or Coinsurance listed on the Description of Coverage and SBC.

- **Prostate Exam**
Annual digital rectal exams are covered for asymptomatic men age 50 and over, African-American men age 40 and over and men with a family history of prostate cancer age 40 and over when authorized by a Physician. Additional Prostate exams and prostate specific antigen tests are subject to the appropriate Deductible and/or Copayment or Coinsurance listed on the Description of Coverage and SBC.
- **Colorectal Cancer Screening**
A screening for colorectal cancer, for Members age 50—75, by means of a colonoscopy once every 10 years or sigmoidoscopy once every five years is covered under the wellness benefit as specified on the Description of Coverage. Colonoscopies and sigmoidoscopies done other than what is listed under Wellness are subject to the office visit and/or Outpatient Surgery/procedure (when there is an associated facility fee) Copayments, Coinsurance and Deductibles as specified on the Description of Coverage and SBC.
- **Bone Mass Measurement**
A onetime bone mass measurement screening for osteoporosis is covered as Wellness for Members. Additional osteoporosis screenings or for screenings done, are subject to the office visit and/or diagnostic testing Copayments, Coinsurance and Deductibles as specified on the Description of Coverage and SBC.
- **Cholesterol/Lipid Screening**
Cholesterol or lipid screenings are covered under the Wellness benefit once every five years for Members age 20 and over. Cholesterol screenings done, other than the Wellness screenings listed here or additional charges, will be subject to the appropriate Copayments, Coinsurance or Deductibles on the Description of Coverage and SBC.
- **Sexually Transmitted Infection Counseling and Screening**
Counseling and screenings for sexually transmitted infections including but not limited to the human immune-deficiency virus (HIV), hepatitis C (HCV), syphilis, gonorrhea and Chlamydia are covered annually under Wellness. Additional charges or visits will be subject to the appropriate Copayments, Coinsurance or Deductibles on the Description of Coverage and SBC.
- **High-Risk HPV(human papillomavirus) testing**
DNA testing in women age 30 and over, once every three years is covered for women under the Wellness benefit. Additional charges or testing will be subject to the appropriate Deductible and/or Copayments or Coinsurance on the Description of Coverage and SBC.
- **Domestic Violence Counseling and Screening**
Annual screening and counseling for interpersonal and domestic violence is covered for women under the Wellness benefit. Additional charges or visits will be subject to the appropriate Deductible and/or Copayments, Coinsurance or Deductibles on the Description of Coverage and SBC.
- **Ultrasound for Abdominal Aortic Aneurysm**
A onetime ultrasound screening for men ages 65-75 who have ever smoked is covered.
- **Alcohol and Drug Misuse Counseling and Screening**
Counseling and Screening for alcohol and drug misuse is covered.
- **Fall Prevention**
Exercise or physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls is covered.
- **Blood Pressure Screenings**
Blood Pressure Screenings are covered.

- **Behavioral Counseling for Skin Cancer Prevention**
Counseling for individuals, ages 10-24 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 with high blood pressure is covered.
- **Healthy Diet and Physical Activity Counseling**
Healthy diet and physical activity counseling for adults with cardiovascular risk factors is covered.
- **Obesity Screenings and Counseling**
An annual obesity screening and counseling as part of a clinical exam for adults is covered. For children age 6 and older, an obesity screening and counseling is covered as part of a clinical exam.
- **Tobacco Use Screening**
A screening as part of a clinical exam to screen for tobacco use and to provide intervention methods 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 55-80 who have a 30 pack/year smoking history and currently smoke or Members who have quit within the past 15 years is covered. Screening would be discontinued once a Member has not smoked for 15 years or the Member develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage and the SBC.
- **BRCA Counseling and Evaluation**
BRCA counseling and evaluation for women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes is covered. Preauthorization is required for BRCA testing.
- **Breast Cancer Chemoprevention Counseling**
Breast Cancer Chemoprevention counseling women at high risk for breast cancer and at low risk for adverse effects of 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 adults 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 sections “Contraceptive Drugs, Devices and Services” under “What is Covered” section and “Outpatient Prescription Pharmacy Contraceptives” under “What is Covered /What is Not Covered—Pharmacy Benefits” section.

- **Preventive Drugs**

The following are covered at Participating pharmacies under the Wellness benefit:

- Folic Acid supplements for women who may become pregnant
- Iron supplements for children ages 6 months to 12 months that are at risk for anemia
- Vitamin D supplements for Members aged 65 and older and who are at risk for falls.
- Gonorrhea preventive medication for the eyes of all newborns
- Aspirin for men 45-79 years of age for a reduction in myocardial infarctions or for women 55-79 years of age for a reduction in ischemic strokes. The potential benefit of a reduction must outweigh the potential harm of an increase in gastrointestinal hemorrhage.
- Aspirin for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years
- Aspirin for women as a preventive medication after 12 weeks of gestation in Members who are at high risk for preeclampsia.
- Statin preventive medication for adults aged 40-75 years with no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater.
- Smoking Cessation products
- Select vaccinations administered at pharmacies
- Bowel Prep Kits used prior to a colonoscopy covered for members 50 and older once per year.
- Tamoxifen and raloxifene used for breast cancer risk reduction.

Also see section “Preventive Drugs” under the “What is Covered/What is Not Covered – Pharmacy Benefits” section.

- **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 preventative exams.
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements and varnish for children without fluoride in their water source
- Hearing screening for newborns
- 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 for children who are at risk for exposure
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Tuberculin testing for children at higher risk of tuberculosis
- Congenital Hypothyroidism screening for newborns
- 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;
- Urinary tract or other infection screenings;
- Gestational diabetes screening;
- Hepatitis B screening;
- Rh Incompatibility screening, which also includes follow up testing for women at high risk;
- Breast feeding counseling and manual breast pumps. Also see the Maternity section in this policy

- **United States Preventive Services Task Force (USPSTF)**
In addition to the Wellness Care listed here, coverage will also include any other the preventive services approved by the United States Preventive Service Task Force (USPSTF) that may be upgraded to Grade A or B during the Benefit year.
- **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 COVERED/WHAT IS NOT COVERED—PHARMACY BENEFITS

Benefits

The following prescription drug benefit is covered under the Health Alliance POS Plan Indemnity Policy. You pay the Copayment or Coinsurance specified on the POS Plan Indemnity Policy Description of Coverage and SBC for prescription drugs obtained at a non-Participating pharmacy.

