

POLICY

Illinois HMO Policy



Health Alliance

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Members' Rights and Responsibilities

Our Members have the right:

- to receive information about Health Alliance, its services, its contracted practitioners and providers and members' rights and responsibilities
- to be treated with respect and recognition of your dignity and right to privacy
- to participate with practitioners in making decisions about your health care
- to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- to voice complaints or appeals about Health Alliance or the care provided
- to make recommendations regarding the Health Alliance members' rights and responsibilities policies
- to reasonable access to health care

Our Members have the responsibility:

- to supply, to the extent possible, information Health Alliance and its contracted practitioners and providers need to care for you
- to follow the plans and instructions for care you have agreed on with your practitioners
- to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- to read and understand your Plan Subscription Certificate or Policy and any attached Riders or Amendments and follow the rules of membership
- to know the providers in your network
- to notify Health Alliance in a timely manner of any changes in your status as a member or that of any of your covered dependents

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 S. Vine St., Urbana, Illinois 61801-3347.

This Policy, along with the Description of Coverage, Amendments and/or Riders 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, Copayments and Coinsurance, as specified on the Description of Coverage.

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 Member 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 Service Area's 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 Service Area. If your Primary Care Physician believes you require care from a specialist or other Provider, your Primary Care Physician will 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

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. Upon enrollment, you must select a Primary Care Physician. The list of Participating Providers (Provider Directory) in your Service Area will be provided to you upon enrollment. You may change your Primary Care Physician by calling the Customer Service Department at the number on the back of your Member Identification Card or writing Health Alliance. Please note that a change in Primary Care Physician may change your Provider network.

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

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 Providers to provide you with covered services. Health Alliance does not provide medical services or make medical treatment decisions. The Participating Providers are independent contractors and 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 will refer you to a Participating Provider in your Service Area. Physicians, Hospitals, mental health and other health care Providers are listed in the Provider Directory for your Service Area 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 Service Area, 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. Women 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, unless your Primary Care Physician refers you and you receive Preauthorization from Health Alliance.

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. You must contact the Customer Service Department at the number on the back of your Member 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. 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 week 13 of your pregnancy by the date of your Physician's termination, Health Alliance will cover continued care with that Provider 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 Service Area, and comply with Health Alliance quality assurance requirements and policies and procedures. You must contact the Customer Service Department 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. Coverage is subject to any applicable Pre-Existing Condition limitation.

- **Maternity Care**

If you are pregnant and have entered week 13 of your pregnancy on your effective date of coverage, Health Alliance will cover continued care with your treating Physician through post-partum care. Pregnancy is not subject to the Pre-Existing Condition limitation.

Preauthorization

Services that require Preauthorization will not be covered if you receive those services prior to approval of the Preauthorization request and it is later determined the services were not Medically Necessary.

Participating Physicians are responsible for the Preauthorization of the services listed below. If there is no Preauthorization, a Retrospective Review will be performed to determine the Medical Necessity of the service.

Your Primary Care Physician or treating specialist is responsible for obtaining Preauthorization on your behalf by calling or submitting a completed Preauthorization Request Form to Health Alliance prior to receipt of services. Preauthorization must be obtained from Health Alliance when your Primary Care Physician or treating specialist recommends any of the following:

- Referral to a non-Participating Provider
- Hospital admissions, including mental health and Substance Abuse
- Admission to a skilled nursing facility and for inpatient rehabilitation
- Surgical procedure at a non-Participating facility for non-emergency surgeries
- Durable medical equipment, and orthopedic appliances, diabetic equipment and supplies
- Gastrointestinal surgery for severe obesity
- Home health services
- Home infusion services
- Hospice care
- Human organ transplant
- Orthotics
- Prosthetic devices
- Reconstructive surgery
- Specialty Prescription Drugs
- Spinal manipulations

If the Preauthorization request is approved, both you and your Primary Care Physician and the ordering Physician will be notified of the effective dates and the care and services you are authorized to receive.

Once your Preauthorization approval expires, it is your responsibility to notify your Primary Care Physician or treating specialist so he/she can determine whether further care is needed, and if so, request another Preauthorization from Health Alliance.

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)

Preauthorization must be obtained prior to a scheduled hospitalization, procedure or purchase of a supply listed above. Health Alliance will make a coverage decision and notify you or your authorized representative in writing within 15 days of receipt of the request for Preauthorization.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within 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.

Coverage Decisions

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.

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.

Notification of Emergency Services

If you are admitted as an inpatient to a non-Participating Hospital or a Participating Hospital outside your Service Area for an Emergency Medical Condition, you must notify the Customer Service Department at the number listed on the back of your Member Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

Concurrent Care Decisions

You will be notified in writing 15 days before coverage of ongoing treatment is reduced or terminated. You or your authorized representative may appeal the concurrent care decision and obtain a determination before the benefit is reduced or terminated.

Coverage Decisions (Post-Service Claims)

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

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

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

Eligibility, Enrollment and Effective Date of Coverage

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

The Policyholder

The Policyholder must be a bona fide employee, regularly employed on a permanent basis by the Group, who enrolls under his or her Group's health plan with Health Alliance. A Policyholder must live or work in the Service Area of the 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 Group's Health Alliance Plan for coverage if he or she lives within the Service Area and has one of the following relationships to the Policyholder:

- Your legally married Spouse
- Your natural-born or legally adopted child, whether or not the child resides with you
- A child for whom you are the court-appointed legal guardian
- A stepchild who lives with you at least 50 percent of the year and is dependent upon you for support
- A child placed for adoption. Placement or placed for adoption means you assume and retain total or partial support of the child in anticipation of an adoption. If the child's placement for adoption terminates, upon termination the child will no longer be eligible for benefits under the Plan.

