Health Alliance 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 does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

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

If you need these services, contact customer service.

If you believe that Health Alliance 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, Customer Service, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

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

Spanish
ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-851-3379 (TTY: 711).

Chinese
注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫1-800-851-3379（TTY: 711）。

Polish
UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-851-3379 (TTY: 711).

Vietnamese
Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-851-3379 (TTY: 711).

Korean
주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 전화 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-851-3379 (TTY: 711).

Tagalog
Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-851-3379 (TTY: 711).

Arabic
تنبيه: إذا كنت تتحدث اللغة العربية ، خدمات المساعدة اللغوية ، مجانا ، تتوفر لك . ستدعاء 1-800-851-3379 (TTY: 711).

German
Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. Anruf 1-800-851-3379 (TTY: 711).

French
ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-851-3379 (TTY: 711).

Gujarati
ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કૉલ 1-800-851-3379 (TTY: 711).

Japanese
注意：あなたは、日本語、無料で言語支援サービスを、話す場合は、あなたに利用可能です。
1-800-851-3379コール（TTY: 711）。

Pennsylvania Dutch
LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-851-3379 (TTY: 711).

Ukrainian
УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-851-3379 (TTY: 711).

Italian
ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-851-3379 (TTY: 711).
.

HEALTH ALLIANCE HMO

TABLE OF CONTENTS

MEMBERS' RIGHTS AND RESPONSIBILITIES 7
INTRODUCTION 8
HOW THE HEALTH ALLIANCE HMO PLAN WORKS 8
Your Relationship with Your Primary Care Physician 8
The Relationship Between Health Alliance and Participating Providers 8
Specialty Care from Participating Providers 9
Non-Participating Providers or Out-of-Network Coverage 9
Termination or non-renewal of Participating Providers 9
Continued Care Coverage with Terminating Physicians 9
Continued Care Coverage for New Members 10
PREAUTHORIZATION 10
Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims) 10
Preauthorization Procedures for Urgent Care (Pre-Service Claims) 10
Notification of Emergency Services 11
COVERAGE DECISIONS 11
Concurrent Care Decisions 11
Coverage Decisions (Post-Service Claims) 11
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE 12
Policyholder 12
Dependent 12
Initial Enrollment 12
Effective Date 12
Newborns, Adopted Children or Children Placed for Adoption 13
Qualified Medical Child Support Order 13
Open Enrollment 14
Special Enrollment 14
Coverage During an Approved Family or Medical Leave of Absence 15
Coverage During Qualified Military Service 16
OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS 16
Copayments, Coinsurance and Deductible 16
Out-of-Pocket Maximum 16
Plan Year Maximum Benefit 17
PREMIUMS 17
Payment of Premiums 17
Premium Rate Revision 17
Premium Due Date 17
Grace Period 17
Unpaid Premiums 17
Reinstatement 17
WHAT IS COVERED 17
Additional Surgical Opinion 18
Allergy Testing and Treatment 18
Ambulance 18
Amino-Based Elemental Formulas 18
Autism Spectrum Disorders 18
Bariatric Surgery for Severe Obesity 19
Blood 19
Cardiac Rehabilitation Services 19
Chemotherapy and Radiation 19
Clinical Trials 19

Contraceptive Drugs, Devices and Services....19
Dental Services....20
Diabetic Equipment and Supplies....20
Diabetic Self-Management Training and Education....20
Diagnostic Testing....20
Dressings and Supplies....20
Durable Medical Equipment and Orthopedic Appliances....21
Emergency Services....21
End-Stage Renal Treatment....21
Erectile Dysfunction....21
Fibrocystic Breast Condition Services....22
Genetic Testing....22
Habilitative Services....22
Hearing Aids....22
Hearing Evaluations....22
Home Health Services....22
Home Infusion Services....22
Hospice Care....22
Hospital Care....23
Human Organ Donor....23
Human Organ Transplant....24
Infertility Services....24
Mandibular and Maxillary Osteotomy....25
Maternity Care....25
Medical Social Services....26
Medical Specialty Prescription Drugs....26
Mental Health Care....26
Oral Surgery....27
Orthotics....27
Outpatient Prescription Drugs....27
Outpatient Surgery....27
Pain therapy....27
Physician Services....27
Podiatry Services....28
Prostheses....28
Pulmonary Rehabilitation....28
Reconstructive Surgery....28
Rehabilitation and Skilled Care—Inpatient....28
Rehabilitative Therapy Services—Outpatient....28
Sexual Assault or Abuse Victims....29
Spinal Manipulation....29
Sterilization Procedures....29
Substance Use Detoxification....29
Substance Use Disorder Treatment....29
Surveillance Tests for Ovarian Cancer....30
Temporomandibular Joint Syndrome (TMJ)....30
Tobacco Cessation Program....30
Urgent Care....30
Vision Care....30
Wellness Care....31
WHAT IS COVERED/WHAT IS NOT COVERED—PHARMACY BENEFITS....35
Benefits....35
Preauthorization....35
Prescription Drug Formulary....35

Preventive Drugs 36
Outpatient Prescription Drugs Coverage and Dispensing Limitations 36
Outpatient Prescription Pharmacy Contraceptives 37
Pharmacy Specialty Prescription Drugs 38
Prescription Drugs Not Covered 38
Drug Limitations 39
WHAT IS NOT COVERED (Exclusions & Limitations) 40
Abortion 40
Acupuncture, Acupressure and Hypnotherapy 40
Blood Processing 40
Circumstances Beyond the Control of Health Alliance 40
Convenience or Comfort Items 40
Cosmetic Surgery 40
Counseling 40
Custodial or Convalescent Care 40
Dental Services 40
Disposable Items 40
Durable Medical Equipment, Orthopedic Appliances and Devices 41
Experimental Treatments/Procedures/Drugs/Devices/Transplants 41
Eyeglasses, Contacts and Refractory Treatment 41
Fitness 41
Governmental Responsibility 42
Hearing Aids 42
Illegal Occupation 42
Infertility Services 42
Institutional Care 42
Medicare Benefits 42
Obesity 42
Reversal of Sterilization 43
Services that are Not Medically Necessary 43
Skin Lesions 43
Supplemental Drinks/Vitamins/Weight Gain Products 43
Other Non-Covered Items 43
APPEALS 43
Notice of Appeal Determination 44
Appeal Procedures for Non-Urgent Care Decisions (Pre-Service Claims) 45
Appeal Procedures for Urgent Care Decisions (Pre-Service Claims) 45
Appeal Procedures for Concurrent Care Decisions 46
Appeal Procedures for Coverage Decisions (Post-Service Claims) 46
Civil Action under ERISA 47
External Review of Appeals 47
Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review 47
Expedited Medical Necessity Review 48
COMPLAINTS 48
TERMINATION 48
COORDINATION OF BENEFITS 50
Definitions 50
Order of Benefit Determination Rules 51
Effect on the Benefits of This Plan 52
Right to Receive and Release Needed Information 52
Facility of Payment 53
SUBROGATION 53
CONVERSION OF COVERAGE 53
Health Alliance HMO Conversion Plan 53

Comprehensive Health Insurance Plan....53
MEDICARE-ELIGIBLE BENEFICIARIES....54
PAYMENT OF CLAIMS....54
PRIVACY AND CONFIDENTIALITY....55
Use of Information....55
Disclosure of Information....56
Your Rights....56
GENERAL PROVISIONS....56
Clerical Error....56
Entire Contract and Changes....56
ERISA....56
Extension of Benefits in the Case of Total Disability....56
Financial Information....57
Genetic Information....57
Guaranteed Renewability....57
Health Alliance Identification Card....57
Hospitalized on Effective Date....57
Legal Action....57
New Medical Technologies....57
Non-Discrimination....57
Notices....58
Time Limit on Certain Defenses....58
Timely Payment of Claims....58
Other Provisions....58
CONTINUATION OF EMPLOYER GROUP COVERAGE....58
STATE CONTINUATION....58
Eligibility....58
Election....59
Termination of Coverage....59
SPOUSAL CONTINUATION....59
Eligibility....59
Election....59
Termination of Coverage....60
DEPENDENT CONTINUATION....60
Eligibility....60
Election....60
Termination of Coverage....60
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)....61
TERMS....67

MEMBERS' RIGHTS AND RESPONSIBILITIES

- A right to receive information about Health Alliance, its services, its 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 policies
- A right to have reasonable access to health care

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

HEALTH ALLIANCE HMO

INTRODUCTION

Health Alliance HMO is a Health Maintenance Organization Plan established as a fully insured product of Health Alliance Medical Plans, Inc. (Health Alliance). The main office of Health Alliance is located at 301 South Vine Street, Urbana, Illinois 61801-3347.

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

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.