You must present your Health Alliance Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Deductible, Copayment and/or Coinsurance at the time it is filled. If you do not present your Health Alliance Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement for payment made at a non-participating pharmacy, you will need to submit a copy of the prescription and paid receipt to Health Alliance Medical Plans, Attn: Pharmacy Department, 301 S. Vine Street, Urbana, Illinois, 61801-3347.

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

Prescription Refill Synchronization

Prescription refill synchronization is the allowance to refill one or more maintenance medication(s) on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications.

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

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

If you have multiple prescriptions filled at different times and would like to sync them to be able to fill them at the same time each month, please contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Preauthorization

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

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

The list of drugs that require preauthorization can be found on our website HealthAlliance.org in the Pharmacy Programs section. Your Physician must contact Health Alliance to obtain a Preauthorization Request Form. Preauthorization can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card. If Preauthorization is not obtained, you will be required to pay a penalty as listed on the Description of Coverage.

Prescription Drug Formulary

Health Alliance has developed a prescription Drug Formulary, which is a list of covered Tier 1, Tier 2 and Tier 3, Preventive Drugs, see “Preventive Drugs” section for a complete description, and Specialty Prescription Drugs, see Pharmacy Specialty Prescriptions Drug for complete description. Tier 1 drugs are generally the lowest cost drugs, which includes most, but not all, generics. Tier 2 drugs are Preferred Formulary drugs. Most of these drugs are brand name. Tier 3 drugs are Non-Preferred Formulary drugs. The three-tier system helps manage costs, but provides flexibility and coverage for Members who choose a higher tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of prescription drugs. The drugs listed in the Health Alliance formulary are reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee. Prescription drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Benefit Year, this could occur up to six times per year or every two months. If a drug moves to a higher tier or is removed from the formulary then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any lower tier or formulary alternatives available to you. Any Member receiving immunosuppressant drugs will be notified at least 60 days prior to the change so that it can be discussed with your Physician.

To access the most up-to-date version of our Standard Drug Formulary visit the Pharmacy Programs section of our website HealthAlliance.org or call Health Alliance at the number listed on the back of your Health Alliance Identification card. Some plan’s pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a prescription drug is included in the formulary and whether the drug will be covered at the Tier 1, Tier 2 or Tier 3 and/or Specialty Prescription Drug Copayment or Coinsurance.

Preventive Drugs

As part of the Wellness benefit, preventive drugs are covered under the prescription Drug Formulary. Preventive drugs are Tier 7 drugs. Tier 7 drugs received out of network are subject to the Prescription Drug Copayments or Coinsurance listed on the Description of Coverage. For additional information see “Preventive Drugs” in the Wellness section of this Policy

For a listing of the Tier 7 drugs please see section “Wellness Care” under “What is Covered” and/or the Health Alliance Drug Formulary. In addition to the preventive drugs listed here, coverage will also include any other preventive drugs approved by the United States Preventive Service Task Force (USPSTF) that may be upgraded to Grade A or B during the Benefit year. The drugs listed in the Health Alliance formulary are also reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee. Prescription drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Benefit Year, this could occur up to six times per year or every two months. If a drug moves to a different tier or is removed from the formulary then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any formulary alternatives available to you.

Outpatient Prescription Drug Coverage and Dispensing Limitations

- Outpatient prescription drugs, Infertility prescription drugs and diabetic supplies are subject to any applicable limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage and SBC
- Copayments or Coinsurance for Outpatient Prescription Drugs, and diabetic supplies apply to any applicable Plan Year Outpatient Out-of-Pocket Maximum limit specified on the Description of Coverage and SBC. Initial prescriptions and prescription refills are limited to the maximum supply specified in the Outpatient Prescription Drugs section on the Description of Coverage and SBC.
- Prescription inhalants are covered. For a listing of specific drugs please visit our Drug Formulary at HealthAlliance.org.
- You pay the lesser of the pharmacy’s regular charge for the drug or the Deductible, Copayment and/or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage and SBC for each initial prescription or prescription refill.
- The following diabetic supplies are covered and will be subject to the Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage and SBC: glucagon

emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors.

- Coverage will be provided for prescription Contraceptives prescribed for the purpose of preventing conception and which are approved by the United States Food and Drug Administration (FDA), or generic equivalents of contraceptives approved as substitutable by the FDA. Tier 2 and Tier 3 prescription contraceptives with generic formulary alternatives will be subject to the Deductible, Copayment and/or Coinsurance specified in the Outpatient Prescription Drug section on the Description of Coverage and/or SBC.
- Most, but not all, generic drugs (as defined by a National Drug Information Provider) will be dispensed under the Tier 1 Deductible, Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law. If you or your Physician requests a brand name drug when a generic exists, you pay the Tier 3 Copayment or Coinsurance, plus the difference in cost between the Tier 2 or Tier 3 drug, whichever is dispensed, and the generic drug.
- If a Tier 2 or Tier 3 drug is prescribed and a generic does not exist, you pay the Tier 2 or Tier 3 Copayment or Coinsurance.
- If a higher tiered drug is determined to be Medically Necessary by your Physician and Health Alliance, you may qualify to pay a reduced tier copay. To determine if you would qualify you can contact Health Alliance at the number on the back of your Health Alliance Identification Card.
- Injectable syringes are covered when the injectable drug is covered.
- Coverage includes Medically Necessary emergency opioid antagonist available without Prior Authorization
- Coverage will be provided for prescription topical eye medication used to treat a chronic condition of the eye, if the refill is requested prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and the prescribing physician or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the member do not exceed the total number of refills prescribed.
- Coverage includes Medically Necessary emergency opioid antagonist available without Prior Authorization
- Coverage includes Medically Necessary pain medication for the treatment of breast cancer.
- A limited number of over-the-counter (OTC) medications are covered. A prescription is required from your Physician for covered OTC products and the Tier 1 or Tier 2 Deductible, Copayment and/or Coinsurance applies.
- Tobacco Cessation pharmacological therapy, as defined by the Health Alliance formulary is covered.
- Health Alliance covers Medically Necessary immune gamma globulin therapy for members diagnosed with a primary immunodeficiency. Initial authorization will be for no less than 3 months; reauthorization may occur every 6 months thereafter. For Members who have been in treatment for 2 years, reauthorization shall be no less than every 12 months, unless more frequently indicated by your Physician.
- For a 30-day supply of medication or less, you pay the applicable copayment as indicated on the Description of Coverage
- For a 31- 60 day supply of medication, you pay 2 times the copay applicable to a 30-day supply as indicated on the Description of Coverage.
- Coverage for a 90 day supply of prescribed medication is covered with Participating Providers only.