Examples of some dependents who would not be eligible for coverage under the Plan are foster children, grandchildren (unless you are the legal guardian), parents or other relatives.

A person is not an eligible Dependent if on active duty in the armed forces of any country or if covered under the Plan as an employee.

Any child covered must be unmarried and under the age of 19, unless otherwise specified in the Group Enrollment Agreement. A child may remain covered under the Plan if the child is enrolled as a full-time student at an educational institution. Residency in the Service Area is not required for the full-time student, but coverage outside the Service Area is limited to Emergency Services only. Coverage may continue for the full-time student through the last day of the month of graduation, cessation of studies or age 25, whichever is earlier, unless otherwise specified in the Group Enrollment Agreement.

A child may continue coverage as a Dependent under the Plan if upon his or her 19th birthday, an apparent handicapped condition makes the child incapable of self-sustaining employment, and the child is Totally Disabled and dependent on his or her parent or other care providers for lifetime care and supervision. You must submit documentary proof of the disability and dependency when requested by Health Alliance or your employer. Such requests will be made no more often than annually from the date when Health Alliance was first notified of the child's disability and dependency.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any

such Member or responsible parent or guardian in case of a minor is required to reimburse Health Alliance for any and all sums paid on his or her behalf for health care services together with any reasonable attorneys' fees and expenses incurred in collection of such sums.

Initial Enrollment

If you meet the requirements stated in the "Policyholder" or "Dependent" subsections and you also meet the Group's eligibility requirements, you may enroll by submitting a completed 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 Group's eligibility requirements. The eligibility requirements are specified in the Group Enrollment Agreement between the Group and Health Alliance. Coverage under this Policy begins on the Effective Date shown on the Description of Coverage, and remains in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Group or Health Alliance.

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 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 birth. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed application form to your employer within 31 days following the birth. If no additional premium is due, a completed 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, including the signature of the judge on a final order of adoption, guardianship or placement for adoption, accompanied by a completed 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. 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 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 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, 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 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 Group eliminates Dependent coverage for all Policyholders.
- The 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

A Group may have an Open Enrollment Period where eligible employees and their eligible Dependents may enroll in the Plan by submitting a completed group application form to your employer within 31 days of the Group's renewal date. Individuals who enroll under an Open Enrollment Period may be considered Late Entrants if they did not previously enroll when initially eligible. Refer to the "Pre-Existing Condition Limitation" section of this Policy to see if you are subject to a limitation period.

Late Entrant

A Group may allow employees and their eligible Dependents to enroll as Late Entrants (see "Terms" Late Entrant). Eligible employees and their Dependents may enroll by submitting a completed group application form to your employer within 31 days of the Group's eligibility date. Coverage is effective the first of the month following the receipt of the group application form. Refer to the "Pre-Existing Condition Limitation" section of this Policy to see if you are subject to a limitation period.

Special Enrollment

"Special Enrollment" is a period of time in which you have the option to enroll

or disenroll in the Plan if you or your Dependents experience a change in family status or have a special enrollment event occur. Individuals who are eligible for Special Enrollment are not considered Late Entrants. To be eligible to enroll under a special enrollment period, you must submit a written request to Health Alliance requesting changes in your coverage within 31 days of the event. Any request to add or drop 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 status.

You and your Dependents are eligible for a special enrollment period when marriage, birth, adoption, placement for adoption or other loss of coverage events occur such as:

- If you acquire a new Dependent through marriage, you may enroll yourself and/or your new Dependents in the Plan.
- If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Spouse, the newborn or newly adopted child and any other eligible dependent children not currently enrolled in the Plan.
- You and your eligible Dependents may enroll in the Plan 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 or termination of employer contributions.
- If you have other coverage (such as a plan offered by your Spouse's employer) and you lose coverage as a result of a change in status (such as death, legal separation, divorce), you and your eligible Dependents may enroll in 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 are enrolled in another plan option offered by your employer and you have reached the Lifetime Maximum on that plan option, you and your eligible Dependents may enroll in the Plan.

The Effective Date of coverage of a Dependent added through a change in status is the date of the status change event.

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 your employer offers more than one benefit plan option under the Plan, you are eligible to enroll in one of these other benefit plan options at the time your Dependent experiences a special enrollment right.

Coverage During an Approved Family or Medical Leave of Absence

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

Pre-Existing Condition Limitation

If you do not have the necessary Creditable Coverage and health care expenses are incurred in connection with a Pre-Existing Condition, you may be subject to a Pre-Existing Condition limitation. Coverage for a Pre-Existing Condition is limited to 50 percent of covered medical expenses, unless otherwise specified on the Description of Coverage, and the Copayment or Coinsurance for such services will not apply to your Out-of-Pocket Maximum.

If you are pregnant, your pregnancy is not subject to a Pre-Existing Condition limitation. Newborns, adopted children and children placed for adoption are not subject to a Pre-Existing Condition limitation provided they meet the eligibility requirements stated in the "Eligibility, Enrollment and Effective Date of Coverage" section.

