

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:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o 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: 1-800-851-3379, TTY: 711 or, fax: 217-365-7494, [customerservice@HealthAlliance.org](mailto:customerservice@HealthAlliance.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

### **For Language Access Services:**

#### **English:**

If you, or someone you're helping, has 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:**

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Health Alliance Medical Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-247-3296.

**Polish:**

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Health Alliance Medical Plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-866-247-3296.

**Chinese:**

如果您，或是您正在協助的對象，有關於插入SBM項目的名稱 Health Alliance Medical Plans,方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話在此插入數字 1-866-247-3296.

**Korean:**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health Alliance Medical Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-247-3296 로 전화하십시오.

**Tagalog:**

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Health Alliance Medical Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-247-3296.

**Arabic:**

يفق حل الكي دلف Health Alliance Medical Plans صوصخب فلئسأ هدعاست صخش ىدل وأ كيدل ناك نإ  
تامول عمل او ددعاسملا ىلع لوصحلا  
ب لصتا مچرت م عم ثدحتلل . ففلكت ةي انود نم كت غلب ةي ورضلا  
1-866-247-3296

**Russian:**

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health Alliance Medical Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-866-247-3296.

**Gujarati:**

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને એસબીએમ ક ર્યકમન ાં ન મ મ કો વિશે  
પ્રશ્નો હોર તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર  
છે. દ ભ વષરો િ ત કરિ મ ટે, આ અહીં દ ખલ કરો નાંબર પર કોલ કરો. 1-866-247-3296.

**Vietnamese:**

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Alliance Medical Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-247-3296.

**Italian:**

Se tu o qualcuno che stai aiutando avete domande su Health Alliance Medical Plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-866-247-3296.

**French:**

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health Alliance Medical Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-866-247-3296.

**German:**

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Alliance Medical Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-247-3296

**Japanese**

この通知には重要な情報が含まれています。この通知には、Health Alliance Medical Plansの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-866-247-3296 までお電話ください。

**Pennsylvanian Dutch**

Die Bekanntmachung gebt wíchdichi Auskunft. Die Bekanntmachung gebt wíchdichi Auskunft baut dei Application oder Coverage mit Health Alliance Medical Plans Geb Acht fer wíchdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schpooch griegie, un die Hilf koschtet nix.

**Ukranian**

Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального покриття через Health Alliance Medical Plans Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1-866-247-3296.

**HEALTH ALLIANCE MEDICAL PLANS, INC.**  
**Health Alliance SHORT TERM PLAN**

THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

The Health Alliance Short Term Plan (Plan) is a limited duration plan, established as a fully insured product of and insured by Health Alliance Medical Plans, Inc. (Health Alliance), a domestic stock insurance company. Health Alliance administers all aspects of Health Alliance which is located at 301 S. Vine St., Urbana, Illinois 61801-3347.

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

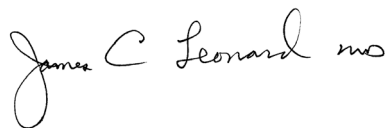
It is important for you to read this Policy as it explains your rights, benefits and responsibilities as a Health Alliance Member. As a Member, you are subject to all terms and conditions of this Policy, and payment of Copayments, Coinsurance and Deductible amounts, as specified on the Description of Coverage.

This is a short term limited duration Plan. The Effective Date of coverage under this Plan is stated on the Application. This Plan will terminate at the end of the length of this policy, as determined upon application, unless canceled or terminated at an earlier date by you or Health Alliance as provided 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 has duly executed this Policy.