Outpatient Prescription Pharmacy Contraceptives

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

Up to 12 months of prescription contraceptive products can be obtained at once (including but not limited to contraceptive pills, rings, patches, female condoms and injections). Male condoms are excluded from this benefit. Your cost share will be your 1 month copayment multiplied by the number of months obtained.

Pharmacy Specialty Prescription Drugs

Pharmacy Specialty Prescription Drugs are defined as any prescription drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty 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 Pharmacy Specialty Prescription Drugs include, but are not limited to, fertility drugs, biological specialty drugs, growth hormones, organ transplant specialty drugs and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription drug formulary at HealthAlliance.org.

Pharmacy Specialty Prescription Drugs are available from a Specialty Pharmacy vendor. Coverage is subject to a prior written order by your Physician and Preauthorization by Health Alliance. You pay the Specialty Prescription Drugs Copayment or Coinsurance amount specified in the Outpatient Prescription Drugs section of the POS Plan Indemnity Policy Description of Coverage and SBC. Specialty Prescription Drugs are subject to any applicable Specialty Prescription Drug limitations specified in the Maximum/Deductible/Limitations section on the POS Plan Indemnity Policy Description of Coverage and SBC.

If a Tier 5 or Tier 6 drug is prescribed and a generic does not exist, you pay the Tier 5 or Tier 6 Copayment or Coinsurance.

Prescription Drugs Not Covered

- Non-prescription drugs or medicines are not covered, except for covered diabetic supplies, injectable syringes for covered injectable drugs and a limited number of over-the-counter (OTC) medications as stated above. This includes non-prescription Infertility drugs.
- When a medication is available both by prescription only (federal legend) and as an OTC product, the prescription drug is not covered.
- Prescription drugs which are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by Health Alliance, including but not limited to: BOTOX[®], psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiant or weight loss medications, anabolic steroids, oral fluoride preparations and hair removal or hair growth promoting medications.
- Devices of any type, other than prescription Contraceptive devices, even if such devices may require a prescription, including but not limited to: therapeutic devices, artificial appliances, support garments, bandages, etc.
- Dermatologic products (oral and topical) that offer no additional clinical benefit over existing covered alternatives, including but not limited to: Clobex Lotion/Shampoo, Vanos, Capex, Luxiq, Olux, and Solodyn
- Prescription strength benzoyl peroxide and combination products
- Compounded claims in which one or more ingredient is a bulk powder
- Compounded products, including compounding kits, of two or more commercially available drugs (prescription or over-the-counter) that offer no additional clinical benefit compared to taking the individual components (please note the existing drugs do not have to be commercially available in the same strengths as the compounded product).
- Any drug labeled, "Caution - Limited by Federal Law to Investigational Use", or experimental or other drugs which are prescribed for unapproved uses. Prescription Drugs for treatment are covered if the FDA has given approval for at least one indication and is recognized for the treatment of the indication for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network's Drugs & Biologics Compendium; (3) the Thomson Micromedex's Drug Dex; (4) the Elsevier

Gold Standard's Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health And Human Services, or if not in the compendia, recommended for that particular indication in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States or Great Britain.

- Prescription drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or any medication furnished by any other Drug or Medical Service for which there is no charge to you.
- Any charge for the administration of a drug.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before seventy-five percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Erectile Dysfunction drugs related to lifestyle enhancement or performance are not covered.
- Medications used for treatment of decreased sexual desire (Addyi) are also not considered medically necessary
- Products classified as Medical Food or supplements.
- Non-sedating antihistamines and combinations
- Any charge for administration of a drug.
- Any drug determined by a physician, pharmacy or through retrospective claims review to be abused or otherwise misused by you.
- Medical marijuana is excluded from coverage since it is classified by the federal government as a Schedule I controlled substance, and therefore cannot be prescribed by a health professional.
- V-Go Insulin Delivery Device is excluded from coverage due to a lack of sufficient evidence and conclusions on its safety and efficacy.
- Drugs which have not been approved as effective by the Food and Drug Administration, including DESI drugs, are not covered.
- Infertility prescription drugs which are not approved by the United States Food and Drug Administration (FDA) for the treatment of Infertility.
- Any prescription drug purchased or imported from outside of the United States of America.
- Any prescription drug received outside of the United States of America, unless received as part of Emergency Services or Urgent Care.

Drug Limitation

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

WHAT IS NOT COVERED (Exclusions & Limitations)

The following services are excluded from coverage under this Policy.

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.

Acupuncture, Acupressure and Hypnotherapy

Charges for treatment and services related to acupuncture, acupressure and hypnotherapy are not covered.

Blood Processing

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

Circumstances Beyond the Control of Health Alliance

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

Convenience or Comfort Items

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

Cosmetic Surgery

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

Counseling

Charges for social counseling or marital counseling are not covered unless otherwise specified in this Policy.

Custodial or Convalescent Care

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

Dental Services

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

Disposable Items

Self-administered dressings and other disposable supplies are not covered.

Durable Medical Equipment and Orthopedic Appliances and Devices

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

Experimental Treatments/Procedures/Drugs/Devices

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

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

- The medical treatment, procedure, drug, or device for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.