The Pre-Existing Condition Limitation Period

If you are eligible to enroll in the Plan as a new employee or Dependent during an Open Enrollment period or a Special Enrollment period and you have a Pre-Existing Condition you may be subject to the limitation during the first 12 consecutive months after coverage is effective. If you enroll as a Late Entrant and you have a Pre-Existing Condition you may be subject to the limitation during the first 18 consecutive months after coverage is in effect.

It is your responsibility to supply your employer with documentation of Creditable Coverage for you and any Dependents. If you do not provide documentation or the documentation suggests a break in coverage of 63 days or more, you will be notified in writing of the Pre-Existing Condition limitation period that has been applied to you and your Dependents. The notification will include steps on how you can provide documentation of Creditable Coverage. Upon receipt of additional Creditable Coverage documentation, the length of the Pre-Existing Condition limitation period may be reduced or eliminated, depending on the amount of Creditable Coverage you have from another health plan. Health Alliance will send you written notification of any change in the Pre-Existing Condition limitation period.

You have a right to request a Certificate of Creditable Coverage from the prior group health plan or health insurance issuer if necessary to properly establish the period of Creditable coverage. You may request a Certificate of Creditable Coverage within 24 months after losing coverage. Your employer will assist you in obtaining this certificate if requested. You will be provided a Certificate of Creditable Coverage from this Plan if you request one either before losing coverage or within 24 months of coverage ceasing.

Out-of-Pocket Expenses and Maximum Benefits

Copayments and Coinsurance

In no event will any single Copayment or Coinsurance amount exceed 50 percent of the Usual, Customary and Reasonable (UCR) charge determined by Health Alliance for a specific Basic Health Care Service. Copayments and Coinsurance applicable to non-Basic Health Care Services are not subject to this limitation. For purposes of this subsection, a UCR charge is a charge that is not more than the normal level of charges made by Providers for covered medical services in a geographic area. Health Alliance will determine the UCR charges. Basic Health Care Services are: emergency care, inpatient Hospital and Physician care, Outpatient medical services, mental health care and Substance Abuse treatment.

All Copayment and Coinsurance amounts are specified on the Description of Coverage. 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. This is the maximum amount you are required to pay in Copayments and Coinsurance for Basic Health Care Services during the Plan 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 Plan Year.

Any Copayments or Coinsurance for non-Basic Health Care Services that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage. Payments for non-covered items or services and amounts over the Usual, Customary and Reasonable do not apply to your Out-of-Pocket Maximum.

Plan Year Maximum Benefit

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

Payment of Premiums

Payment of premiums must be made as follows: you, or anyone paying on your behalf, for example your 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 Group's renewal date. Notice of such change in the premium rate will be provided to the Group not less than 31 days prior to the effective date of the change.

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

Premium Due Date

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

Premiums

What Is Covered

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 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.

The following are health care services covered under this Policy subject to the Copayments, Coinsurance and maximum lifetime and Plan Year benefits specified on the Description of Coverage. 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. Those services are noted on the Description of Coverage and in the descriptions below.

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 the Customer Service Department at the number listed on the back of your Member Identification Card to verify coverage.

Additional Surgical Opinion

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

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.

Blood

Blood and blood products are covered when determined to be Medically Necessary by your Primary Care 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.

Cancer Chemotherapy, Chemotherapeutics and Biologicals

Coverage for chemotherapy (including high-dose chemotherapy with bone marrow or peripheral stem cell transplantation), chemotherapeutics and/or biologicals prescribed for the treatment of cancer is provided when the chemotherapy, chemotherapeutics and/or biologicals are provided to you in accordance with an established protocol or a protocol that is the subject of an on-going phase II or III clinical trial.

For coverage of a phase II or III clinical trial, the trial must be approved by the National Cancer Institute and Preauthorized by Health Alliance.

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.)

Diabetic Equipment and Supplies

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

Diabetic Self-Management Training and Education

Outpatient self-management training and education for the treatment of types 1 and 2 diabetes and gestational diabetes mellitus are covered when Medically Necessary and provided by a qualified Participating Provider.

Diagnostic Testing

X-ray examinations, laboratory tests and pathology services are covered when ordered by a Participating Provider.

Dressings and Supplies

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

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 and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. Items and supplies provided under this subsection must be prescribed by a Participating Physician and Preauthorized by Health Alliance. Health Alliance determines whether 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 Health Alliance determines the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered.

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

Emergency Services

Emergency Services received inside or outside your Service Area 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 Service Area is not covered. Unexpected hospitalization due to complications of pregnancy is covered.

If you receive Emergency Services either inside or outside the Service Area from a non-Participating Provider for an Emergency Medical Condition, you or someone acting on your behalf must notify the Customer Service Department at the number listed on the back of your Member Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

Erectile Dysfunction

Treatment is covered for males with documented erectile dysfunction without a correctable cause. A maximum benefit limit may apply. Medications are not covered unless an Outpatient Prescription Drug Rider is attached to this Policy.

Gastrointestinal Surgery for Severe Obesity

Gastrointestinal surgery for severe obesity is covered for procedures that have significant published experience on long-term results for the treatment of severe obesity for patients who have documented failure of a Physician-supervised, integrated, nonsurgical weight loss program of at least six months duration within the last three years and who meet Medical Necessity criteria.