---

Dr. James Leonard  
President & CEO

**HEALTH ALLIANCE  
SHORT TERM PLAN**

**TABLE OF CONTENTS**

MEMBERS' RIGHTS AND RESPONSIBILITIES .....	7
HOW THE HEALTH ALLIANCE SHORT TERM PLAN WORKS .....	8
Selecting a Physician.....	8
Preferred Provider .....	8
Non-Preferred Provider .....	8
The Relationship Between Health Alliance and Preferred Providers.....	9
COVERED BENEFITS AND LIMITATIONS .....	9
Ambulance.....	9
Amino-Based Elemental Formulas.....	9
Autism Spectrum Disorders .....	9
Clinical Trials.....	10
Dental Services.....	10
Diagnostic Testing.....	10
Durable Medical Equipment and Orthopedic Appliances.....	10
Emergency Services .....	11
Hospital Care.....	11
Illegal Occupations or Felony Attempts.....	12
Maternity Care.....	12
Medical Specialty Prescription Drugs .....	12
Physical Therapy Services - Outpatient.....	12
Physician Services.....	12
Prostheses .....	13
Reconstructive Surgery .....	13
Sexual Assault or Abuse Victims .....	13
Urgent Care .....	13
Wellness Care.....	13
PREAUTHORIZATION.....	17
Preferred Provider Preauthorization .....	17
Extended Network Provider Preauthorization.....	17
Non-Preferred Provider Preauthorization.....	17
Non-Preferred Provider and Extended Network Provider Preauthorization Penalty .....	18
Notification of Emergency Services.....	18
ELIGIBILITY .....	18
Policyholder.....	18
Dependent.....	18
Newborns, Adopted Children or Children Placed for Adoption .....	19
PREMIUMS .....	19
Payment of Premiums.....	19
Premium Rate Revision.....	20
Premium Due Date .....	20
INITIAL ENROLLMENT .....	20
EFFECTIVE DATE .....	20
Length of Policy .....	20
TERMINATION .....	20
OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS .....	21
Copayment, Coinsurance and Deductible .....	21
Out-of-Pocket Maximum.....	21
Benefit Period Maximum Benefit .....	21
EXCLUSIONS .....	22

Circumstances Beyond the Control of Health Alliance.....	22
Cosmetic Surgery .....	22
Experimental Treatments/Procedures/Drugs/Devices.....	22
Services That Are Not Medically Necessary.....	22
Other Non-Covered Items .....	23
PRE-EXISTING CONDITION EXCLUSION .....	23
APPEALS.....	23
Administrative Review.....	23
Notice of Appeal Determination.....	24
External Review of Appeals.....	26
COMPLAINTS .....	28
RIGHT OF REIMBURSEMENT.....	28
SUBROGATION .....	28
PRIVACY AND CONFIDENTIALITY .....	29
Use of Information .....	29
Disclosure of Information.....	29
Your Rights .....	29
GENERAL PROVISIONS.....	29
Clerical Error.....	29
Genetic Information.....	30
Legal Action.....	30
Health Alliance Identification Card.....	30
New Medical Technologies .....	30
Non-Discrimination.....	30
Notices.....	30
Payment of Claims .....	30
Physical Examination.....	31
Proof of Loss .....	31
Pro-Rata Refund.....	31
Time Limit on Certain Defenses .....	31
Timely Payment of Claims.....	31
Other Provisions .....	32
TERMS.....	32

## **MEMBERS' RIGHTS AND RESPONSIBILITIES**

- A right to receive information about Health Alliance, its services, its contracted Providers and Members' rights and responsibilities
  - A right to be treated with respect and recognition of your dignity and right to privacy
  - A right to participate with contracted Providers in making decisions about 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

## HOW THE HEALTH ALLIANCE SHORT TERM PLAN WORKS

The Health Alliance Short Term 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 where you choose to receive services. You may choose to receive services from a Preferred Provider and receive the highest level of coverage. You may also choose to receive services from a Non-Preferred Provider. Choosing to receive services, other than Emergency Services, from a Non-Preferred Provider will result in a lower level of coverage and more out-of-pocket expenses.

### Selecting a Physician

It is recommended that you establish a relationship with a Primary Care Physician to coordinate your care, though it is not required. Some specialty care Providers may require a referral before services are provided. The Provider Directory for your Plan is available online at HealthAlliance.org. This Provider Directory lists Preferred Providers in your Plan by specialty. If you do not have access to the internet or prefer to have a printed copy of the Provider Directory, one will be provided upon request.

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

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

### Preferred Provider

Preferred Provider health care services are paid according to the Description of Coverage after any applicable individual or family Deductible, Copayment or Coinsurance has been met. Charges from Preferred Providers are not subject to the Maximum Allowable Charge limitations because of their contract with Health Alliance.

After you provide the necessary information, Preferred Providers will file claims to Health Alliance on your behalf.