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

Eyeglasses, Contacts and Refractory Treatment

Eyeglasses, contact lenses, contact lens evaluations and fittings are not covered, except for eyeglasses and contact lenses following cataract surgery or unless otherwise stated in this Policy. To view covered services or items 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, vision screenings to determine the refractive state of the eyes, 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 Occupation

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 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 cures is not covered.

Medicare Benefits

Health care 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.

Reversal of Sterilization

A surgical procedure to reverse voluntary sterilization is 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, 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 or registered clinical psychologist, care in lieu of detention or correctional placement, family retreats or services with a diagnosis of marriage counseling unrelated to mental health conditions are not covered.

Services that are not primarily medical in nature, including but not limited to traditional mattresses, air filters, Jacuzzis/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.
- 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 that has been disbarred by the federal government.

APPEALS

Appeals are divided into two categories: administrative decisions or denials of coverage based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Health Alliance has one level of appeal available to you. The appeals procedures are detailed in any notice of appeal determination you may receive, as well as detailed in this section of this Policy. You, or any person you have chosen as your authorized representative, including your Physician or other health care Provider or attorney, may request an appeal within 180 days of receiving the initial denial notice by calling the **Member Relations Department at 1-800-500-3373, via facsimile at 1-217-337-8009** or writing to **the Member Relations Department, 301 S. Vine St., Urbana, Illinois 61801-3347**. The party filing the appeal may send us written comments, documents, records, or other information regarding your appeal Administrative Review.

The deadlines for filing an appeal or external review will not be postponed or delayed by health care provider appeal unless the health care provider is acting as an authorized representative for the covered person; i.e., the covered person should be filing internal appeals independently and concurrently unless the health care provider has been designated in writing as the authorized representative.

Notice of Appeal Determination

Health Alliance will make a decision and send a written notice to you, your authorized representative, Physician and any health care Provider who recommended services.

The written notice sent to you or your authorized representative will include:

- The reasons for the decision;
- References to the benefit plan provisions on which the decision is based, and the contractual, administrative or medical policy criteria for the decision;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with the meanings and the standards used. Upon request, diagnosis/ treatment codes with their meanings and the standards used are also available;
- An explanation of Health Alliance's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on internal appeal;
- A statement in non-English language(s) that indicates how to access the language services provided by Health Alliance;

- The right to request, free of charge, reasonable access to and copies of all documents, records, medical policies and other information relevant to the decision;
- Any internal rule, guideline, policy or other similar criteria relied on in the decision, or a statement that a copy of such rule, guideline, policy or other similar policy will be provided free of charge on request;
- An explanation of the clinical judgment relied on in the decision, or a statement that such explanation will be provided free of charge upon request
- A description of the standard that was used in denying the claim and a discussion of the decision.
- Contact information for applicable office of health insurance consumer assistance.

If Health Alliance’s decision is to continue to deny or partially deny your referral, prior authorization or claim or you do not receive timely decision, you may be able to request an external review of your referral, prior authorization or claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the External Review of Appeals section below.

The operations of Health Alliance are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Office of Consumer Health Information
320 West Washington Street
Springfield, Illinois, 62767
1-877-850-4740 toll free phone
217-558-2083 fax
Consumer_complaints@ins.state.il.us
<https://mc.insurance.illinois.gov/messagecenter.nsf>

- **Administrative Review**
Appeals for administrative decisions will be reviewed by a committee or an individual not involved in the initial denial and who does not work under the authority of the initial decision maker. Health Alliance will notify the party filing an appeal within 3 days of any additional information that is required to evaluate the appeal. Health Alliance will notify the party filing the appeal in writing of its decision within 15 days from the date Health Alliance receives all the information requested to complete the review.
- **Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review**
Appeals for denial of coverage of health care services will be reviewed by a Clinical Peer not involved in the denial of coverage of health care services. Health Alliance will notify the party filing an appeal within three business days of any additional information that is required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any other health care Provider who recommended services in writing within 15 days after receipt of all necessary information, but no later than 30 calendar days after receipt of the request for an appeal.

If you have exhausted the internal appeals process, you have the right to request that the decision be reviewed by an independent review organization, see “External Review of Appeals”.

Type of Notice or Extension	Timing
If your claim is filed improperly, Health Alliance must notify you within:	3 days
If your claim is incomplete, Health Alliance must notify you within:	3 days
If you are notified that your claim is incomplete, you must then provide completed claim information to Health Alliance within:	45 days after receiving notice
Health Alliance must notify you of the Claim determination (whether adverse or not):	
if the initial claim is complete within:	15 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
if you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

- **Expedited Medical Necessity Review**

You, your authorized representative, Physician or other health care Provider may request an appeal for denial of Urgent Care services that require Preauthorization. A Clinical Peer not involved in the original decision to deny coverage of health care services will review the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any other health care Provider who recommended services by telephone within 24 hours of receipt of all requested information, but no later than 48 hours after receipt of the request for an appeal. Health Alliance will provide written notification within 3 days of the decision.

If the appeal of your Preauthorization request is denied you have the right to request that decision be reviewed by an independent review organization not associated with Health Alliance by submitting a written request for an external review to the Illinois Department of Insurance, see “External Review of Appeals”. If you have a medical condition where the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the requested health care services are denied and the denial concerns an emergency admission, availability of care, continued stay, or health care service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based on the determination that the requested service or treatment is experimental or investigational and your health care Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review.

If your Preauthorization request for urgent care is denied, you have the right to request an expedited internal appeal of the denial. If your Physician or other health care Provider believes that the denial of coverage of health care 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.

Type of Notice or Extension	Timing
If your claim is incomplete, Health Alliance must notify you within:	24 hours
If you are notified that your claim is incomplete, you must then provide completed claim information to Health Alliance within:	48 hours
Health Alliance must notify you of the Claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical emergencies), but no later than:	72 hours
after receiving the completed claim (if the initial claim is incomplete), within:	24 hours

External Review of Appeals

For denials made on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness, you, your authorized representative, your Physician or other health care Provider or attorney may request an external review by an independent review organization, not associated with Health Alliance, if you are not satisfied with the Health Alliance resolution of denial of coverage for health care services. This can be done by submitting a written request to the Illinois Department of Insurance. The party requesting the external review may contact the Illinois Department of Insurance at 1-877-850-4740.