HOW THE HEALTH ALLIANCE HMO PLAN WORKS

The Health Alliance HMO Plan provides coverage for Medically Necessary health care services in exchange for your agreement to certain limitations. You are required to receive all your covered medical care from the Physicians, Hospitals and other Providers within your Health Alliance Provider network, also referred to as Participating Providers. You are also required to have all your medical care coordinated by your Primary Care Physician whom you select from a list of available Primary Care Physicians in your Provider Network. A Provider Directory listing Participating Providers by specialty with addresses and telephone numbers is available at HealthAlliance.org. Click on "Find a Doctor" in the site's directory. We encourage you to create a login to view your plan specific Providers and other Plan information. A paper directory can be provided upon request. If your Primary Care Physician believes you require care from a specialist or other Provider, your Primary Care Physician may refer you to the appropriate Provider. In addition, Preauthorization from Health Alliance is required for some types of care.

Your Relationship with Your Primary Care Physician
Upon enrollment, you must select a Primary Care Physician. We want you to have an open and honest relationship with your Primary Care Physician because this Physician will direct all your health care needs. You may change your Primary Care Physician by calling Health Alliance at the number on the back of your Health Alliance Identification Card or writing Health Alliance. Please note that a change in Primary Care Physician may change your Provider network.

In addition to their Primary Care Physician, female Members may select a Woman's Principal Health Care Provider 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.

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

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

The Relationship Between Health Alliance and Participating Providers
Participating Providers are responsible for providing you with the services covered by this Policy. Health Alliance has contracted with Participating Providers to provide you with covered services. Health Alliance does not

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

Specialty Care from Participating Providers
If your Primary Care Physician believes specialty care is Medically Necessary, he or she may refer you to a Participating Provider in your Provider Network. Physicians, Hospitals, mental health and other health care Providers are listed in the Provider Directory for your Provider Network by specialty with addresses and telephone numbers. Your Primary Care Physician will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, your Primary Care Physician may give you a standing referral. A standing referral will be effective for either the time period or number of visits specified by your Primary Care Physician. If the specialty services needed are not available from a Participating Provider in your Provider Network, a referral from your Primary Care Physician and Preauthorization from Health Alliance are required for coverage of the specialty services. Non-Participating Provider services are covered only when a Participating Provider cannot provide the requested Medically Necessary services. Female Members may obtain services from a Participating Woman's Principal Health Care Provider without a referral from a Primary Care Physician.

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

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

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

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your Physician for a period of 90 days at their previous level of coverage. The 90-day period starts on the date you receive notice from Health Alliance that your Physician's contract with Health Alliance is terminating.

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

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

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your treating Physician for a period of 90 days from your Effective Date of coverage.

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

PREAUTHORIZATION

Your Primary Care Physician, Participating Provider or Extended Network Provider are responsible for obtaining Preauthorization from Health Alliance on your behalf. If the Preauthorization request is approved, you and the Provider who requested the Preauthorization will be notified of the effective dates and the care and services you are authorized to receive. If the Preauthorization request is denied, your Provider will be notified in writing. If the Preauthorization request is denied, the Plan will not provide coverage for the requested services.

Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims)
Health Alliance will make a coverage decision and notify you or your authorized representative in writing within 15 days of receipt of the request for Preauthorization.

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

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

If your Preauthorization request is denied, you may request an appeal of the denial (see "Appeal Procedures for Non-Urgent Care Decisions"). If your Preauthorization request is denied on the basis of 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").

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

If additional information is needed, Health Alliance will notify you or your authorized representative within 24 hours of the request specifying what information is needed to make a decision. You will have 48 hours to provide

the requested information. Health Alliance will make a decision as soon as possible, and no later than 48 hours, after receipt of the requested information.

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

Notification of Emergency Services
If you are admitted as an inpatient to a non-Participating Hospital or a Participating Hospital outside your Provider Network for an Emergency Medical Condition, you must notify Health Alliance at the number listed on the back of your Health Alliance Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

COVERAGE DECISIONS

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

If your Physician or other health care Provider believes that the denial of coverage of health care services or the timeframe for an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization. If the denial of coverage is based on the determination that the required 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 review by an independent review organization (see "External Review of Appeals," "Expedited Medical Necessity Review").

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

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

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

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

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

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

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

- Your Legal Spouse
- Your natural-born, legally adopted child or stepchild.
- A child for whom you or your Legal Spouse are the court-appointed legal guardian
- A 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 or National Guard of any country or if covered under the Plan as an employee.

An eligible Dependent covered must be under the age of 26. The only exceptions are if it states otherwise in the Group Enrollment Agreement or if the Dependent is under the age of 30, is a veteran and Illinois resident who served in the Armed Forces of the United States (but did not receive dishonorable discharge).

To be eligible for coverage, the Dependent who is a veteran may be required to submit a form approved by the Illinois Department of Veterans' Affairs stating the date on which the Dependent was released from service to Health Alliance.

Coverage for a Dependent will terminate the last day of the month in which the Dependent reaches the limiting age as stated in this Policy.

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

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

Effective Date
The Effective Date of coverage under this Plan depends on the Employer Group's eligibility requirements. The eligibility requirements are specified in the Group Enrollment Agreement between the Employer Group and

Health Alliance. This Plan will remain in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Employer Group or Health Alliance.

Newborns, Adopted Children or Children Placed for Adoption
If you are paying premiums for individual coverage (employee only), your newborn child is covered only if you submit an Employer Group application form to your employer within 31 days of the birth. If you are paying premiums for Family Coverage, your newborn child is covered for the first 31 days of life. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed Employer Group application form to your employer within 31 days following the birth. If no additional premium is due, a completed Employer Group application form must be submitted to your employer within 31 days following the birth. Coverage for a newborn will include Medically Necessary care for illness, Injury, congenital defects, birth abnormalities and premature birth. A newborn of a Dependent child is not covered.

If you adopt a child, serve as a child's legal guardian or a child is placed for adoption, coverage is subject to the submission of written documentation includes, but is not limited to, an interim court order, the signature of the judge on a final order of adoption, guardianship or placement for adoption, accompanied by a completed Employer Group application form within 31 days from the date of the order.

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. Employer Group application forms are available through your employer.

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

Your employer will notify you whether the Dependent is eligible for coverage within 31 days of receipt of the order. If the Employer Group offers more than one Plan option, the Dependent will be enrolled in the same Plan in which the Policyholder is enrolled. The Dependent's eligibility for enrollment will be under the same terms and conditions as other Dependents of the Plan. Your employer does not need approval from you to add a Dependent to the Plan. Children covered under a Qualified Medical Child Support Order and who reside in a Health Alliance Service Area that is different from the Health Alliance Service Area of the Policyholder will receive the same covered benefits as the Policyholder when utilizing contracted Providers in the Dependent's Health Alliance Service Area and following the Plan's requirements.

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

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

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

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

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

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

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

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

- If you and/or your Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours, a reduction in or termination of employer contributions, or you receive a notice of the loss of minimum essential coverage you and your eligible Dependents may enroll in the Plan.
- You and your Dependents are eligible for a special enrollment period under another employer-sponsored Group health plan if you are no longer eligible for the Plan because you cease to live or work in the Service Area and there is no other benefit plan option available under the Plan.
- If you or your eligible Dependents exhaust COBRA continuation or state continuation coverage, you and your eligible Dependents losing coverage may enroll in the Plan.
- If you gain a Dependent through a court order you may enroll yourself, your eligible Legal Spouse, the new Dependent or any other eligible Dependent children not currently enrolled in the Plan.
- If you or your eligible Dependents enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, intentional misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace for Health and Human Services(HHS), or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, intentional misrepresentation or inaction.

The Effective Date of coverage of you and your Dependent added through one of these qualifying events is the first of the month following the date of the qualifying event.

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

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

- In the case of a permanent move, if plan selection is made on or before the day of the move, the coverage effective date is the first of the month following the month of the move. A consumer has 60 days after a permanent move to select a Plan. If enrollment is requested between the first and fifteenth of the month

then the Effective Date is the first day of the month following the month of the move or if enrollment is requested between the sixteenth and last day of the month, the Effective Date will be the first day of the second month following the month of the move.

To be eligible to enroll under one of these qualifying events, you must submit a written request to your employer requesting changes in your coverage within 31 days of the event. Any request to add yourself or eligible Dependents after the 31-day period will not be granted. You may be required to provide supporting documentation for the change in enrollment to Health Alliance.
If you have other coverage (such as a plan offered by your Legal Spouse's employer) and you lose coverage as a result of a qualifying event (such as death, legal separation, divorce), you and your eligible Dependents may enroll in the Plan. The Effective Date will be the day following the qualifying event

To be eligible to enroll due to a loss of coverage, you must submit a written request to your employer requesting changes in your coverage within 31 days of the event. Any request to add yourself or eligible Dependents after the 31-day period will not be granted. You may be required to provide supporting documentation for the change in enrollment to Health Alliance.

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

- If you are eligible for coverage but not enrolled in this Plan and you or your Dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you and your eligible Dependents may enroll in the Plan.
- If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you and your eligible Dependents may enroll in the Plan.
- If you or your eligible Dependent is enrolled in an eligible employer-sponsored plan that is not considered qualifying coverage, you are allowed to terminate existing coverage, and may enroll in the Plan.