### Non-Preferred Provider

Non-Preferred Provider health care services are paid according to the Description of Coverage, up to the Maximum Allowable Charges after any applicable individual or family Deductible, Copayment or Coinsurance has been met.

To ensure the most timely payment claims from Non-Preferred Providers should be submitted to Health Alliance within 90 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 (see "Payment of Claims" section). The Provider will bill the portion you are responsible for directly to you after the Plan has determined its payment

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PREFERRED PROVIDERS ARE USED.** Be aware that when you use the services of a Non-Preferred Provider for a covered service in non-emergency situations, benefit payments to such Non-Preferred 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 (which is the amount determined by Health Alliance to be the maximum amount payable for a covered service or another method as defined by the Policy. **YOU CAN EXPECT TO PAY MORE THAN THE DEDUCTIBLE, COPAYMENT OR COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Preferred 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. Preferred 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 Preferred status of professional Providers and information on out-of-pocket expenses by calling the Customer Service Department at the number on the back of your Health Alliance Identification Card.

### **The Relationship Between Health Alliance and Preferred Providers**

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

## **COVERED BENEFITS AND LIMITATIONS**

**The following health care services are covered under this Policy subject to the Copayments, Coinsurance, Deductibles and Benefit Period Maximum Benefits specified on the Description of Coverage.** Expenses for the health care services listed below 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 in the “Preauthorization” section.) Services not specifically listed are not covered.

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, HealthAlliance.org 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.

### **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 are covered when prescribed by a Physician as Medically Necessary.

### **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.

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

### **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.

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

1. Preauthorized by Health Alliance
2. 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
3. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration: or
4. 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.

### **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.

### **Diagnostic Testing**

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

Genetic testing and counseling are not covered.

### **Durable Medical Equipment and Orthopedic Appliances**

Corrective and orthopedic appliances (including but not limited to leg braces and knee sleeves) and rental of durable medical equipment for home use (such as wheelchairs, surgical beds, insulin pumps and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. Items and supplies provided under this subsection must be prescribed by a Provider. Corrective and orthopedic appliances and devices including but not limited to ear molds, shoes, heel cups, arch supports, gloves, lifts and wedges are not covered. This includes any dispensing fees incurred in obtaining these items.

Ostomy supplies are also covered, but other disposable supplies are not covered.

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 the Member Services Department at the number listed on the back of your Health Alliance Identification Card.

### **Emergency Services**

Emergency Services 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.

Care required to treat and stabilize an Emergency Medical Condition when received from a Non-Preferred Provider will be covered at no greater expense to you than if the service had been provided by a Preferred Provider. Emergency Services are subject to the Preferred (In-Network) Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage.

The Emergency Services Copayment or Coinsurance is waived if you are admitted to the Hospital when the Plan requires an inpatient Hospital Copayment or Coinsurance. Elective care or care required as a result of circumstance which could reasonably have been foreseen prior to leaving your Service Area will be covered at the Non-Preferred Provider level of benefits.

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

### **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.

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.

Inpatient services for rehabilitation and Skilled Care are not covered.

Custodial Care or convalescent care in an acute general Hospital, skilled nursing facility or home is not covered.

**Illegal Occupations or Felony Attempts**

Emergency or other medical, Hospital or surgical expenses incurred as a result of and related to an Injury acquired while intoxicated or under the influence of any narcotic is covered.

Charges for any service, supply or treatment that occurred or in which the contributing cause was while you were engaged in an illegal occupation or in the commission of or attempt to commit a felony are not covered.

**Maternity Care**

Maternity care is not covered except for complications of pregnancy.

**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.

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.

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

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 the Health Alliance at the phone number listed on the back of your Member Identification Card or at our website [HealthAlliance.org](http://HealthAlliance.org).

**Physical Therapy Services - Outpatient**

Physical therapy for medical conditions directed at improving your physical functioning are covered up to the limits specified on the Description of Coverage.

Medically Necessary physical therapy for the treatment of multiple sclerosis is covered up to the limits specified on the Description of Coverage when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis, but only where 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.

Rehabilitative therapy services including but not limited to speech therapy, occupational therapy and vocational rehabilitation services are not covered.

**Physician Services**

Diagnostic and treatment services and wellness care 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. 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.