You may contact the Office of Consumer Health Insurance (OCHI) within the Illinois Department of Insurance External Review Unit at 320 West Washington Street, Springfield, IL 62727-0001; toll free at 1-877-850-4740; via facsimile at 1-217-557-8495; by email at doi.externalreview@illinois.gov or at <https://mc.insurance.illinois.gov/messagecenter.nsf>; or with the Illinois Department of Insurance, 122 South Michigan, 19th Floor, Chicago, Illinois 60603.

Except in the case of an expedited review at the initial urgent Preauthorization request denial, see “Preauthorization”, you must exhaust the internal review process before a request for an external review can be made.

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

- You have not received our written decision on your internal appeal within 30 days or 60 days if it involves a retrospective appeal, see “Appeals” and “Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review”;
- You have not received our written decision on your expedited internal appeal within 48 hours, see “Appeals” and “Expedited Medical Necessity Review”; or
- Health Alliance agrees to waive the internal review exhaustion requirement

Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review

A written request for external review may be submitted within 4 months after receipt of notification that your Preauthorization request or the appeal for approval of coverage of health care services has been denied. Assignment of an independent review organization will be made within 5 business days of determining your request is eligible for an external review. The independent reviewer will make a decision within 5 days, but in no event later than 45 days after receipt of all necessary information and provide written notification of its decision to all parties involved in the appeal.

Type of Notice or Extension	Timing
If your Preauthorization request or the appeal for approval of coverage is denied you must submit your request for external review within:	4 months
If it is determined that your request is ineligible for an external review, Health Alliance will notify you why your request is ineligible or incomplete within:	1 business day
The Department of Insurance will assign an independent review organization after determining your request is eligible within:	1 business day
You and your authorized representative must provide any additional information to the independent review organization from the date you receive notice within:	5 business days
Illinois Department of Insurance must notify you of the external review determination within:	1 business day

Expedited Medical Necessity Review

An expedited external review may be requested orally or in writing if you, your Physician or other health care Provider involved in the appeal believe that the denial of coverage of health care services or a standard external review would jeopardize your life, your health or your ability to regain maximum function.

After determining the request is eligible for external review, Illinois Department of Insurance will immediately assign an independent review organization to conduct the review. The independent review organization will make a decision no later than two business days after receipt of the required information and provide written notification of its decision to all parties involved in the appeal.

An expedited external review is not available for review of denials for health care services that have already been provided.

Type of Notice or Extension	Timing
The health carrier shall notify the Director, the covered person, and if applicable the covered person's authorized representative of the requests eligibility for external review within:	Immediately
Upon determining the request is eligible for external review, the Director will assign an IRO within:	Immediately
The health carrier shall provide all necessary documents and information for consideration to the IRO within:	24 Hours of notification of assignment of IRO
The IRO will provide their decision to the Director, the health carrier and you within:	As expeditiously as the condition or circumstances require by no more than 72 hours of the review request
If IRO notice was not provided in writing then IRO will provide written confirmation of their decision within:	48 Hours provide notice of their decision

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 Identification Card or write to Health Alliance Medical Plans, Inc., 301 S. Vine Street, Urbana, Illinois 61801-3347.

You may file a complaint with the Office of Consumer Health Insurance, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767 or with the Illinois Department of Insurance, 122 South Michigan, 19th Floor, Chicago, Illinois 60603. You may also contact the Department of Insurance at 1-877-527-9431, by facsimile at 1-217-558-2083, via email consumer_complaints@ins.state.il.us or at <https://mc.insurance.illinois.gov/messagecenter.nsf>.

TERMINATION

You may terminate coverage under this Policy at any time by giving written notice to Health Alliance prior to the effective date of termination. Termination will become effective on the last calendar day of the month the notice is received by Health Alliance. All rights to benefits and services will cease as of the effective date of termination.

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

- The Health Alliance Identification Card is provided for use by any person not eligible for covered services under this Policy.
- You no longer live in the Service Area. The Service Area is specified on the Description of Coverage.
- Failure to pay the required premium under the “Premiums” section of this Policy, subject to the grace period.
- You enroll in another Health Alliance individual health insurance plan.

If the age or tobacco status of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

Health Alliance may terminate your rights and the rights of any covered Dependent and cancel this Policy as of your Effective Date if any material information has been withheld or omitted and thereafter such information is discovered by Health Alliance. Any such Member, or responsible parent or guardian in the case of a minor, shall be required to reimburse Health Alliance for any and all sums expended on his or her behalf for health care services from the Effective Date of coverage to the date of termination, together with reasonable attorneys’ fees and expenses incurred in collection of such sums. You will be provided at least 30 days written advanced notice before Your Policy is rescinded. You have the right to appeal any such rescission.

Coverage of a Dependent child will terminate on the last day of the month in which the Dependent reaches the Limiting Age.

If the child is incapable of self-sustaining employment by reason of an apparent disabled condition and the child is dependent on 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.

A Legal Spouse whose coverage as a Dependent would cease due to divorce or the death of the Policyholder has the option of converting to his or her own individual Policy without a lapse in coverage if the individual lives in the Service Area. To apply for coverage, the individual must submit a completed application form and the required premium due to Health Alliance within 60 days following the entry of such judgment or the death of the Policyholder. There is no requirement for underwriting approval if application is made for the same level of coverage the Member has as a Dependent under the Plan. If the application is not received within 60 days following issuance of the divorce decree or the death of the Policyholder, the individual may reapply for coverage but will be required to provide Evidence of Insurability.

A child whose coverage as a Dependent would cease upon reaching the Limiting Age has the option of converting to his or her own individual Policy without a lapse in coverage if the individual lives in the Service Area. To apply for coverage, the individual must submit a completed application and the required premium due to Health Alliance within 60 days prior to the termination of the Policy. If the application is not received within 60 days prior to the termination of the Policy, the individual may reapply for coverage but will be required to apply during the Open Enrollment Period.