Surgery must be Preauthorized by Health Alliance. Subsequent surgery because of failure to achieve long-term weight loss is not covered.

Hearing Evaluations

Hearing evaluations performed by Participating Providers are covered. Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered.

Home Health Services

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

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 the Member's Primary Care Physician or treating specialist and Preauthorized by Health Alliance. For purposes of this subsection, hospice care program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Member and the Member's family, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. Hospice refers to a program that meets the following requirements:

- It must be licensed by the laws of the jurisdiction where it is located and must be operated as a Hospice as defined by those laws.
- It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their 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. Hospital admissions, including mental health and Substance Abuse, require Preauthorization by Health Alliance.

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 Transplant

Human organ transplants are covered for non-experimental 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 or Coinsurance apply as specified on the Description of Coverage.

Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.

The Plan covers transportation, lodging and meals for the transplant recipient and a companion for travel to and from the Health Alliance designated transplant center. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

Mandibular and Maxillary Osteotomy

A mandibular or maxillary osteotomy is covered 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 Copayment or Coinsurance specified on the Description of Coverage. 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 Copayments or Coinsurance as specified on the Description of Coverage.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the properly enrolled newborn. 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. Routine prenatal care or delivery at 36 weeks or greater outside your Service Area is not covered unless you are outside of your Service Area against medical advice or due to circumstances beyond your control.

Coverage for the properly enrolled newborn is provided subject to the newborn Copayment amount specified on the Description of Coverage for up to five days following birth or the Coinsurance amount specified on the Description of Coverage. If the mother is subject to a Copayment for Hospital care, the newborn will be subject to a separate Copayment for Hospital care

beginning with the sixth day of hospitalization.

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.

Mental Health Care

Mental health care services for short-term treatment and/or crisis intervention are covered as determined necessary and appropriate by your Primary Care Physician. Care in a day Hospital program or intensive Outpatient program may be substituted on a two-to-one basis for inpatient Hospital services subject to any inpatient mental health coverage limitations specified on the Description of Coverage. Inpatient admissions require Preauthorization by Health Alliance.

Group Outpatient mental health care visits may be substituted on a two-to-one basis for individual mental health care visits subject to any Outpatient limitations specified on 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, court-ordered evaluations or treatment, care in lieu of detention or correctional placement, care in long-term or residential facilities and marriage or social counseling.

Oral Surgery

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

- Traumatic Injury to sound natural teeth for Medically Necessary non-restorative services within 30 days of Injury.
- Traumatic Injury to the jaw bones or surrounding tissue within 30 days of the Injury.
- Correction of a non-dental pathological condition such as cysts and tumors.

Orthotics

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

Physician Services

Diagnostic and treatment services and preventive medical services provided by a Physician or under the supervision of a Physician, including recommended periodic health care examinations are covered.

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.

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 the Customer Service Department at the number listed on the back of your Member Identification Card.

Reconstructive Surgery

Services are covered to correct a functional defect resulting from an acquired and/or congenital disease or Injury when Preauthorized by Health Alliance. Services are also covered when performed to correct a seriously disfiguring condition resulting from accidental Injury or incident due to surgery. However, coverage is provided only if such condition has a major effect on your appearance and the condition can be reasonably corrected by the surgery. Correction of a congenital defect or birth abnormality of an enrolled newborn is covered.

Coverage is provided for reconstructive surgery or a prosthetic device following a mastectomy when Preauthorized by Health Alliance. Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed.
- Reconstructive surgery of the other breast to produce a symmetrical appearance.
- Prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive surgery and prosthetic devices for non-malignant mastectomy is limited to within two years after the date of the mastectomy.

Rehabilitation and Skilled Nursing Care–Inpatient

Inpatient services for rehabilitation and skilled nursing 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. Inpatient admissions require Preauthorization by Health Alliance.

Rehabilitative Therapy Services–Outpatient

Speech, physical and occupational therapies for medical conditions received in the Outpatient or home setting when you are homebound, which are directed at improving your physical functioning and are expected to result in significant improvement within two months of commencement, are covered subject to any Outpatient rehabilitation coverage limitations specified on the Description of Coverage. Continued coverage requires evidence of expected

further significant improvement. Therapies are counted by type and date of service.

Speech therapy is covered if the speech loss or impairment is a result of trauma, stroke or surgery to the voice box or due to a congenital abnormality and significant improvement is expected within two months.

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 or Coinsurance will be waived.

Smoking Cessation Program

One smoking cessation program per 12-month period up to a total of two smoking cessation programs per lifetime are covered. Members who are enrolled in the smoking cessation program and who have pharmacy benefits through a Health Alliance Prescription Drug Rider are eligible for two months of coverage for either Zyban[®] or over-the-counter Nicotine Replacement Therapy (NRT). NRT must be obtained via prescription for the Copayment specified on the Prescription Drug Rider to apply.

Specialty Prescription Drugs

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

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. Examples of Specialty Prescription Drugs include, but are not limited to: oncology agents and biotechnology pharmaceuticals, i.e. Interferons, Erythropoetin, Human Growth Hormone and granulocyte colony stimulating factor (G-CSF). Coverage can be verified by calling the Customer Service Department at the phone number listed on the back of your Member Identification Card.