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

The Effective Date of coverage for you or your Dependents added through one of these qualifying events is the first day of the month following receipt of the special enrollment request.

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

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

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

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

Coverage for a Dependent will not be continued beyond the date it would otherwise terminate. If your coverage terminates because your approved FMLA leave is deemed terminated by the Employer Group, you may be

eligible for continuation coverage under COBRA. If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for continued coverage on the same terms as an employee actively at work.

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

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

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

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

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

If a Policyholder decides to waive coverage during the qualified military service and returns to employment following the leave, prior Plan coverage will be reinstated immediately upon re-employment if the Policyholder reports to work within the required timeframes established under USERRA and appropriate documentation is provided upon request.

OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS

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

Out-of-Pocket Maximum
The Out-of-Pocket Maximum amount for an individual and family is specified on the Description of Coverage and the SBC. This is the maximum amount you are required to pay in Deductibles, Copayments and Coinsurance for Basic Health Care Services during the Benefit Year.

Any Copayment or Coinsurance amount for Basic Health Care Services exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Benefit Year.

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

PREMIUMS

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

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

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

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

Unpaid Premiums
Any premium due and unpaid or covered by any note or written order may be deducted from the payment of a claim under this Policy.

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

WHAT IS COVERED

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

Expenses for health care services, including Basic Health Care Services, are covered only if your Primary Care Physician or a Participating Provider considers the service to be Medically Necessary for the treatment, maintenance or improvement of your health. Some health care services are subject to Preauthorization by Health Alliance.

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 under "Medical and Pharmacy Policies," or you can request a paper copy of a medical policy by contacting Health Alliance at the number listed on the back of your Health Alliance Identification Card.

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

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

Additional Surgical Opinion
A consultation with a board certified surgeon is covered at 100% after you receive a recommendation for surgery. If a second opinion does not confirm the primary surgeon's opinion, a third opinion is covered. If your Primary Care Physician or treating specialist recommends a second or third opinion with a Provider outside your Provider Network, a referral and Preauthorization from Health Alliance is required.

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

Ambulance

Air Transportation – Emergency transportation by air ambulance is covered for an Emergency Medical Condition when Medically Necessary. Air ambulance services are not covered when you could be safely transported by ground ambulance or by means other than by ambulance.

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

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

Autism Spectrum Disorders
The Medically Necessary diagnosis and treatment of Autism Spectrum Disorders for Members under the age of 21 are covered. "Autism Spectrum Disorders" means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association, including Autism, Asperger's disorder, and pervasive developmental disorder.

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

- Habilitative or rehabilitative care includes counseling and treatment programs intended to develop, maintain, and restore the functioning of a Member under the age of 21 who has been diagnosed with Autism Spectrum Disorder.

- Therapeutic care for Autism Spectrum Disorders includes behavioral, speech, occupational, and physical therapies addressing self-care and feeding; pragmatic, receptive, and expressive language; cognitive functioning, applied behavioral analysis, intervention, and modification; motor planning, and sensory processing.

Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Coverage for Medically Necessary early intervention services must be delivered by a certified early intervention specialist.

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

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

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

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

Cardiac Rehabilitation Services
Cardiac Rehabilitation Phase I, provided on an inpatient basis for an acute cardiac episode or surgery, is covered. Cardiac Rehabilitation Phase II, which is initiated immediately following Phase I, is covered. Repeat Phase II rehab for the same acute cardiac episode, surgery or event is a provisionally covered benefit. Cardiac Rehabilitation Phase III is not covered. Cardiac Rehabilitation services are covered at the other covered services benefit as listed on your Description of Coverage and/or SBC.

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

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

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

- Preauthorized by Health Alliance
- Approved by one of the follow agencies: the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs or the United States Department of Energy: and/or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is drug trial that is exempt from having such an investigational new drug application.

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

Contraceptive Services as specified in this section that are prescribed or recommended to treat medical conditions with a medical diagnosis and are not used for Contraceptive purposes or for unintended pregnancy for females are

not considered Wellness and are subject to the medical Deductible, Copayment or Coinsurance as specified on Description of Coverage and the SBC.

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

Injectables and the injection intended for female Contraceptive purposes only are covered under the Wellness benefit. This includes but is not limited to DepoProvera®. Additional charges with a medical diagnosis are subject to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage and the SBC.

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

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

Dental Services
Hospitalization for Dental work 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 when Preauthorized by Health Alliance. (See "Oral Surgery" in this section for other covered services).

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

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

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

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

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

Durable Medical Equipment and Orthopedic Appliances
Corrective and orthopedic appliances (such as leg braces and knee sleeves) and durable medical equipment for home use (such as wheelchairs, surgical beds, insulin pumps and oxygen administration and 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 Participating Physician and Preauthorized by Health Alliance.

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

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

Emergency Services
Emergency Services received inside or outside your Provider Network for an Emergency Medical Condition are covered. In an emergency, seek immediate care or call 911 if it is available in your area. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The Emergency Services Copayment or Coinsurance is waived if you are admitted to the Hospital when your Plan requires an inpatient Hospital Copayment or Coinsurance. Elective care or care required as a result of circumstances which could reasonably have been foreseen prior to leaving your Provider Network is not covered. Unexpected hospitalization due to complications of pregnancy is covered.

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

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

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

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

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

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

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

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

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

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

- Habilitative services include occupational therapy, physical therapy, speech therapy, and other services prescribed by the treating Physician pursuant to a treatment plan to enhance the individual's ability to function.

- Congenital, genetic and early acquired disorders include hereditary disorders, autism or an autism spectrum disorder, cerebral palsy or disorders resulting from illness or Injury, which occurred prior to a child developing functional life skills, such as walking, speaking or self-care skills.

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

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

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

Hearing Evaluations
Hearing evaluations performed by Participating Providers are covered.

Home Health Services
Intermittent skilled nursing and skilled therapeutic home services are covered when you are homebound and the services are given under the direction of a Participating Physician and Preauthorized by Health Alliance.

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

Home Infusion Services
Home infusion services, including medication and supplies, are covered when given under the direction of a Participating Physician and Preauthorized by Health Alliance.

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

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

Hospice refers to a program that meets the following requirements:

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

Hospital Care
Hospital services are covered for an unlimited number of days when hospitalization is ordered by and provided by a Participating Provider. 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. Hospital admissions, including mental health and Substance Use Disorder, require Preauthorization by Health Alliance.

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, Health Alliance will not require you to substitute your Primary Care Physician for a hospitalist.

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

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

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

If both the recipient of the living human organ donation and the living organ donor are Members with Health Alliance policies each will have benefits paid by their own policy.

Human Organ Transplant
Human organ transplants are covered for organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, upon prior order and written referral of a Member's Primary Care Physician or treating specialist, and upon the findings of a Medical Director that the recommended treatment is Medically Necessary and is not excluded from coverage under any other sections of this Policy. Transplants must be performed at a Health Alliance approved facility. Coverage for benefits under this subsection begins with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and through one year after transplant. Office visit and Hospital Care Copayments, Coinsurance or Deductible applies as specified on the Description of Coverage.

Coverage includes, but is not limited to:

- Inpatient and Outpatient medically necessary services related to the transplant Surgery.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor.
    - Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preparing, preserving and transporting the donated organ or tissue.
- The transportation of the donor organ to the location of the transplant Surgery.
    - The Plan covers transportation, lodging and meals for the transplant recipient and a companion for travel to and from the Health Alliance designated transplant center. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

Infertility Services
Infertility services for the diagnosis and treatment of Infertility will be covered subject to the following terms, conditions and limitations. Infertility services are covered upon prior order and written referral from a Member's Primary Care Physician or Woman's Principal Health Care Provider and upon prior written approval of a Medical Director that the Member meets all Health Alliance criteria for coverage. Prescribed and approved services must be received at an Infertility center or other provider approved by and under contract with Health Alliance. Any services not covered are described in the "What is Not Covered" section of this policy. The following Infertility services are covered:

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

Benefit Limitation/Oocyte Retrieval Limitation:

- For treatments that include Oocyte Retrievals, coverage for such treatments will be provided only if the Member has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments. This requirement shall be waived in the event that the Member or partner has a medical condition that renders such treatment useless.
    1) following the final completed Oocyte Retrieval for which coverage is available, coverage for one subsequent procedure used to transfer the Oocytes or sperm to the covered recipient shall be provided.
    2) the maximum number of completed Oocyte Retrievals that shall be eligible for coverage is four per Plan Year.

Donor Expenses:

- The medical expenses of an Oocyte or sperm donor for procedures utilized to retrieve Oocytes or sperm, and the subsequent procedure used to transfer the Oocytes or sperm to the covered recipient will be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening and prescription drugs, will also be covered if established as prerequisites to donation by the insurer.
- Coverage for a known donor is provided. In the event the Member does not have arrangements with a known donor, the use of a contracted facility is required. If the Member uses a known donor, use of contracted Providers by the donor for all medical treatment, including but not limited to testing, prescription drug therapy and ART procedures, is required.
- If an Oocyte donor is used, then the completed Oocyte Retrieval performed on the donor will count against the Member as one completed oocyte retrieval.