Coverage for health care 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 health care services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered health care services after the effective date of termination. "Effective date of termination," for the purposes of this section, will mean that date 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 stated in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when you or your covered Dependent have health care 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 coverages for Members of an Employer Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - "Plan" includes: Employer Group insurance, closed panel or other forms of Employer Group or Employer Group-type coverage (whether insured or uninsured), individual or family insurance, closed panel or other individual coverage, medical care components of Employer Group long-term care contracts, such as skilled nursing care; medical benefits under Employer 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 Employer Group long-term care policies, and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
 - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
 - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
 - When there are more than 2 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 health care service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
 - If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private

Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans provides coverage for Hospital private rooms).

- If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and Reasonable fee for a specific benefit is not an allowable expense.
 - If a person is covered under two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
 - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable fees and another plan that provides its benefits or services on the basis of a negotiated fee, the primary plan's payment arrangement shall be the allowable expense for all plans.
 - The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, Preauthorization or when the covered person has a lower benefit because he or she did not use a Participating Provider.
4. "Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.
 5. "Closed Panel Plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with Health Alliance, and that limits or excludes benefits for services provided by other Providers, except in cases of an Emergency Medical Condition or referral by a Provider on the panel.
 6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules that applies:

1. A plan with no provision for coordination with other benefits is considered to pay its benefits before a plan that contains such a provision.
2. **Non-Dependent/Dependent.** The benefits of the plan that covers the person as an employee or Member (that is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent.
3. **Dependent Child/Parent not Legally Separated or Divorced.** Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents:"
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
 - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in the first bullet immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. **Dependent Child/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 health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply to any claim determination period or Benefit Year when any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Dependent Child/Joint Custody.** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans 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 plan the plans covering the Dependent will follow the order of benefit determination rules outlined in (9) below.
 - In the event that the Dependent's coverage under the Spouse plan began on the same date as the Dependent's coverage under either or both parent's plans, the plans covering the Dependent will follow the order of benefit determination rules outlined in (3) above.
7. **Active/Inactive employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as the employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this requirement will be ignored.
8. **Continuation Coverage.** If a person whose coverage is provided by a federal or state law right of continuation is also covered by another plan, the following will be the order of benefit determination:
 - The benefits of the plan covering the person as a Member, or as that person's Dependent, will pay first.
 - The benefits of the plan providing continuation coverage will pay second.

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

9. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee or Member longer are determined before those of the plan that covered that person for the shorter term. 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 plan contracts, as well as the benefits payable by any other plan 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 Provider, 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 health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Health Alliance may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Health Alliance need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Health Alliance any facts it needs to apply those rules and determine benefits payable.

Health Alliance may also request updated information from you annually or when information is received that indicates a change from the information we have on file to verify or update your Coordination of Benefits information. You may fill out and return the request via mail or you may 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 for information, 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 Covered Person recovers expenses for sickness or Injury that occurred due to the negligence of a third party the Plan shall have the right to first reimbursement for all benefits paid by the Plan from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, Covered Person’s parents, if the Covered Person is a minor, or Covered Person’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.

Health Alliance may also request information from you based on claims or other information received to verify Third Party Liability information or to verify if a Third Party is involved. You must fill out the requested form in writing and return via mail or fax to Health Alliance Medical Plans 301 South Vine Street, Urbana, IL 61801 or to our Recovery Department at 217-365-7486. If no response is received within one year from the request, claims will not be considered for payment.

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.

PRIVACY AND CONFIDENTIALITY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) together with the Standards for Privacy of Individually Identifiable Health Information aim to safeguard the confidentiality of private information and protect the integrity of health care 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 health care Providers
- Corresponding with you
- Participating in accreditation, auditing and quality improvement activities
- Participating in disease management studies to improve health care
- Providing you with health care 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

Disclosure of Information

Nonpublic personal and Protected Health Information is disclosed under the following circumstances:

- To you or your authorized representative
- To another party with your signed authorization
- For Plan administration (health care operations and payment)
- To persons or companies that perform health care 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 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 health care arrangements with: Carle and their affiliates; OSF, Springfield Clinic and Memorial Hospital.

Your Rights

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

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

MEDICARE-ELIGIBLE BENEFICIARIES

The federal “Medicare Secondary Payor” (MSP) laws regulate how health plans certain employers may offer group health care coverage to Medicare-Eligible employees and Dependents. Under the MSP laws, Medicare generally pays secondary to the Group health 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 age 65 and over who are covered under this Plan, due to their or their Legal Spouse’s current employment status with the Group, if the 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 Group, if the Group employs more than 100 employees.

To assist Health Alliance in complying with the MSP laws, you must notify Health Alliance 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 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 age 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 health care services and items from Providers according to the terms and conditions of this Policy. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.
- Assign his or her claim for Medicare benefits to the Provider. For services received from 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 the number on the back of your Member Identification Card to speak with one of our Member Service Representatives with any questions about the benefits available and how to obtain them.

GENERAL PROVISIONS

Clerical Error

Clerical error 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.

Extension of Benefits in the Case of Total Disability

In the event of total disability, if this Policy is terminated and replacement coverage is not available, then this Plan will continue to provide benefits according to the Policy and the benefit levels specified on the Description of Coverage and SBC until the first one of the following occurs: twelve months following the effective date of termination; the date the maximum benefit reached or the end of total disability.

Genetic Information

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

Health Alliance Identification Card

The Health Alliance Identification Cards issued to you pursuant to this Policy are for identification only. Possession of a Health Alliance Identification Card confers no right to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Policy have actually been paid.

Hospitalized on Effective Date

If on your Effective Date under the Plan, you or any of your covered Dependents are inpatient 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 written proof of loss was furnished.

Medicare Eligible Beneficiaries

The federal “Medicare Secondary Payor” (MSP) laws regulate how health plans may offer health care coverage to Medicare-Eligible employees and Dependents. Under the MSP laws, Medicare generally pays primary to the individual health coverage provided under this Policy. In the event you or one of your Dependents become eligible for Medicare, or your current Medicare status has terminated or changed while you are an active member of this plan, you must notify Health Alliance promptly to ensure timely claims payment.