### **Prostheses**

Prosthetic devices (such as artificial limbs) are covered when Medically Necessary due to an illness or Injury and 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 the Member Services Department at the number listed on the back of your Member Identification Card.

### **Reconstructive Surgery**

Services are covered to correct a functional defect resulting from an acquired and/or congenital disease or Injury when Preauthorized by Health Alliance for the length of time determined by the attending Physician. 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 physical complications at all stages of mastectomy, including lymph edemas. Removal or replacement of an implant is covered if Medical Necessity. Post-discharge office visits or in-home nurse visits within 48 hours of discharge.

### **Sexual Assault or Abuse Victims**

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

### **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, 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 any Plan guidelines as defined in this Policy.

### **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 or Coinsurance and/or Deductible on the Description of Coverage.

Other preventive health services include:

- **Immunizations**

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

- human papillomavirus vaccine
- 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 preventative care guidelines.

For a complete listing of the immunization schedules and immunizations please visit [HealthAlliance.org](http://HealthAlliance.org) or [www.cdc.gov](http://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 Deductibles, Copayments or Coinsurance listed on the Description of Coverage.

A comprehensive breast ultrasound or breast MRI may be considered wellness if 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.

- **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.

- **Prostate Exams**

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.

- **Colorectal Cancer Screening**

A screening for colorectal cancer for Members aged 50-75, by means of a colonoscopy every ten 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.

- **Bone Mass Measurement** A onetime bone mass measurement screening for osteoporosis is covered as wellness for Members age 65 and over. Additional osteoporosis screenings or for screenings done under the age of 65, are subject to the office visit and/or diagnostic testing Deductibles, Copayments and Coinsurance as specified on the Description of Coverage.

- **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 Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **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, Chlamydia and human papillomavirus (HPV) are covered annually under wellness. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **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 Copayments or Coinsurance on the Description of Coverage.
- **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 Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **Ultrasound for Abdominal Aortic Aneurysm**  
A onetime ultrasound screening for men ages 65-75 for men who have ever smoked.
- **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 for Members aged 18 and older is 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
- **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**  
An annual obesity screening and counseling as part of a clinical exam for adults is covered. For children age six 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. Also 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.
- **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.
- **Hepatitis B virus(HBV) Screening**  
Screening for hepatitis B virus (HBV) infection for Members at high risk for infection is covered.
- **Breast Cancer Chemoprevention Counseling**  
Breast Cancer Chemoprevention counseling women at high risk for breast cancer and at low risk for adverse effects of chemoprevention.
- **Wellness services for children, in addition to any wellness services already listed, which 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 for children without fluoride in their water source
  - Hearing screening for newborns
  - Height, Weight and Body Mass Index as part of preventative 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, which 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 pumps.
- **Physical examinations** for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.



## **PREAUTHORIZATION**

### **Preferred Provider Preauthorization**

Preferred Providers are responsible for obtaining Preauthorization on your behalf. If the Preauthorization request is approved, your Preferred Provider who requested the Preauthorization will be notified of the effective dates, and the care and services you are authorized to receive. If the Preauthorization request is denied, you and your Preferred Provider will be notified in writing. If your Preauthorization request is denied, the Plan will not provide coverage for the requested services.

If your Preauthorization request is denied, you may request an appeal (See “Appeals,” “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,” “Expedited Medical Necessity Review”). If your Physician or other health care Provider believe 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,” “Expedited Medical Necessity Review”).

### **Extended Network Provider Preauthorization**

When using 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 Member 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.

### **Non-Preferred Provider Preauthorization**

When using Non-Preferred 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. (See Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims), Preauthorization Procedures for Urgent Care (Pre-Service Claims)).

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.

To determine what procedures or supplies would require preauthorization visit the Health Alliance website [HealthAlliance.org](http://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-Preferred Providers and have benefits paid at the Preferred Provider level only when services are not available from a Preferred Provider and if you have received Preauthorization from Health Alliance, or in a Medical Emergency. In other words, the Plan will pay at the Preferred Provider benefit level for Non-Preferred 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 Preferred Provider.**

If your Preauthorization request is denied, you may request an appeal (See “Appeals,” “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,” “Expedited Medical Necessity Review”). If your Physician or other health care Provider believe 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,” “Expedited Medical Necessity Review”).