Spinal Manipulations

Spinal manipulation and mobilization are covered for the care of musculoskeletal spinal disorders where long term significant improvement can be expected from such treatment when Preauthorized by Health Alliance. Hot/cold pack therapy used in conjunction with approved manipulation and mobilization is also covered.

Sterilization Procedures

Elective sterilization procedures, such as tubal ligation are covered. Vasectomies performed as an office procedure are covered. Surgical procedures performed to reverse voluntary sterilization are not covered.

Substance Abuse Detoxification

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

Substance Abuse Treatment

Substance Abuse rehabilitation services or treatment is covered for Medically Necessary short-term treatment, subject to any coverage limitations specified on the Description of Coverage.

Inpatient benefits include acute inpatient or short-term residential care. Inpatient admissions require Preauthorization by Health Alliance. Care in a day Hospital program or intensive Outpatient treatment program may be substituted on a two-to-one basis for inpatient services. Outpatient benefits include individual counseling sessions. Group Outpatient visits may be substituted on a two-to-one basis for individual Outpatient visits.

Inpatient and Outpatient Substance Abuse treatment coverage does not include services in a long-term residential facility, court-ordered evaluation or treatment, care in lieu of detention or correctional placement or family retreats.

Urgent Care

Urgent Care that requires immediate attention for an unforeseen illness, Injury or condition to prevent serious deterioration is covered when services are provided in a Participating Urgent Care center or Participating Physician's office.

Vision Care

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

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).

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 the Customer Service Department at the number listed on the back of your Member Identification Card.

Wellness Care

Well-child care and annual physicals including immunizations are covered. Coverage is limited to one physical per Plan Year for eligible children over age two. Other preventive health services include, but are not limited to:

- **Injections and Immunizations**
Medically Necessary injections and immunizations are covered. Drugs 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.
- **Mammograms**
Mammograms are covered at the age and intervals considered Medically Necessary by the woman's health care Provider for breast cancer or other risk factors.

What Is Not Covered (Exclusions and Limitations)

- **PAP Smear**
One cervical smear or PAP smear test each year is covered for females.
- **Surveillance Test for Ovarian Cancer**
An annual screening for ovarian cancer using CA-125 serum tumor marker testing, transvaginal ultrasound or pelvic examination is covered for females who are at risk of ovarian cancer.
- **Prostate-specific Antigen Tests**
Annual digital rectal exams and prostate-specific antigen tests 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.
- **Colorectal Cancer Screening**
A screening for colorectal cancer by means of colonoscopy every 10 years (preferred) or sigmoidoscopy (every three years) and yearly fecal occult blood testing are covered for average risk Members 50 years of age and older, and beginning at 30 years of age if you or a first degree family member has a history of colorectal cancer. Outpatient Surgery Copayments or Coinsurance apply when procedures are performed in an Outpatient setting for which there is an associated facility fee. Outpatient admission to an out-of-network freestanding surgical center or the Outpatient department of a Hospital requires Preauthorization by Health Alliance.

The following services are excluded from coverage under this Policy unless specifically agreed upon by the Group and Health Alliance and documented in any Amendments and/or Riders.

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

Abortion

Charges for and in connection with an abortion, unless the life or physical health of the mother is in imminent danger, 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.

Contraceptive Drugs and Devices

Contraceptive drugs, treatments, injections, injectables, devices and services are not covered, unless otherwise specified in a Rider attached to this Policy.

Convenience or Comfort Items

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

Cosmetic Surgery

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

Counseling

Charges for social counseling or marital counseling are not covered.

Custodial or Convalescent Care

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

Dental Services

Dental services are not covered. Surgical removal of wisdom teeth and services related to Injuries caused by or arising out of the act of chewing are also not covered. Hospitalizations for dental work are not covered unless the hospitalization is necessary due to a medical condition and Preauthorized by Health Alliance. (See "What Is Covered" under Dental Services and Oral Surgery.)

Disposable Items

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

Durable Medical Equipment, Orthopedic Appliances and Devices

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

Experimental Treatments/Procedures/Drugs/Devices/Transplants

Unless otherwise stated in this Policy, such as coverage for "Cancer Chemotherapy, Chemotherapeutics and Biologicals," 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 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.

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. (See "What Is Covered" under Vision Care.) 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. Not included in this exclusion is rehabilitative therapy.

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. Any service, supply or treatment for the rehabilitation of hearing impairment is also not covered.

Human Organ Donor

When you serve as the organ donor for a non-Member recipient, organ donor treatment or services are not covered. This includes the charges related to the

procurement of an organ or tissue.

Illegal Activities

Charges for any service, supply or treatment that arose out of or occurred while the Member was engaged in any illegal or criminal enterprise or activity are not covered.

Infertility Services

Infertility services are not covered, unless otherwise specified in an Amendment and/or Rider attached to this Policy.

Institutional Care

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

Outpatient Prescription Drugs

Outpatient prescription drugs are not covered, unless otherwise specified in a Rider attached to this Policy.

Reversal of Sterilization

A surgical procedure to reverse voluntary sterilization and any resulting infertility services are not covered.

Services that Are Not Medically Necessary

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered. Vocational rehabilitation services or other services or supplies, other than Basic 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, court-ordered evaluations or treatment, care in lieu of detention or correctional placement, family retreats or marriage counseling are not covered.

Services that Are Not Primarily Medical In Nature

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.

Sex Changes and Sex Therapy

Charges for any service, supply or treatment for a sex change or sex therapy are not covered.