For a Medicare-Eligible Member to obtain the greatest level of benefit, a Medicare-Eligible Member should:

- Enroll in Part A and Part B of Medicare.
- Obtain needed health care services and items from Providers according to the terms and conditions of this Policy. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the “What is Covered” section that Medicare does not cover.
- Assign his or her claim for Medicare benefits to the Provider. For services received from 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 the number on the back of your Health Alliance Identification Card to speak with one of our Customer Service Representatives with any questions about the benefits available and how to obtain them.

The benefits of this Plan for Medicare-eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available for such services or items if the Member enrolled in Medicare and made a proper claim for Medicare payment. Refer to “Medicare Benefits” under the “What is Not Covered” section for this exclusion, and to the “Terms” section for the definition of Medicare-eligible Beneficiary.

Members may not be enrolled in Medicare and a qualified high deductible health plan to be paired with a health savings account (HSA).

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-Discriminatory

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

Notices

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 Medical Plans, Inc., 301 S. Vine St., Urbana, Illinois 61801-3347. All notices given in the manner provided for in this section will be deemed to have been received by the party to whom addressed five business days after deposit in said post office.

You may notify us of a change of address by calling Health Alliance at the number on the back of your Health Alliance Identification Card or by sending the change of address information to the Membership Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois 61801-3347.

Payment of Claims

The Plan pays benefits or assigns payment of benefits to the health care Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. Any claim for reimbursement or bills for covered health care services must be submitted within 20 days, but no later than 90 days or as soon thereafter as reasonably possible after the occurrence or commencement of any loss covered by the Policy. 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
301 South Vine St.
Urbana, Illinois 61801-3347

The company, upon receipt of a notice of a claim, will furnish to the claimant such claims forms, as requested, within 15 days of this notice or request. If after 15 days, if 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 their 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 any 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 will 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 health care benefits unpaid at your death will be paid to the health care Provider rendering the service for which benefits are due or reimbursement to your estate. If benefits payable are \$1,000 or less, Health Alliance may pay someone related to you by blood or marriage whom Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

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

Physical Examination

Health Alliance has the right, at its expense, to request that you have a physical examination performed by a Physician when and as often as it may be reasonably required while a claim is pending or open.

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.

Pro-Rata Refund

In the event of the death of the Policyholder, Health Alliance will, upon receipt of notice of the Policyholder's death and a request for a pro-rata refund, supported by a valid death certificate supplied by a party entitled to claim such refund, shall refund the unearned premium pro-rated to the month of the Policyholder's death. Refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the Policyholder's death. Coverage of persons insured under the same Policy other than the Policyholder shall not be affected by the premium refund provided for in this section nor shall the obligation of such other insureds to pay required premiums be diminished pursuant to this section.

Time Limit on Certain Defenses

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

Timely Payment of Claims

All benefits due will be paid upon receipt of proof of loss. If you need any forms or information from Health Alliance for claims submission, Health Alliance will notify you or send you the information upon request within 15 business days. 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 9% interest on benefits due.

Other Provisions

The obligation of Health Alliance is limited to furnishing health care coverage to Members through contracts with such 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 health care coverage provided for in this Policy is not transferable to another party by any Member.

If an Illinois Member is activated for military service and the Member and his or her Dependents become eligible for a federal government sponsored health program, including Tri-Care, they shall not be denied reinstatement of the same individual Plan coverage if they lose their federal government sponsored health program due to deactivation. Except in the case of birth or adoption that occurs during the lapse in individual coverage, the reinstatement must be into the same individual coverage held previously or at a higher Deductible level as decided by the Member. This reinstatement is not available to those deactivated or discharged dishonorably.

The Member must notify Health Alliance of his or her loss of federal government health program coverage within 63 days of the later of his or her deactivation or loss of coverage

In the event Health Alliance modifies or chooses to no longer offer this Plan to members, you will be notified 90 days prior to the discontinuation of the Plan and another option to purchase another individual Plan that is being offered at that time.

In the event Health Alliance modifies or chooses to no longer offer any Plan in the individual market, then notification would be made to the Department of Insurance 180 days prior to discontinuation of our individual products.

The insured has a right to designate a beneficiary. The consent of the beneficiary or beneficiaries shall not be required for surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

TERMS

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

Approved Clinical Trials

An Approved Clinical Trial means 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.

Artificial Insemination (AI)

The introduction of sperm into a woman's vagina or uterus by noncoital methods, for the purpose of conception.

Assisted Reproductive Technologies (ART)

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 shall include prescription drug therapy used during the cycle where Oocyte Retrieval is performed.

Basic Health Care Services

Emergency care, inpatient Hospital and Physician care, Outpatient medical services, mental health care and Substance Use Disorder treatment.

Benefit Year

The year on which the plan's annual benefits are calculated. Benefits for this plan run on a Calendar year.

Breast Tomosynthesis

A radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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 including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

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

Center of Excellence

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

Civil Union

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

Clinical Peer

A health care professional who is in the same profession and the same or similar specialty as the health care 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.

Contract Year Maximum Benefits

The maximum amount of visits per year Health Alliance would cover for services. Services that have Contract Year Maximum Benefit are specified on the Description of Coverage in the Contract Year Maximum Benefits section.

Copayment

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

Contraceptives

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

Creditable Coverage

Coverage you have had prior to enrolling in Health Alliance under any of the following:

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

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

Custodial Care

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

Deductible

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

Dependent

A child or Legal Spouse of a Policyholder who meets the eligibility requirements of this Plan.

Description of Coverage

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

Donor

An Oocyte Donor or sperm donor.

Drug Formulary

A Drug Formulary is a listing of drugs that your plan covers.

Effective Date

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

Embryo

A fertilized egg that has begun cell division and has completed the pre-embryonic stage.

Embryo Transfer

The placement of the pre-embryo into the uterus or, in the case of Zygote Intrafallopian Tube Transfer, into the fallopian tube.