Mandibular and Maxillary Osteotomy
A mandibular or maxillary osteotomy is covered only if you have significant functional problems that have not been corrected with Dental and/or orthodontic treatment.

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

Prenatal HIV testing is covered.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the newborn. Newborn charges are applied to the eligible covered mother's inpatient benefit for the first 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. Coverage for the newborn would begin at birth following enrollment requirements as specified in the "Newborns, Adopted Children or Children Placed for Adoption" section of this policy. Your Primary Care Physician, Woman's Principal Health Care Provider or attending Physician, may determine after consultation with you that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of your Physician, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge is also covered.

Coverage for the properly enrolled newborn, not covered under the eligible covered mother's inpatient benefits, is provided subject to any applicable newborn care Copayment, Coinsurance and Benefit Year Medical Deductible amount specified on the Description of Coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

Services not covered include care provided by a Non-Participating Provider or non-licensed mental health professional, care in lieu of detention or correctional placement, non-Medically Necessary services, and services with a diagnosis of marriage or social counseling unrelated to mental health conditions.

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

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

Orthotics
Specially molded and custom-made orthotics are covered when prescribed by a Physician and Preauthorized by Health Alliance. The orthotic and orthopedic appliance Deductible, Coinsurance or Copayment amount as specified on the Description of Coverage and the SBC applies. Special shoe inserts for arch or foot supports that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure are covered.

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

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

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

Physician Services
Diagnostic and treatment services and Wellness services, for illness or Injury, provided by a Physician or under the supervision of a Physician including the recommended periodic health care examinations and well child care are covered, as specified on the Description of Coverage, are covered. 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” subsections of this Policy.

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

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

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

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

Reconstructive Surgery
Services 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 all physical complications at all stages of mastectomy including lymphedemas.
- Removal or replacement of an implant is covered if the original reconstruction qualified for coverage and there is a documented medical problem.
- Post-discharge office visits or in-home nurse visits within 48 hours of discharge

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

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

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

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

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

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

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.

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

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

Substance Use Detoxification
Acute inpatient Substance Use detoxification is covered if determined by your Primary Care Physician or Participating Provider that Outpatient management is not medically appropriate. Treatment is considered medical and does not apply to the Substance Use Disorder Treatment benefit until the patient is discharged from the Hospital or transferred to a Substance Use Disorder unit. Inpatient admissions require Preauthorization by Health Alliance.

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

Inpatient benefits include Medically Necessary Inpatient hospitalization and residential care and are subject to the Substance Use Disorder Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and the SBC. Inpatient admissions require Preauthorization by Health Alliance except in emergency situations.

Outpatient benefits include individual counseling sessions or group Outpatient visits.

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

Inpatient and Outpatient Substance Use Disorder treatment coverage does not include care in lieu of detention or correctional placement or family retreats.

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

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

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

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

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

Temporomandibular Joint Syndrome (TMJ)
Temporomandibular Joint services and treatment as defined in this Policy are covered.

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

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

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

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

One pair of eyeglasses, which includes lenses and frames, is covered once every 12 months for all members under the age of 19.Subject to the limitations listed on the Description of Coverage. Contacts for members under the age of 19 are covered once every 12 months as follows:

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

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

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

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

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

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

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

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

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

Vision care is covered with an Optometrist, Ophthalmologist or other physician that is licensed to provide care to the eye for vision care services. See Physician Services for medical care of the eye, in addition to the items listed in this section.

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

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 preventive care guidelines.

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

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

- **Clinical Breast Exams**
  A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer at least every three years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older is covered.

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

  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 and the SBC.

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

- **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 prostate cancer age 40 and over when authorized by your Primary Care Physician. Additional Prostate exams and prostate specific antigen tests are subject to the appropriate Copayment or Coinsurance listed on the Description of Coverage and the SBC.

- **Colorectal Cancer Screening**
  A screening for colorectal cancer for Members age 50-75, by means of a colonoscopy every 10 years or sigmoidoscopy once every five years is covered under the Wellness benefit as specified on the Description of Coverage and the SBC. Colonoscopies and sigmoidoscopies done other than what is listed under Wellness are subject to the office visit and/or Outpatient Surgery/procedure (when there is an associated facility fee) Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and the SBC.

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

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

- **Sexually Transmitted Infection Counseling and Screening**
  Counseling and screenings for sexually transmitted infections including but not limited to the human immune-deficiency virus (HIV) , hepatitis C virus (HCV), syphilis, gonorrhea and, Chlamydia are covered annually

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

- **High-Risk HPV(human papillomavirus) testing**
  DNA testing in women age 30 and over, once every three years is covered for women under the Wellness benefit. Additional charges or testing will be subject to the appropriate Copayments or Coinsurance on the Description of Coverage and the SBC.

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

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

- **Alcohol and Drug Misuse Counseling and Screening**
  Counseling and Screening for alcohol and drug misuse is covered.

- **Fall Prevention**
  Exercise or physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls is covered.

- **Blood Pressure Screenings**
  Blood Pressure Screenings are covered.

- **Behavioral Counseling for Skin Cancer Prevention**
  Counseling for individuals, ages 10-24 with fair skin, regarding minimizing his or her exposure to ultraviolet radiation to reduce risk for and prevent incidence of skin cancer is covered.

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

- **Diabetes Screenings.**
  Diabetes screenings for Members with high blood pressure is covered.

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

- **Obesity Screenings and Counseling**
  An annual obesity screening and counseling as part of a clinical exam for adults is covered. For children age 6 and older, an obesity screening and counseling is covered as part of a clinical exam.

- **Tobacco Use Screening**
  A screening as part of a clinical exam to screen for tobacco use and to provide intervention methods is covered. See “Tobacco Cessation Program” section of this Policy regarding the tobacco cessation program that is covered.

- **Lung Cancer Screening**
  Annual screening with low-dose computed tomography (LDCT) for Members 55-80 who have a 30 pack/year smoking history and currently smoke or Members who have quit within the past 15 years is covered. Screening would be discontinued once a Member has not smoked for 15 years or the Member develops a

health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage and the SBC.

- **BRCA Counseling and Evaluation**
  BRCA counseling and evaluation for women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes is covered. Preauthorization is required for BRCA testing.

- **Breast Cancer Chemoprevention Counseling**
  Breast Cancer Chemoprevention counseling women at high risk for breast cancer and at low risk for adverse effects of chemoprevention is covered.

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

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

- **Preventive Drugs**
  The following are covered at Participating pharmacies under the Wellness benefit:
  - Folic Acid supplements for women who may become pregnant.
  - Iron supplements for children ages 6 months to 12 months that are at risk for anemia
  - Vitamin D supplements for Members aged 65 and older and who are at risk for falls.
  - Gonorrhea preventive medication for the eyes of all newborns.
  - Aspirin for men 45-79 years of age for a reduction in myocardial infarctions or for women 55-79 years of age for a reduction in ischemic strokes. The potential benefit of a reduction must outweigh the potential harm of an increase in gastrointestinal hemorrhage.
  - Aspirin for women as a preventive medication after 12 weeks of gestation in Members who are at high risk for preeclampsia.
  - Smoking Cessation products
  - Select vaccinations administered at pharmacies
  - Bowel Prep Kits used prior to a colonoscopy covered for members 50 and older once per year.
  - Tamoxifen and raloxifene used for breast cancer risk reduction.

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

- **Wellness services for children, in addition to any Wellness services already listed, include:**
  - Autism screening for children at 18 and 24 months
  - Behavioral assessments as part of preventive exams.
  - Dyslipidemia screening for children at higher risk of lipid disorders
  - Fluoride Chemoprevention supplements and varnish for children without fluoride in their water source
  - Hearing screening for newborns
  - Height, Weight and Body Mass Index as part of preventive exams for children
  - Hematocrit or Hemoglobin screening for children
  - Hemoglobinopathies or sickle cell screening for newborns
  - Lead screening for children who are at risk for exposure
  - Oral health risk assessment for young children
  - Phenylketonuria (PKU) screening for this genetic disorder in newborns

- Tuberculin testing for children at higher risk of tuberculosis
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Vision screening for children

- **Wellness services for pregnant women, in addition, to any Wellness service already listed, include:**
  - Anemia screenings;
  - Urinary tract or other infection screenings;
  - Gestational diabetes screening;
  - Hepatitis B screening;
  - Rh Incompatibility screening, which also includes follow up testing for women at high risk;
  - Breast feeding counseling and pumps. Also see the Maternity section in this Policy

- **United States Preventive Services Task Force (USPSTF)**
  In addition to the Wellness Care listed here, coverage will also include any other preventive services approved by the United States Preventive Service Task Force (USPSTF) that may be upgraded to Grade A or B during the Benefit year.