Skin Lesions

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

Speech Therapy

Any service, supply or treatment for speech therapy connected with a learning disability, developmental disorder or functional nervous disorder is not covered. Therapy for conditions when improvement is not anticipated within two months is also 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.

Temporomandibular Joint Syndrome (TMJ)

Any service, supply or treatment connected with TMJ pain dysfunction syndrome (TMJ-PDS) is 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.
- Services 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. You, your authorized representative, Physician or other health care Provider may request an appeal of either category. The party filing the appeal may send us written comments,

documents, records, or other information regarding your appeal. All available information relevant to your appeal will be considered when reviewing your appeal. A Clinical Peer not involved in the initial denial will review Medical Necessity appeals. A review committee or an individual not involved in the initial denial and who does not work under the authority of the initial decision maker will review administrative appeals.

You, your authorized representative, Physician or other 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, or by writing to the Member Relations Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois, 61801-3347.

Appeal Procedures for Non-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 notify the party filing the appeal within three business days of all information requested 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 the request for an appeal.

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 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.

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.

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 three business days of all information requested 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 the request for an appeal.

Civil Action under ERISA

You 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 Medical Necessity denials, you, your Physician or other health care Provider may request an external review if you are not satisfied with the Health Alliance resolution of denial of coverage for health care services. The party requesting the review may call the Member Relations Department at 1-800-500-3373, or write to the Member Relations Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois, 61801-3347.

The Member Relations Department will facilitate the process for selection of an external independent review organization. Selection of the independent reviewer must be agreed upon by you, your Physician or other health care Provider and Health Alliance.

- **Medical Necessity Review**

An external review may be requested in writing within 30 days after receipt of notification that your appeal for approval of coverage of health care services has been denied. Records and supporting documentation will be forwarded within 30 days of your request to the external independent review organization. The independent reviewer will make a decision within five days after receipt of necessary information. Health Alliance will provide oral and written notification of the decision to all parties involved in the appeal.

- **Expedited Medical Necessity Review**

An expedited review may be requested orally or in writing if you, your Physician or other health care Provider involved in the appeal believe that the denial of coverage of health care services could significantly increase risk to your health. On Saturday, Sunday, holidays or after business hours, leave a message that includes a telephone number of the party to contact. The party requesting the review will be contacted within 24 hours of the appeal submission for information that is required to evaluate the appeal. A decision will be made within 24 hours after receipt of the required information. Health Alliance will provide oral and written notification of the decision to all parties involved in the appeal.

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 the Customer Service Department at the number listed on the back of your Member Identification Card, or write to the Customer Service Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois, 61801-3347.

You may file a complaint with the Illinois Department of Financial and Professional Regulation, Division of Insurance, 320 West Washington Street, Springfield, Illinois 62767 or with the Illinois Department of Financial and Professional Regulation, Division of Insurance, James R. Thompson Center, 100 West Randolph Street, Suite 9-301, Chicago, Illinois 60601-3251. You may also contact the Department of Insurance directly at www.ins.state.il.us.

Termination

In the event the Group terminates this Policy, all rights to benefits and services will cease on the effective date of termination. The 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 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 Group while the Group Enrollment Agreement between Health Alliance and the Group is in effect, you may be eligible for continuation of coverage subject to the provisions stated in the "Continuation of 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 move outside 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 Member Identification Card is provided for use by any person not eligible for covered services under this Policy.

Health Alliance may terminate your rights and cancel this Policy as of your initial Effective Date by reason of fraud. Any discovery of material misrepresentation in enrollment made by you may subject you to a premium revision.

Coverage of a Dependent child will terminate on the last day of the month in which the child becomes 19 years of age, unless the child is enrolled as a full-time student, or as otherwise specified in the Group Enrollment Agreement. If the child is enrolled as a full-time student, coverage may continue through the last day of the month of graduation, cessation of studies, or the age of 25, whichever is earlier, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon you for support and maintenance, the child will continue to be included under Family Coverage 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 the Group Enrollment Agreement terminates, 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.

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 a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured), medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts, no-fault automobile insurance (by whatever name it is called) and Medicare or other governmental benefits, as permitted by law.
 - "Plan" does not include: individual or family insurance, closed panel or other individual coverage (except for group-type coverage), Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of group long-term care policies, and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
 - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
 - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
 - When there are more than 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 (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
 - If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and

Reasonable 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 Plan Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a plan that provides health benefits to 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 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/Separated or Divorced.** If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- The plan of the parent with custody of the child.
- The plan of the Spouse of the parent with custody of the child.
- The plan of the parent who does not have custody of the child.

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 Plan Year when any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Dependent Child/Joint Custody.** If the specific terms of a court decree state that the parents 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. **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.

7. **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.

8. **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 Group contracts, as well as the benefits payable by any other 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.

9. **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.

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

Effect on the Benefits of This Plan

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

Right to Receive and Release Needed Information

Certain facts about 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.

Facility of Payment

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

Right of Recovery

Health Alliance may recover any overpayment, which has been made to any person, any other insurance companies or any other organizations.