#### **Non-Preferred Provider and Extended Network Provider Preauthorization Penalty**

If you or your Non-Preferred Provider or Extended Network Provider do not notify Health Alliance of Hospital admissions to a Non-Preferred or Extended Network Provider Hospital or do not Preauthorize any of the Outpatient Surgical procedures that are required and they are performed by a Non-Preferred Provider or Extended Network Provider and/or performed at a Non-Preferred freestanding surgical center or the Outpatient department of a Non-Preferred Hospital, the Plan imposes an additional penalty amount. The penalty amount is the lesser of 50% or \$1,000 of the billed charges. The Preauthorization penalty does not apply to your Benefit Year Medical Out-of-Pocket Maximum.

#### **Notification of Emergency Services**

If you are admitted as an inpatient to a Non-Preferred Hospital or Extended Network Provider Hospital 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.

### **ELIGIBILITY**

#### **Policyholder**

To be eligible to enroll as a Policyholder under this Plan, you must not be enrolled under any other health insurance or group plan while covered under this Plan, must not be eligible for Medicare, must live or work in the Service Area, must accurately and fully complete a health questionnaire and be approved by the Health Alliance Underwriting Department. Children that do not have Family Coverage may enroll as a Policyholder with single coverage.

#### **Dependent**

Your Dependent may be eligible to enroll for coverage under the Plan if he or she is not enrolled under any other individual or group health insurance plan while covered under this Plan, is not eligible for Medicare, lives in the

Service Area, and accurately and fully completes a health questionnaire, is approved by the Underwriting Department and has one of the following relationships to you:

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

Examples of Dependents who are not eligible for coverage under the Plan include but are not limited to: 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 of any country.

A child must be unmarried and (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 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 shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the Dependent was released from service.

A child may continue coverage as a Dependent under the Plan if, upon reaching his or her Limiting Age, an apparent handicapped condition makes the child incapable of self-sustaining employment, and the child is 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.

### **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 form to Health Alliance and pay applicable premium within 31 days of the birth. If you are paying premiums for Family Coverage, your newborn child is covered for the first 31 days of birth. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed application form and payment of the additional premium to Health Alliance within 31 days following the birth. If no additional premium is due, a completed application form must be submitted to Health Alliance within 31 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 is subject to the submission of written documentation accompanied by a completed application form within 31 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 31 days from the date your request for coverage is received.

## **PREMIUMS**

### **Payment of Premiums**

You, or anyone paying on your behalf, must remit the entire premium in full for the entire Benefit Period of the Policy to Health Alliance on or before the Effective Date of the Policy. You are entitled to the benefits of this Policy only if Health Alliance receives the full amount of the premium on or before the Effective Date.

**Premium Rate Revision**

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 no less than 31 days prior to the premium rate change.

**Premium Due Date**

The full premium amount must be paid on or before the Effective Date of this Policy.

**INITIAL ENROLLMENT**

If you meet the eligibility requirements stated in the “Policyholder” or “Dependent” subsections, you will be notified by letter of the approval of your enrollment application and the amount of premium due. Initial enrollment is completed upon receipt by Health Alliance of your initial premium payment. If the premium is not received on or before the Plan Effective Date, it will be necessary for you to reapply for coverage.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in case of a minor is required to reimburse Health Alliance for any and all sums paid on his or her behalf for health care services together with any reasonable attorneys’ fees and expenses incurred in collection of such sums

**EFFECTIVE DATE**

The Effective Date of coverage under this Plan is stated on the cover page of the Description of Coverage.

**Length of Policy**

The length of this Policy will be as indicated on the Application for this Policy unless otherwise terminated by Health Alliance for the reasons listed in the Termination section. The minimum length of this Policy is one month. The maximum a person can select for the length of this Policy must be less than three months. A person may apply for one short term Policy per Calendar Year. Application is subject to approval.

**TERMINATION**

You may terminate coverage under this Policy at any time by giving written notice to Health Alliance at least 31 days 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 as of the date we are notified or receive information that you are no longer eligible for this Policy for any of the following reasons:

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

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

The Member shall be required to reimburse Health Alliance for any and all sums expended on their 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.

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

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," "Initial Enrollment" or "Effective Date of Coverage" section of this Policy.