WHAT IS COVERED/WHAT IS NOT COVERED—PHARMACY BENEFITS

Benefits
Health Alliance administers pharmacy benefits through a national pharmacy benefit manager. Many independent pharmacies and most national chains are Participating pharmacies. To find out if a pharmacy is a Participating pharmacy, call Health Alliance at the number listed on the back of your Health Alliance Identification Card. You must present your Member Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Deductible, Copayment or Coinsurance at the time it is filled. If you do not present your Health Alliance Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement you may submit your itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager's address noted on the back of your Health Alliance Identification Card.

Prescription drugs obtained at a Participating pharmacy when prescribed by a Participating Physician, hereinafter referred to as Physician for purposes of this section, in connection with Medically Necessary services are covered for Members subject to the following terms, conditions and limitations.

Prescription Drugs obtained from a Non-Participating pharmacy in conjunction with emergency services are covered subject to the terms, conditions and limitations listed below.

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

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

Your Physician must contact Health Alliance to obtain Preauthorization. Preauthorization can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card. If Preauthorization is not obtained, Health Alliance will not provide coverage and you will be required to pay the full cost of the drug.

Prescription Drug Formulary
Health Alliance has developed a prescription Drug Formulary, which is a list of covered Tier 1, Tier 2, Tier 3, Preventive Drugs (see "Preventive Drugs" section for a complete description) and Specialty Prescription Drugs

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

Some prescription drugs are not included on the Health Alliance Drug Formulary. Non-formulary drugs have covered formulary alternatives in most instances. Coverage of non-formulary drugs requires a request for Medical Exception from your physician. The Medical Exception request must explain the reason covered formulary alternatives cannot be used. Medical Exception can be requested using the Preauthorization Request Form.

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

Preventive Drugs

As part of the Wellness benefit, preventive drugs are covered under the prescription Drug Formulary. Preventive drugs are Tier 7 drugs. Tier 7 drugs are covered at no charge when prescribed by a Participating Provider and obtained at a Participating Pharmacy. For a listing of the Tier 7 drugs please see section "Wellness Care" under "What is Covered" and/or the Health Alliance Drug Formulary. In addition to the preventive drugs listed here, coverage will also include any other preventive drugs approved by the United States Preventive Service Task Force (USPSTF)that may be upgraded to Grade A or B during the Benefit year. The drugs listed in the Health Alliance formulary are also reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee. Prescription drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Benefit Year, this could occur up to six times per year or every two months. If a drug moves to a different tier or is removed from the formulary then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any formulary alternatives available to you.

Outpatient Prescription Drugs Coverage and Dispensing Limitations

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

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

- Coverage will be provided for prescription Contraceptives prescribed for the purpose of preventing conception, and which are approved by the United States Food and Drug Administration (FDA), or generic equivalents of Contraceptives approved as substitutable by the FDA. Prescription contraceptives will be subject to the Deductible and/or Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage or that may be listed in this section.
- Most, but not all, generic drugs (as defined by a National Drug Information Provider) will be dispensed under the Tier 1 Deductible, Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law.
- If you or your Physician requests a brand name drug when a generic exists, you pay the Tier 3 Copayment or Coinsurance, plus the difference in cost between the brand name drug and the generic drug.
- If a Tier 2 or Tier 3drug is prescribed and a generic does not exist, you pay the Tier 2 or Tier 3 Copayment or Coinsurance.
- If a higher tiered drug is determined to be Medically Necessary by your Physician and Health Alliance, you may qualify to pay a reduced tier copay. To determine if you would qualify you can contact Health Alliance at the number on the back of your Health Alliance Identification Card.
- Injectable syringes are covered when the injectable drug is covered.
- Coverage includes Medically Necessary emergency opioid antagonist available without Prior Authorization
- Coverage will be provided for prescription topical eye medication used to treat a chronic condition of the eye, if the refill is requested prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and the prescribing physician or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the member do not exceed the total number of refills prescribed.
- Coverage includes Medically Necessary pain medication for the treatment of breast cancer
- A limited number of over-the-counter (OTC) medications are covered. A prescription is required from your Physician for covered OTC products and the Tier 1 or Tier 2 Deductible, Copayment or Coinsurance applies.
- Tobacco cessation pharmacological therapy, as defined by the Health Alliance formulary is covered.
- For a 30-day supply of medication or less, you pay the applicable copayment as indicated on the Description of Coverage.
- For a 31- 60 day supply of medication, you pay 2 times the copay applicable to a 30-day supply as indicated on the Description of Coverage.
- For a 90-day supply of maintenance medications obtained through a Participating 90 day network pharmacy or via mail order, you pay 2.75 Copayments as indicated on the Description of Coverage.

Outpatient Prescription Pharmacy Contraceptives

Medically Necessary, Federal Drug Administration (FDA) approved prescription pharmacy Contraceptive methods are covered under this section when prescribed by a Physician. This includes contraceptive pills, patches, ring, injections and over the counter methods.

- Tier 7 Prescription Contraceptive pills, patches, ring and injection will be covered under this section at a Participating Pharmacy with $0 Copayment as part of the Wellness benefit.
- Tier 2 and/or Tier 3 Prescription Contraceptive pills will be subject to the Tier 2 and/or Tier 3 Deductible, Copayments and/or Coinsurance listed on the Description of Coverage.
- FDA approved over the counter Contraceptive products (including but not limited to condoms, sponges, and spermicide) are also covered for women with a prescription at a Participating Pharmacy with $0 Copayment as part of the wellness benefit. Coverage is limited to one package per month.
- One type of Contraceptive product is covered per month under this Pharmacy section.

Pharmacy Specialty Prescription Drugs
Pharmacy Specialty Prescription Drugs are defined as any prescription drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty Prescription Drug on the Health Alliance Drug Formulary: (1) Specialized procurement handling; distribution, or is administered in a specialized fashion; (2) Complex benefit review to determine coverage; (3) Complex medical management; or (4) FDA mandated or evidence-based medical-guideline determined comprehensive patient and/or Physician education. Examples of Pharmacy Specialty Prescription Drugs include, but are not limited to, fertility drugs, biological specialty drugs, growth hormones, organ transplant specialty drugs, and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription Drug Formulary at HealthAlliance.org.

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

Health Alliance has developed a specialty drug listing, which has a list of covered Tier 4, Tier 5 and Tier 6 Specialty Pharmacy Prescription Drugs. Tier 4 Specialty Drugs are the most clinically and cost effective, these are also known as Preferred Formulary Specialty Drugs. Tier 5 Specialty Pharmacy Prescription Drugs are at a higher cost then Tier 4 and usually have clinically comparable alternatives available at the Tier 4 level. These are also known as Non-Preferred Formulary Specialty Drugs. Tier 6 Specialty Pharmacy Prescription Drugs are the highest cost specialty drugs or drugs that may not have the clinical advantages of Tier 4 or Tier 5 Specialty Drugs. The three-tier system helps manage costs, but provides flexibility and some coverage for Members who choose a higher tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of Specialty Prescription Drugs. The drugs listed in the Health Alliance formulary are reviewed at least annually by the Health Alliance Pharmacy and Therapeutics Committee. Pharmacy Specialty Prescription Drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Benefit Year, this could occur up to six times per year or every two months. If a drug moves to a higher tier or is removed from the formulary then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any lower tier or formulary alternatives available to you.

To access the most up-to-date version of our Drug Formulary list visit Pharmacy Program section of our website HealthAlliance.org or call Health Alliance at the number listed on the back of your Health Alliance Identification card. Some plan's pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a Specialty Prescription Drug is included in the formulary and whether the drug will be covered at the Tier 4, Tier 5 or Tier 6 specialty drug tier Copayment or Coinsurance.

Specialty Prescription Drugs are subject to any applicable Specialty Prescription Drug limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage. Copayments or Coinsurance for Specialty Prescription Drugs apply to any applicable Plan Year Out-of-Pocket Maximum limit specified in the Maximums/Deductibles/Limitations section on the Description of Coverage.

Prescription Drugs Not Covered

- Prescription drugs prescribed by a Non-Participating Physician or obtained at a Non-Participating pharmacy, unless obtained for treatment of an Emergency Medical Condition.
- Non-prescription drugs or medicines are not covered, except for covered diabetic supplies, injectable syringes for covered injectable drugs and a limited number of over-the-counter (OTC) medications as stated above. This includes non-prescription Infertility drugs.
- When a medication is available both by prescription only (federal legend) and as an OTC product, the prescription drug is not covered unless otherwise stated in this section.
- Prescription drugs which are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by Health Alliance, including but not limited to: BOTOX®, psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiants or weight loss medications, anabolic steroids, oral fluoride preparations and hair removal or hair growth promoting medications.