Liable Third Party

If you and/or any of your covered Dependents incur a claim for medical expenses as a result of Injuries caused by someone else's negligence, wrongful act or omission, this Plan is not responsible to pay these expenses. This Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments including auto or medical expense type coverage. However, this Plan will provide benefits, otherwise payable under this Plan, only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be

subrogated to all of your and/or your Dependent's rights of recovery against any person or organization to the extent of the benefits provided. Subrogation is a legal right allowing the Plan to recover medical expenses paid by the Plan on behalf of a Member from another party if the Member's Injuries are caused by the other party's negligence. You and/or your covered Dependents agree to do whatever is necessary to secure the rights of the Plan. You and/or your covered Dependents agree not to do anything after loss to prejudice the rights of the Plan. You and/or your covered Dependents agree to cooperate with the Plan and/or any representatives of the Plan in completing forms and in giving information surrounding any accident the Plan or its representatives believe necessary to fully investigate the incident.

2. The Plan is also granted a right of reimbursement from the proceeds of any recovery by settlement, judgment or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.
3. The Plan, by payment of any benefits, is granted a lien on the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents. You and/or your covered Dependents consent to the lien and agree to take whatever steps are necessary to assist the Plan to secure a lien.
4. The Plan, by payment of any benefits, is granted an assignment of the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents to the extent of the benefits paid. By accepting benefits, you and/or your covered Dependents consent to assignment and authorize and direct his and/or her attorney, personal representative or any insurance company to directly reimburse the Plan or its designee to the extent of the benefits paid. This assignment becomes effective and is binding upon any attorney, personal representative or any insurance company upon service of a copy of this provision upon them by the Plan or its designee.
5. The subrogation and reimbursement rights, assignments and liens apply to any recoveries made by or on behalf of you and/or your covered Dependents as a result of the Injuries sustained, including but not limited to the following:
 - Payments made directly by the third party responsible for Injuries or any insurance company on behalf of the third party responsible for Injuries or any other payments on behalf of the third party responsible for Injuries.
 - Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of you and/or your covered Dependents or other person.
 - Any other payments from any source designed or intended to compensate you and/or your covered Dependents for Injuries sustained as the result of negligence or alleged negligence of a third party.
 - Any workers' compensation award or settlement.
6. The Plan's right to recover (whether by subrogation or reimbursement)

shall apply to decedents, minors and incompetent or disabled persons settlements or recoveries.

7. You and/or your covered Dependents shall not make any settlement that specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by you and/or your covered Dependents, which right shall not be defeated or reduced by the application of any so-called Made-Whole Doctrine, or any other such doctrine that intends to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

9. You and/or your covered Dependents shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, no court costs or attorneys fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called Fund Doctrine or Common Fund Doctrine, or Attorney's Fund Doctrine.

10. The Plan shall recover the full amount of benefits without regard to any claim of fault on the part of you and/or your covered Dependents, whether under comparative negligence or otherwise.

11. The benefits under this Plan are secondary to any coverage under no-fault of similar insurance.

12. In the event that you and/or your covered Dependents fails or refuses to comply with the terms of this agreement, you and/or your covered Dependents shall reimburse the Plan for any and all costs and expenses including attorneys' fees, incurred by the Plan in enforcing its rights.

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 Group Enrollment Agreement
- Non-renewal of the Group Enrollment Agreement

To convert your coverage, you must submit a completed group application form 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 a Group plan for failure to make timely premium payments; for fraud or material 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.
- The Group Enrollment Agreement has been terminated in its entirety, and there is a succeeding carrier providing coverage to the Group in its entirety.
- 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 move outside 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 group health coverage to Medicare-Eligible employees and dependents. Under the MSP laws, Medicare generally pays secondary to the Group health coverage provided under this Policy for the following Medicare-Eligible Beneficiaries:

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

To assist your Group and Health Alliance in complying with the MSP laws, you must notify your 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 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). Health Alliance 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 Beneficiary enrolled in Medicare and made a proper claim for Medicare payment.

Payment of Claims

For a Medicare-Eligible Beneficiary to obtain the greatest level of benefit, a Medicare-Eligible Beneficiary 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 Participating Providers according to the terms and conditions of this Policy.
- assign his or her claim for Medicare benefits to the Provider. Health Alliance HMO benefits will then cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.

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

We encourage you to call the number on the back of your Member Identification Card to speak with one of our Customer Service Representatives with any questions about the benefits available and how to obtain them.

The Plan pays benefits to the health care Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. Any claim for reimbursement or bills for covered health care services must be submitted within 60 days of the service or as soon thereafter as reasonably possible. All claims should be submitted to:

Claims Department
Health Alliance Medical Plans
301 S. Vine St.
Urbana, Illinois 61801-3347

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.

Unless Health Alliance receives prior written instruction from you, any health care benefits unpaid at your death will be paid to the health care Provider rendering the service for which benefits are due or reimbursement to your estate. If benefits payable are \$1,000 or less, Health Alliance may pay someone related to you by blood or marriage whom Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

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 Clinic Association.

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 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.

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.

Entire Contract and Changes

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

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 or the succeeding insurer has an allowable Pre-Existing Condition limitation, this Plan will continue to provide benefits according to the Policy and the benefit levels specified on the Description of Coverage until the first one of the following occurs: satisfaction of the succeeding insurer's Pre-Existing Condition limitation; 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 Group.

Guaranteed Renewability

Health Alliance will renew benefits under this Policy at the option of the 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 Group, which includes payments not made in a timely manner
- Acts of fraud or any material misrepresentation by the Group
- Violation of participation or contribution rules under the Group Enrollment Agreement
- Health Alliance ceases to offer coverage in the market
- Movement outside the Service Area by either the Member, Group or Health Alliance

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 Member 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.