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 furnished by a Provider qualified to provide such services and needed to evaluate or stabilize an Emergency Medical Condition.

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. Essential Health Benefits provided within your Policy are not subject to any annual dollar maximums.

Extended Network Provider

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

Family Coverage

The health care 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.

Gamete

A reproductive cell. In a man the Gametes are sperm. In a woman the Gametes are eggs or ova.

Gamete Intrafallopian Tube Transfer (GIFT)

The direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

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.

Health Alliance Identification Card

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

Health Insurance Marketplace

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

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.

Individual Health Plan

The program of health care benefits covered by this Individual Policy.

Infertility

The inability to conceive after one year of Unprotected Sexual Intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy. In the event a Physician determines a medical condition exists that renders conception impossible through Unprotected Sexual Intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal by a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments, the one year requirement shall be waived.

Injury

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

Intoxication

Intoxication is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

In Vitro Fertilization (IVF)

A process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and divided egg is then transferred into the woman's uterus.

Legal Spouse

The adult person whom the Policyholder is legally married to or is in a legally recognized Civil Union partnership with under the laws of the state where the covered employee lives. Health Alliance may require documentation of marriage or Civil Unions.

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 a child is no longer eligible for coverage.

Low tubal ovum transfer

The procedure in which Oocytes are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus.

Maximum Allowable

The Maximum Allowable charge is based on 100% of Medicare's charges, including use of a Medicare gap-fill fee schedule, or the average discount Health Alliance has negotiated with Participating Providers. This is the maximum amount payable for a covered service. If the amount billed by a Non-Participating Provider is more than the Maximum Allowable charge, you will be responsible for the difference between the Maximum Allowable charge and the actual amount billed in addition to Copayments, Coinsurance and Deductibles. Amounts in excess of the Maximum Allowable charges do not apply to your Plan Year Out-of-Pocket Maximum.

Medical Director

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

Medically Necessary (Medical Necessity)

A service or supply which is required to identify or treat your condition and:

- Is appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or Injury.
- 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 which can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an Outpatient.

Medicare-Eligible Beneficiary

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

Member (also referred to as "you", "your" or "covered person" 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 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.

Naprapathic Services

Covered services rendered by a licensed Naprapathic practitioner. Services are intended to restore structural balance or release tension using techniques such as the manipulation of connective tissues.

National Drug Information Provider

A company that establishes an industry level setting on medications. Information provided includes medication pricing, as well as which generics are only available from a single entity and therefore should be treated as a brand medication.

Non-Formulary Drugs

Drugs that are not included in the list of medications your plan covers.

Non-Participating Provider (Non-Participating)

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

Non-Preferred Drugs

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

Oocyte

The female egg or ovum formed in an ovary.

Oocyte Donor

A woman determined by a Physician to be capable of donating eggs in accordance with the standards recommended by the American Society for Reproductive Medicine.

Oocyte Retrieval

The procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. This procedure is also called ova aspiration.

Out-of-Pocket Maximum

The maximum dollar amount you and/or your family will pay in accumulated Copayments, Coinsurance and Deductible amounts for most health care services during a Plan Year. Amounts paid for non-covered health care 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.

Outpatient Surgery

Surgery or a procedure that is performed in a Physician's office, the Outpatient department of a Hospital, freestanding surgical center or freestanding medical clinic and would include medically appropriate assistant surgeon and surgical assistant charges. Outpatient surgery Copayments, Coinsurance and Deductibles apply to any associated facility fee for a surgery or procedure.

Participating Provider (Participating)

A Physician, Provider or pharmacy that has entered into a valid contract with Health Alliance to provide health care services to Members.

Physician

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

Plan

The program of health care benefits covered by this Policy.

Plan Year

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

Plan Year Maximum Benefit

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

Policy

Means the Indemnity Policy and the SBC that are issued to a Policyholder and that describe the coverage provided by the Indemnity Policy under the Plan.

Policyholder (also referred to as “you,” “your” or “covered person” within this Policy)

An individual who lives in the Service Area and is enrolled in the Plan.

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.

Prescription Refill Synchronization

The allowance to refill one or more maintenance medication(s) on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications.

Private Duty Nursing Service

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

Protected Health Information

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

Provider

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

Regular Effective Date

The Effective Date determined for special enrollment periods. If enrollment is requested between the first and fifteenth of the month then the Effective Date is the first day of the following month or if the event falls between the sixteenth and last day of the month, the Effective Date will be the first day of the second following month.

Retrospective Review

A review performed after a claim for benefits is received.

Serious Mental Illness

Illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

- Schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizoaffective disorders (bipolar or depressive);
- pervasive developmental disorders;
- obsessive-compulsive disorders;
- depression in childhood and adolescence;
- panic disorder;

- post-traumatic stress disorders (acute, chronic, or with delayed onset); and anorexia nervosa and bulimia nervosa.

Service Area

The geographic region listed on the Description of Coverage of this Policy that contains the counties within which the Plan is authorized to do business.

Skilled Care

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

Skilled Nursing Facility

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

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 following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- substance use disorders
- substance dependence disorders; and
- substance induced disorders

Summary of Benefits and Coverage (SBC)

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

Surrogate

A woman who carries a pregnancy for a woman who has Infertility coverage.

Telemedicine

Health care services delivered by use of interactive audio, video, or other electronic media, services would include medical exams and consultations; and behavioral health, including substance use disorder evaluations and treatment.

Unprotected Sexual Intercourse

Sexual union without the use of any process, device or method that prevents conception, including but not limited to oral Contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

Urgent Care

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

Uterine Embryo Lavage

A procedure by which the uterus is flushed to recover a preimplantation Embryo.

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 and/or gynecology or family practice.

Zygote

A fertilized egg before cell division begins.

Zygote Intrafallopian Tube Transfer (ZIFT)

A procedure by which an egg is fertilized in vitro, and the Zygote is transferred to the fallopian tube prior to the pronuclear stage before cell division takes place. The eggs are harvested and fertilized on one day and the Embryo is transferred at a later time.