- Devices of any type, other than prescription Contraceptive devices, even if such devices may require a prescription, including but not limited to: therapeutic devices, artificial appliances, support garments, bandages, etc.
- Dermatologic products (oral and topical) that offer no additional clinical benefit over existing covered alternatives, including but not limited to: Clobex Lotion/Shampoo, Vanos, Capex, Luxiq, Olux, and Solodyn
- Prescription strength benzoyl peroxide and combination products
- Compounded claims in which one or more ingredient is a bulk powder
- Compounded products, including compounding kits, of two or more commercially available drugs (prescription or over-the-counter) that offer no additional clinical benefit compared to taking the individual components (please note the existing drugs do not have to be commercially available in the same strengths as the compounded product).
- Any drug labeled, "Caution - Limited by Federal Law to Investigational Use", or experimental or other drugs which are prescribed for unapproved uses. Prescription Drugs for treatment are covered if the FDA has given approval for at least one indication and is recognized for the treatment of the indication for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network's Drugs & Biologics Compendium; (3) the Thomson Micromedex's Drug Dex; (4) the Elsevier Gold Standard's Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health And Human Services, or if not in the compendia, recommended for that particular indication in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States or Great Britain.
- Prescription drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or any medication furnished by any other Drug or Medical Service for which there is no charge to you.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Erectile Dysfunction drugs related to lifestyle enhancement or performance are not covered.
- Medications used for treatment of decreased sexual desire (Addyi) are also not considered medically necessary
- Products classified as Medical Food or supplements.
- Non-sedating antihistamines and combinations
- Any charge for administration of a drug.
- Any drug determined by a physician, pharmacy or through retrospective claims review to be abused or otherwise misused by you.
- Medical marijuana is excluded from coverage since it is classified by the federal government as a Schedule I controlled substance, and therefore cannot be prescribed by a health professional.
- V-Go Insulin Delivery Device is excluded from coverage due to a lack of sufficient evidence and conclusions on its safety and efficacy.
- Drugs which have not been approved as effective by the Food and Drug Administration, including DESI drugs, are not covered.
- Infertility prescription drugs which are not approved by the United States Food and Drug Administration (FDA) for the treatment of Infertility.
- Any prescription drug purchased or imported from outside of the United States of America.
- Any prescription drug received outside of the United States of America, unless received as part of Emergency Services or Urgent Care.

Drug Limitations

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

WHAT IS NOT COVERED (Exclusions & Limitations)

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

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

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

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

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

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

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

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

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

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

Dental Services
Dental services are not covered unless specifically addressed as covered in this policy. Injuries caused by or arising out of the act of chewing are also not covered. Hospitalizations for dental work are not covered unless the hospitalization is necessary due to a medical condition and Preauthorized by Health Alliance. (See “Dental Services” and “Oral Surgery” under “What Is Covered”).

Disposable Items
Self-administered dressings and other disposable supplies are not covered. (See “Durable Medical Equipment” under "What Is Covered”).

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

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

- The medical treatment, procedure, drug, device or transplant is the subject of on-going phase I, II or III or phase IV clinical trials or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the 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, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided. The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.
- Organ Transplants will be deemed experimental or investigational if the Office of health Care Technology Assessment within the Agency for Health Care Policy and Research, as part of the federal Department of Health and Human Services (HHS) determines that such procedures is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
- If Health Alliance has made a written request or had one made on its behalf by a national organization, for determination by HHS as to whether a specific organ transplant procedure is 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, device or transplant for the treatment or diagnosis of your condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature, discussion with medical experts and other technological assessment bodies designated by Health Alliance. Each review will be on a case-by-case basis regarding coverage of a requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness.

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

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

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

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

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

Infertility Services
The following services are not covered:

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

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

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

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

Reversal of Sterilization
A surgical procedure to reverse voluntary sterilization is not covered.

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

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

Care ordered or directed by individuals other than a Physician or registered clinical psychologist, care in lieu of detention or correctional placement, family retreats or services with a diagnosis of marriage counseling unrelated to mental health conditions are not covered.

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

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

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

Other Non-Covered Items
- Any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.
- Any service, supply, treatment, diagnosis or advice for which you are not legally required to pay.
- Any service, supply or treatment prohibited by the laws of the United States or the state where the expense was incurred.
- Any care, treatment, service or supply furnished by a facility owned or operated by a state or national government. Charges are covered if you have a legal obligation to pay for the care or treatment or if the United States has the authority to recover or collect the reasonable cost of such care or service.
- Any Injury or illness arising out of or occurring in the course of your job for wage or profit and which is covered by Worker's Compensation or similar law.
- Charges for appointments scheduled and not kept (missed appointments).
- Charges incurred before you became covered under the Plan or after you terminate from the Plan.
- Complications arising directly from rightfully excluded conditions.
- Services provided by a non-licensed professional.
- Services furnished or billed by a Provider that has been excluded or debarred by the federal government.
- Any service, supply or treatment received outside of the United States of America, other than Emergency Services or Urgent Care.

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 of either category. The party filing the appeal may send us written comments, documents, records, or other information regarding your appeal. All available information relevant to your appeal will be considered when reviewing your

appeal. A Clinical Peer not involved in the initial denial will review appeals made on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. A review committee or an individual not involved in the initial denial and who does not work under the authority of the initial decision maker will review administrative appeals.

You, your authorized representative, Physician or other health care Provider may request an appeal within 180 days of receiving the initial denial notice by calling the **Member Relations Department at 1-800-500-3373, via facsimile at 1-217-337-8009** or writing to the **Member Relations Department, Health Alliance Medical Plans, 301 S. Vine Street, Urbana, Illinois, 61801-3347.**

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

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

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

- The reasons for the decision;
- References to the benefit plan provisions on which the decision is based, and the contractual, administrative or medical policy criteria for the decision;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with the meanings and the standards used. Upon request, diagnosis/ treatment codes with their meanings and the standards used are also available;
- An explanation of Health Alliance's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on internal appeal;
- A statement in non-English language(s) that indicates how to access the language services provided by Health Alliance;
- The right to request, free of charge, reasonable access to and copies of all documents, records, medical policies and other information relevant to the decision;
- Any internal rule, guideline, policy or other similar criteria relied on in the decision, or a statement that a copy of such rule, guideline, policy or other similar policy will be provided free of charge on request;
- An explanation of the clinical judgment relied on in the decision, or a statement that such explanation will be provided free of charge upon request
- A description of the standard that was used in denying the claim and a discussion of the decision.
- Contact information for applicable office of health insurance consumer assistance.

If Health Alliance's decision is to continue to deny or partially deny your referral, prior authorization or claim or you do not receive timely decision, you may be able to request an external review of your referral, prior

authorization or claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the External Review of Appeals section below.

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

The Illinois Department of Insurance can be contacted at:

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

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

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

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

Appeal Procedures for Urgent Care Decisions (Pre-Service Claims)
You, your authorized representative, Physician or other health care Provider may request an appeal for denial of requested health care services that require Preauthorization. Health Alliance will make a decision and notify you, your authorized representative, Physician and any 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. You, your authorized representative, Physician and any health care Provider who recommended services will receive written notice within 3 days of the decision.

If the appeal of your Preauthorization request is denied, you have the right to request that decision be reviewed by an independent review organization not associated Health Alliance (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 in incomplete, you must then provide completed claim information to Health Alliance within:	48 hours
Health Alliance must notify you of the Claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical emergencies), but no later than:	72 hours
after receiving the completed claim (if the initial claim is incomplete), within:	24 hours

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

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

Appeal Procedures for Coverage Decisions (Post-Service Claims)
You, your authorized representative, Physician or other health care Provider may request an appeal for denial to pay or reimburse health care services that have already been provided. Health Alliance will notify the party filing the appeal within 3 days of all information required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and/or other health care Provider in writing within 15 days of receipt of all requested information, but no later than 60 calendar days after receipt of the request for an appeal.

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

Type of Notice or Extension	Timing
If your claim is incomplete, Health Alliance must notify you within:	3 days
If you are notified that your claim in incomplete, you must then provide completed claim information to Health Alliance within:	45 days after receiving notice
Health Alliance must notify you of any adverse Claim determination:	
if the initial claim is complete within:	15 days
after receiving the completed claim (if the initial claim is incomplete), within:	15 days

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

External Review of Appeals
For denials made on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness, you, your authorized representative, your Physician, other health care Provider, attorney or any other authorized representative 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 the 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 review may contact the Illinois Department of Insurance External Review Unit at 1-877-850-4740; via facsimile at 1-217-557-8495; by email at doi.externalreview@illinois.gov or at https://mc.insurance.illinois.gov/messagecenter.nsf.or write to them at 320 W. Washington Street, Springfield, Illinois, 62767 or at 122 South Michigan Ave. 19th Floor, Chicago, Illinois 60603.

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

- You have not received our written decision on your Pre-Service Claim appeal within 30 days or 60 days if it involves a retrospective appeal(see "Appeal Procedures for Non-Urgent Care Decisions Pre-Service Claims");
- You have not received our decision on your Urgent Pre-Service Claim appeal within 48 hours (see "Appeal Procedures for Urgent Care Decisions Pre-Service Claims"); or
- Health Alliance agrees to waive the internal review exhaustion requirement.

Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review
A written request for external review may be submitted within 4 months after receipt of notification that your Preauthorization request for the appeal for approval of coverage of health care services has been denied.