In the event Health Alliance decides to no longer offer a particular type of insurance product the following processes will be followed:

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

## **OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS**

### **Copayment, Coinsurance and Deductible**

All Copayment, Coinsurance and Deductible amounts are listed on the Description of Coverage. Any Coinsurance for Preferred Providers is based on the amount the Preferred Provider has agreed with health Alliance to accept as full payment for the service, which is referred to as the discounted or allowed amount.

### **Out-of-Pocket Maximum**

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

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

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

### **Benefit Period Maximum Benefit**

The Benefit Period Maximum Benefit is the total benefit amount for an individual and is specified on the Description of Coverage. This is the maximum amount the Plan will pay for medical services during the Benefit Period. You must reimburse the Plan for any amounts exceeding the Benefit Period Maximum that the Plan pays on your behalf.

## **EXCLUSIONS**

Services not specifically stated as covered under the Covered Benefits and Limitations section are not covered. Additionally, the following services are excluded from coverage under this Policy.

### **Circumstances Beyond the Control of Health Alliance**

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

### **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.

### **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, III, 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 or 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 is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- The medical treatment, procedure, drug or device for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.
- If Health Alliance has made a written request or had one made on its behalf by a national organization, for determination by HHS as to whether a specific organ transplant procedure is clinical acceptable and the organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is deemed 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 the Member’s 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 the Member’s condition, disease or illness.

### **Services That Are Not Medically Necessary**

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.

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 marriage counseling is 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 device/filters for residential heating and air conditioning systems, car seats and educational services unless specified elsewhere in the Policy, 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.
- Any service, supply or treatment received outside of the United States of America, other than Emergency Services.

### **PRE-EXISTING CONDITION EXCLUSION**

Pre-Existing Conditions are not covered. The Pre-Existing Condition exclusion will apply to conditions for which medical advice, diagnosis, care or treatment, including prescribed drugs or medicine, was recommended or received within the 12-month period preceding your Effective Date under this Policy. Properly enrolled newborns, adopted children and children placed for adoption are not subject to a Pre-Existing Condition exclusion.

### **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, Health Alliance Medical Plans, Inc., 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  
[Consumer\\_complaints@ins.state.il.us](mailto: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 three business 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 business 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 business 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”)

<b>Type of Notice or Extension</b>	<b>Timing</b>
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
<b>Health Alliance must notify you of the Claim determination (whether adverse or not):</b>	
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 three days of the decision.

If the appeal of your Preauthorization request is denied and you have exhausted the internal appeals process, you have the right to request that 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 (See “External Review of Appeals,” “Expedited Medical Necessity Review”).

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
<b>Health Alliance must notify you of the Claim determination (whether adverse or not):</b>	
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; or with the Illinois Department of Insurance, 122 South Michigan, 19<sup>th</sup> Floor, Chicago, Illinois 60603 or via facsimile at 1-217-557-8495; by email at [doi.externalreview@illinois.gov](mailto:doi.externalreview@illinois.gov) or at <https://mc.insurance.illinois.gov/messagecenter.nsf>.

Except in the case of an expedited review at an 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

- You have not received our written decision on your expedited internal appeal within 48 hours (See “Appeals,” “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 four 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 five business days of determining your request is eligible for an external review. The independent reviewer will make a decision within five days after receipt of all necessary information and provide written notification of its decision to all parties involved in the appeal.

<b>Type of Notice or Extension</b>	<b>Timing</b>
The health carrier shall notify the Director, the covered person, and if application the covered person's authorized representative of the requests eligibility for external review within:	1 business day
Upon determining the request is eligible for external review, the Director will assign an IRO within:	1 business day
The health carrier and covered person shall provide all necessary documents and information for consideration to the IRO within:	5 business days
The IRO will provide their decision to the Director, the health carrier and you within:	5 business days; but no later than 45 days after receipt of the request

- **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.

<b>Type of Notice or Extension</b>	<b>Timing</b>
The health carrier shall notify the Director, the covered person, and if application 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 the Member Services Department, Health Alliance Medical Plans, Inc., 301 S. Vine St., Urbana, Illinois 61801-3347.