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

Expedited Medical Necessity Review
An expedited review may be requested orally or in writing if you, your Physician, other health care Provider or authorized representative involved in the appeal believe that the denial of coverage of health care services could significantly increase risk to your health. You can contact the Department of Insurance at 1-877-850-4740.

Type of Notice or Extension	Timing
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:	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 Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois, 61801-3347.

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

TERMINATION

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

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

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

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

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

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

Coverage of a Dependent child will terminate on the last day of the month in which the child reaches the limiting age as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self-sustaining employment by an apparent disabled condition and the child is dependent upon his or her parent or other care providers for lifetime care and supervision, the child will continue to be covered as a Dependent child for the duration of the disability and dependency.

Coverage for 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 on which Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date you no longer meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

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

- Health Alliance will notify you and your employer at least 90 days prior to the date that the insurance product is discontinued.
- Health Alliance will offer your employer the option to purchase a plan available that is currently offered.
- If an insurance product is discontinued, Health Alliance would do so uniformly and without regard to any specific employer's claims or member health conditions.

COORDINATION OF BENEFITS

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

Definitions

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverages for Members of an Employer Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   - "Plan" includes: Employer Group insurance, closed panel or other forms of Employer Group or Employer Group-type coverage (whether insured or uninsured), individual or family insurance, closed panel or other individual coverage, medical care components of Employer Group long-term care contracts, such as skilled nursing care; medical benefits under Employer Group or individual automobile contracts, no-fault automobile insurance (by whatever name it is called) and Medicare or other governmental benefits, as permitted by law.
   - "Plan" does not include: Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of Employer Group long-term care policies, and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
   - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
   - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
   - When there are more than 2 health plans covering the person, the Plan may be primary as to one or more of the other health plans and secondary to different health plan(s).

3. "**Allowable Expense**" means a health care service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
   - If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans provides coverage for Hospital private rooms).
   - If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and Reasonable fee for a specific benefit is not an allowable expense.
   - If a person is covered under two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
   - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable fees and another plan that provides its benefits or services on the basis of a negotiated fee, the primary plan's payment arrangement shall be the allowable expense for all plans.
   - The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, Preauthorization or when the covered person has a lower benefit because he or she did not use a Participating Provider.

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

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

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

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

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

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

3. **Dependent Child/Parent not Legally Separated or Divorced**. Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":
   - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
   - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in the first bullet immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. **Dependent Child/Legally Separated or Divorced**. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   - The plan of the parent with custody of the child.
   - The plan of the Legal Spouse of the parent with custody of the child.
   - The plan of the parent who does not have custody of the child.

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

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

6. D**ependent Adult.** If a married Dependent has his or her own coverage as a dependent under a Spouse's plan and has coverage as a Dependent under either or both parent's plan the plans covering the Dependent will follow the order of benefit determination rules outlined in (9) below.
   - In the event that the Dependent's coverage under the Spouse plan began on the same date as the Dependent's coverage under either or both parent's plans, the plans covering the Dependent will follow the order of benefit determination rules outlined in (3) above.

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

8. **Continuation Coverage**. If a person whose coverage is provided by a federal or state law right of continuation is also covered by another plan, the following will be the order of benefit determination:
   - The benefits of the plan covering the person as a Member, or as that person's Dependent, will pay first.
   - The benefits of the plan providing continuation coverage will pay second.

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

9. **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee or Member longer are determined before those of the plan that covered that person for the shorter term. Benefits by this Policy will not be increased by virtue of this coordination of benefits limitation. It will be the obligation of any Member claiming benefits by this Policy to notify Health Alliance of the existence of all other Employer Group contracts, as well as the benefits payable by any other Employer Group contract. Health Alliance will have the right to release and obtain from any Physician, other medical professional, insurance company or other person or organization, any claim information (including copies of records) to pay to any other organization any amount determined to be warranted by this Policy. Health Alliance may recover any overpayment, which may have been made to any person, insurance company, or organization under the provisions of this section. Each Member claiming benefits by this Policy must give Health Alliance any information it needs to pay the claim.

10. **Network**. If the primary plan has a network of Providers and the secondary plan does not have such a network, the secondary plan must pay benefits as if it were primary when a covered individual uses a Non-Participating Provider, unless the services are rendered on an emergency basis or are authorized and paid for by the primary plan.

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

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

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

Health Alliance may also request updated information from you annually or when information is received that indicates a change from the information we have on file to verify or update your Coordination of Benefits information. You may fill out and return the request via mail or you may contact Health Alliance at the number listed on the back of your Health Alliance Identification Card to respond to these requests. If no response is received within 45 days from the receipt of the request of information, claims will not be considered for payment.

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

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.

CONVERSION OF COVERAGE

Health Alliance HMO Conversion Plan
You may be eligible for the Health Alliance HMO Individual Conversion Plan if one of the following qualifying events occurs:

- Cancellation of eligibility for coverage under this Policy
- Cancellation of the Employer Group Plan
- Non-renewal of the Employer Group Plan

To convert your coverage, you must submit a completed an application and applicable premium payment to Health Alliance within 31 days after the date coverage under this Policy is terminated.

Coverage under the Health Alliance HMO Conversion Plan will not be available to you if one or more of the following occur:

- Cancellation of your coverage under an Employer Group plan for failure to make timely premium payments; for fraud or material intentional misrepresentation in enrollment or in the use of services or facilities; or for material violation of the terms of this Policy.
- You have not been continuously covered under this Policy during the three months prior to the termination date.
- You are covered by any other insured or uninsured plan, which provides Hospital, surgical or medical coverage.
- You are covered by or entitled to Medicare.
- You have moved outside of the Service Area.
- Your coverage under this Policy terminates because of Health Alliance being placed in rehabilitation or liquidation proceedings pursuant to section 5-6 of the Illinois Health Maintenance Organization Act.

Benefits under the Conversion Plan will be terminated upon any of the following:

- You fail to make timely payments
- You become eligible under another health plan or become entitled to Medicare
- You no longer live or work within the Service Area

Comprehensive Health Insurance Plan
A Member who is losing coverage under this Policy may be eligible to convert coverage to the CHIP-HIPAA Plan, which is a comprehensive medical benefit plan offered under Section 15 of the Illinois Comprehensive Health Insurance Plan (CHIP) Act. This plan is available only to federally eligible individuals who qualify. You have 60 days from the date of the qualifying event to convert coverage. For more information on the CHIP-

HIPAA Plan, you should call 1-800-962-8384. If you enroll in a Health Alliance individual plan, you will lose eligibility to enroll under the CHIP-HIPAA Plan.

MEDICARE-ELIGIBLE BENEFICIARIES

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

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

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

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

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

- Enroll in Part A and Part B of Medicare.
- Obtain needed health care services and items from Providers according to the terms and conditions of this Policy. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.
- Assign his or her claim for Medicare benefits to the Provider. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.

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

We encourage you to call Health Alliance at the number on the back of your Health Alliance Identification Card with any questions about the benefits available and how to obtain them.

PAYMENT OF CLAIMS

The Plan pays benefits or assigns payment of benefits to the health care Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. Any claim for reimbursement or bills for covered health care services must be submitted within 20 days, but no later than 90 days or as soon thereafter as reasonably possible after the occurrence or commencement of any loss covered by the Policy. Notice given by or on behalf of the insured or the beneficiary to Health Alliance at the address listed below, via electronic claims billing, or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company. All claims should be submitted to:

Claims Department
Health Alliance Medical Plans
301 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 his or her initial notice and as long as proof of notice was within the timeframes listed in this section. Health Alliance also accepts itemized bills in lieu of completed claim forms from Providers.

The Plan is not responsible for claims or bills submitted more than one year after the provision or initiation of the service to which the claim or bill relates. Health Alliance will notify you and your Provider if additional information is needed to process your claim. You, your authorized representative or Provider have 45 days from the receipt of the notice to provide the requested information. The Claim 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 that Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

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

PRIVACY AND CONFIDENTIALITY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) together with the Standards for Privacy of Individually Identifiable Health Information aim to safeguard the confidentiality of private information and protect the integrity of 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
- Coordination of Benefits with other plans

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

- To you or your authorized representative
- To another party with your signed authorization
- For Plan administration (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 the behalf of Health Alliance are contractually obligated to keep the information confidential and use it only to carry out the services they are contracted to provide. Health Alliance also shares information with its affiliate, 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, whether of the Employer Group or Health Alliance, in quoting benefits or in processing or maintaining any record pertaining to the coverage under this Policy, will not invalidate coverage otherwise validly in force or reinstate coverage otherwise validly terminated.

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

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

Extension of Benefits in the Case of Total Disability
If this Plan is terminated for reasons other than those specified in the Eligibility, Termination and Guaranteed Renewability sections of this Policy and replacement coverage is not available, this Plan will continue to provide

benefits according to the Policy and the benefit levels specified on the Description of Coverage and the SBC until the following occurs: twelve months following the effective date of termination; the date the maximum benefit is reached or the end of Total Disability.

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

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

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

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

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

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

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

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

Non-Discrimination
Health Alliance does not make or permit unfair discrimination between Members or potential Members that have like insuring, risk, and other factors and elements. Health Alliance will not refuse to issue or cancel any contract,

notices of proposed insurance or decline renewal to such contract because of sex, sexual preference, marital status or health or treatment status of the Member or any potential Member.

Notices
Any notice to be given under the terms of this Policy by Health Alliance to the Employer Group will be in writing and may be affected by deposit in any post office in the United States addressed to the Employer Group at the most recent address of the Employer Group shown in the records of Health Alliance. Any notice to be given under the terms of this Policy by Health Alliance to a Member will be in writing and may be affected by deposit in any post office in the United States addressed to the Member at the address shown on the Description of Coverage attached to this Policy, unless notice of change of such address has been given by the Member in the manner as specified below. Any notice to be given under the terms of this Policy to Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to Health Alliance Medical Plans, Inc., 301 S. Vine St., Urbana, Illinois 61801-3347. All notices given in the manner provided for in this section will be deemed to have been received by the party to whom addressed five business days after deposit in said post office.

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

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

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

This Policy is not intended to meet the requirements of a Federally Qualified HMO.

CONTINUATION OF EMPLOYER GROUP COVERAGE

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

STATE CONTINUATION

Eligibility
You, your covered Legal Spouse and Dependent children may be eligible for twelve months of continuation coverage if you are a Member whose coverage under this Policy would otherwise terminate due to termination of the Policyholder's employment (termination of employment cannot be due to a felony or theft at work), termination of membership, or the reduction of the Policyholder's hours and if you:

- Have been continuously enrolled under the Employer Group contract during the entire three-month period ending with the termination date
- Are not covered under another Employer Group health insurance policy or entitled to Medicare
- Have not exercised your conversion coverage rights
- Have not moved outside the Service Area

Election
To elect continuation coverage, you must submit a completed Employer Group application form and applicable premium payment to Health Alliance within 30 days (but no later than 60 days following the date your coverage under this Policy ended) after you receive notification of your right to choose continuation coverage.

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

- You have exhausted the maximum twelve-month period
- You have failed to make timely premium payments
- The Group Enrollment Agreement is terminated
- You become covered under another Employer Group health insurance policy
- You become eligible for Medicare
- You have moved outside the Service Area

SPOUSAL CONTINUATION

Eligibility
Health Alliance will provide continuation coverage if you are a Legal Spouse or Dependent whose coverage under this Policy would otherwise terminate due to one of the following qualifying events and you were covered under this Plan on the day before the qualifying event:

- Divorce from the Policyholder
- Death of the Policyholder
- Retirement of the Policyholder and the Legal Spouse is age 55 or older
- You are not covered under another Employer Group health insurance policy or eligible for Medicare
- You have not moved outside the Service Area
- You have not exercised your conversion coverage rights

For purposes of this section the term "Legal Spouse" means the Retired Employee's Legal Spouse or a former Legal Spouse due to death or divorce of the employee.

Within 30 days from the date of the divorce, death or retirement of the employee, the Legal Spouse of the employee must provide written notice to the employer or Health Alliance. The employer has 15 days to notify Health Alliance of the divorce, death or retirement of the employee.

Election
Upon the receipt of written notice by the Employer Group of the divorce, death or retirement of the employee, Health Alliance will notify the Legal Spouse of the employee of his or her rights to spousal continuation coverage. To elect continuation coverage, you must submit the completed Employer Group application form and applicable premium payment to Health Alliance within 31 days after receipt of the notice.

Termination of Coverage
Continuation coverage under this Policy shall terminate for the Legal Spouse and any Dependents if one of the following occurs:

- The Legal Spouse is under 55 years of age and has exhausted the maximum two-year period
- The Legal Spouse is age 55 or older and becomes eligible for Medicare
- The Legal Spouse remarries
- The Legal Spouse has failed to make timely premium payments
- The Group Enrollment Agreement is terminated
- The Legal Spouse becomes covered as an employee under another Employer Group health insurance policy

Upon termination, the Member may be eligible to enroll in a conversion plan, subject to the requirements stated in the "Conversion of Coverage" section of this Policy.

DEPENDENT CONTINUATION

Eligibility
Health Alliance will provide continuation coverage if you are a Dependent whose coverage under this Policy would otherwise terminate due to the death of the Policyholder or your attainment of the limiting age under the terms of this Policy if you:

- Were a covered Dependent under the terms of the Policy on the day before the qualifying event
- Are not eligible for coverage under Spousal Continuation
- Are not covered under another Employer Group health insurance policy
- Have not exercised your conversion coverage rights
- Have not moved outside the Service Area

Within 30 days of the date your coverage would terminate due to the death of the Policyholder or your attainment of the limiting age, you or a responsible adult acting on your behalf must provide written notice of the death of the Policyholder or your attainment of the limiting age to the employer or Health Alliance. The employer has 15 days to notify Health Alliance.

Election
Upon receipt of written notice from you, a responsible adult acting on your behalf or the Employer Group of the death of the Policyholder or your attainment of the Limiting Age, Health Alliance will notify you or the responsible adult acting on your behalf of your rights to Dependent continuation coverage. To elect continuation coverage, you or a responsible adult acting on your behalf must submit a completed Employer Group application form and applicable premium payment to Health Alliance within 31 days after receipt of the notice.

Termination of Coverage
Your dependent continuation coverage under this Policy will terminate upon the earliest of the following:

- You or a responsible adult fails to make timely premium payments
- Coverage would terminate under the terms of the existing Policy if you were still an eligible Dependent of the Policyholder
- The date you become covered as an employee under another Employer Group health insurance policy
- Two years from the date dependent continuation coverage began
- The Group Enrollment Agreement is terminated

Upon termination, you may be eligible to enroll in a conversion plan, subject to the requirements stated in the "Conversion of Coverage" section of this Policy.

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

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

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

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

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

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

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

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

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Legal Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Dependent who does not qualify as a Policyholder's tax Dependent under IRS rules is not considered a Qualified Beneficiary.

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

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

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

(i) The death of a covered employee.

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

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

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

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

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

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

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

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

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

What is the election period and how long must it last?
The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

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

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

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

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

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

NOTICE PROCEDURES:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under what circumstances can the maximum coverage period be expanded?
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded

to more than 36-months after the date of the first Qualifying Event. The employer must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the employer.

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

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

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

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

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

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

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?
If a Qualified Beneficiary's COBRA continuation coverage under an Employer Group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

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

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

TERMS

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

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

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

Assisted Reproductive Technologies (ART)
The treatments and/or procedures in which the human Oocytes and/or sperm are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an Oocyte Retrieval is performed.

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

Benefit Year
The year on which the plan's annual benefits are calculated.

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

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

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

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

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

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

Clinical Peer
A 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.

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

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

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

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

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

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

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

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

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

Donor
An Oocyte donor or sperm donor.

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

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

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

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

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

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

Employer Group
An employer, association, union or other Employer Group who has contracted with Health Alliance to offer health care benefits to its employees.

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

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

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.

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.

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

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

Gamete intrafallopian tube transfer (GIFT)
The direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

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

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

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

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

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

Hospital
An institution that meets the following requirements:

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

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

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

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

Legal Spouse
The adult person whom the Policyholder is legally married to or in a legally recognized Civil Union partnership with under the laws of the state where the covered employee lives.

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

Limiting Age
The age a child is no longer eligible for coverage.

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

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 that is required to identify or treat your condition and is:

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

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

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

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

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

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

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

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

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

Oocyte
The female egg or ovum formed in an ovary.

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

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

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

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

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

Outpatient Surgery
Surgery or procedure that is performed in the Outpatient department of a Hospital, freestanding surgical center or freestanding medical clinic. Charges billed as part of outpatient surgery may include surgeon fees, including assistant surgeons, surgical assistant, facility fees and surgical supplies. Outpatient Surgery Copayments, Coinsurance and Deductibles apply to any associated facility fee for a surgery or procedure.

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

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

Plan
The program of health care benefits adopted by the Employer Group for its eligible employees.

Plan Year
Plan Year is the 12-month period beginning and ending on January 1 and ending December 31 of the same calendar year unless otherwise defined by the Group Enrollment Agreement.

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

Policy
Policy means this booklet which is issued to a Policyholder that describes the coverage provided under the Plan.

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

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

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

Preferred Drugs
Formulary drugs that are considered well-suited for most members.

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

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

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

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

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

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

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

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

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

- Schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizoaffective disorders (bipolar or depressive);
- pervasive developmental disorders;
- obsessive-compulsive disorders;
- depression in childhood and adolescence;
- panic disorder;
- post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- anorexia nervosa and bulimia nervosa.

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

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

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

Small Employer
An employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the Plan Year.

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

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

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

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

Surrogate
A woman who carries a pregnancy for a woman who has infertility coverage.

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

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

Uterine embryo lavage
A procedure by which the uterus is flushed to recover a preimplantation embryo.

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

Zygote
A fertilized egg before cell division begins.

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