You may file a complaint with the Illinois Department of Financial and Professional Regulation, Division of Insurance, 320 West Washington Street, Springfield, Illinois 62767 or with the Illinois Department of Insurance, 122 South Michigan Avenue 19<sup>th</sup> 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](mailto:consumer_complaints@ins.state.il.us) or at <https://mc.insurance.illinois.gov/messagecenter.nsf>.

## **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 to Health Alliance Medical Plans 301 South Vine Street, Urbana, IL 61801 or via facsimile to our Recovery Department at 217-365-7488. If no response is received within 45 days 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.

## **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**

Non-public 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; Springfield Clinic and Memorial Hospital.

### **Your Rights**

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

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

## **GENERAL PROVISIONS**

### **Clerical Error**

Clerical error 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.

**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.

**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.

**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.

**New Medical Technologies**

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

**Non-Discrimination**

Health Alliance does not make or permit unfair discrimination between Members or potential Members that have like insuring, risk, and other factors and elements. Health Alliance does not refuse to issue any contract, notices of proposed insurance or decline renewal to such contract because of sex, sexual preference, and marital 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, 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 a 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 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 S.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-Preferred 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 made in the application for this Policy will be used to void this contract or to deny a claim for loss incurred after two years from the Effective date of Coverage. This provision does not include fraudulent misstatements.

#### **Timely Payment of Claims**

All benefits due will be paid upon receipt of proof of loss. We will notify you within 30 days if additional information is needed.

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.

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.

**Amendment**

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

**Benefit Period**

The time period which begins on the Effective Date of the Plan and ends at the date of termination.

**Benefit Period Maximum Benefit**

The total health care benefits allowed under this Plan.

**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.

**Calendar Year**

January 1 through December 31 each year.

**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.

**Copayment**

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

**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.



**Dependent**

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

**Description of Coverage**

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

**Effective Date**

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

**Emergency Medical Condition**

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

**Emergency Services**

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

**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.

**Health Alliance Identification Card**

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

**Hospital**

An institution that meets the following requirements:

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

**Injury**

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

**Legal Spouse**

The adult person whom the Policyholder is legally married to or in a legally recognized Civil Union partnership with.

**Limiting Age**

The age a child is no longer eligible for coverage.

**Maximum Allowable Charge**

The Maximum Allowable Charge is determined by Health Alliance based on a percentage of Medicare, including use of a Medicare gap-fill fee schedule, or the average discount Health Alliance has negotiated with Preferred Providers. This is the maximum amount payable for a covered service. If the amount billed by a non-Preferred 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 Benefit 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 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.

**Member** (Also referred to as “you” or “your” or “covered person” within this Policy)

A Policyholder or a covered family Dependent who is entitled to benefits under the Plan.

**Non-Preferred Provider**

A Provider who has not entered into a valid contract with Health Alliance to provide health care services to Members.

**Out-of-Pocket Maximum**

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

**Outpatient**

The care or services 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 or a freestanding surgical center. Charges billed as part of Outpatient Surgery may include medically appropriate, surgeon fees, including assistant surgeons or surgical assistance charges, facility fees and surgical supplies. Outpatient surgery Copayments, Coinsurance and Deductibles apply to any associated facility fee for a surgery or procedure.

**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.

**Policy**

Policy means this booklet and any attached Amendments and Riders issued to a Policyholder that describes the coverage provided by the Plan.

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

An individual who lives or works in the Service Area and is enrolled in Health Alliance.

**Preauthorization (Preauthorized)**

A review by Health Alliance to determine and authorize the coverage level of Medically Necessary services for which the Plan will pay prior to receiving the services.

**Pre-Existing Condition**

A condition for which medical advice, diagnosis, care or treatment, including prescribed drugs or medicine, was recommended or received within the 12-month period preceding the Effective Date.

**Preferred Provider**

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

**Primary Care Physician**

A Preferred 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. These Physicians are designated in the online Provider Directory.

**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 they provide services.

**Provider Directory**

A list of Preferred Providers for your Plan and the area they serve.

**Retrospective Review**

A review performed after a claim for benefits is received.

**Rider**

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

**Service Area**

The geographic region 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, physical, occupational or speech therapist.

**Specialty Prescription Drugs**

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

**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.

**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 they provide services, specializing in Obstetrics and/or Gynecology or Family Practice.