Member Identification Card

The Member Identification Cards issued to you pursuant to this Policy are for identification only. Possession of a Health Alliance Member 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. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Policy will be charged the Usual, Customary and Reasonable fee, in addition to any other remedies available to the Plan as set forth in this Policy.

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.

Notices

Any notice to be given under the terms of this Policy by Health Alliance to the Group will be in writing and may be effected by deposit in any post office in the United States addressed to the Group at the most recent address of the 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 effected 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 effected 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 the Customer Service Department number on the back of your Member 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 made in the application for this Policy will be used to void this contract or to deny a claim for loss incurred after two years from the effective date of coverage. This provision does not include fraudulent misstatements.

Timely Payment of Claims

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

Other Provisions

The obligation of Health Alliance is limited to furnishing 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.

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

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

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.

Eligibility

You, your covered Spouse and Dependent children may be eligible for nine months of continuation coverage if you are a Member whose coverage under

Continuation of Group Coverage

State Continuation

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 Group contract during the entire three-month period ending with the termination date
- Are not covered under another 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 group application form and applicable premium payment to Health Alliance within 60 days after the date coverage under this Policy is terminated.

Termination of Coverage

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

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

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.

Spousal Continuation

Eligibility

Health Alliance will provide continuation coverage if you are a 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 Spouse is age 55 or older
- You are not covered under another 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 "Spouse" means the retired employee's Spouse or a former 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 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.

Dependent Continuation

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 Spouse of the employee of his or her rights to spousal continuation coverage. To elect continuation coverage, you must submit the completed 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 will terminate for the Spouse and any Dependents if one of the following occurs:

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

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.

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 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 group application form and applicable premium payment to Health Alliance within 31 days after receipt of the notice.

**CONSOLIDATED
OMNIBUS BUDGET
RECONCILIATION ACT
OF 1985 (COBRA)**

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 health insurance policy
- Two years from the date dependent continuation coverage began
- The Group Enrollment Agreement is terminated
- You move outside the Service Area

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.

This section applies only to Members of a Group with 20 or more employees.

Continuation Coverage Rights Under COBRA

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

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Policyholders and their eligible Dependents (called "Qualified Beneficiaries") at 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 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 Spouse, surviving Spouse or Dependent child of such a covered employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

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

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not 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 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 group health plan (but only after any applicable Pre-Existing condition exclusions of that other plan have been satisfied).

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

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

If your employer is subject to the Family and Medical Leave Act of 1993 (FMLA), the taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note: 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. First, the right to avoid having Pre-Existing condition exclusions applied to you by other group health plans can be lost if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, the guaranteed right to purchase individual health insurance policies that do not impose such Pre-Existing condition exclusions can be lost if you do not get COBRA coverage for the maximum time available to you. Finally, 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 group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your 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 group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the employer for further information.

Is a covered employee or Qualified Beneficiary responsible for informing the employer of the occurrence of a Qualifying Event?

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

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

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify your employer 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 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 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 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 group health plan (including a successor plan) to any employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any Pre-Existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) 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).
- (vi) 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 Spouse, surviving 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 a 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 group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website at www.dol.gov/ebsa.

Keep Your Employer Informed of Address Changes

In order to protect your family's rights, you should keep your employer informed of any changes in 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.

Amendment

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

Basic Health Care Services

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

Clinical Peer

A health care professional who is in the same profession and the same or similar specialty as the health care Provider who typically manages the medical condition, procedures or treatment under review.

Coinsurance

A percentage of a charge you must pay directly to the Provider for services rendered to you by the Provider.

Copayment

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

Creditable Coverage

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

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

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

Dependent

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

Description of Coverage

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

Effective Date

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

Emergency Medical Condition

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

Emergency Services

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

ERISA (Employee Retirement Income Security Act of 1974)

A federal law that regulates the majority of private pension and welfare group benefit plans in the United States.

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.

Group

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

Group Enrollment Agreement

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

Hospital

An institution that meets the following requirements:

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

Injury

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

Late Entrant

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

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 seq.).

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

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

Member 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.

Open Enrollment

A period of time determined by the 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 and Coinsurance amounts for Basic Health Care Services during a Plan Year. Amounts paid for non-covered health care services and certain other expenses will not apply to the Out-of-Pocket Maximum.

Outpatient

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

Outpatient Surgery

Surgery or procedure that is performed in the Outpatient department of a Hospital, freestanding surgical center or freestanding medical clinic. Outpatient Surgery Copayments and Coinsurance apply to any associated facility fee for a surgery or procedure.

Participating

A Physician or Provider who 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 Group for its eligible employees.

Plan Year

The calendar, Policy or fiscal year on which the records of the Plan are kept.

Plan Year Maximum Benefit

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

Policy

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

Policyholder (Also referred to as "you" or "your" within this Policy)

A person who is a bona fide employee, regularly employed on a permanent basis by the Group and enrolled in Health Alliance. A Policyholder must live or work in the Service Area of the Group's plan and is subject to the terms and conditions of the Group Enrollment Agreement.

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.

Pre-Existing Condition

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

Primary Care Physician

A Participating Physician trained in family practice, internal medicine or pediatrics. These Physicians are designated in the Provider Directory.

Protected Health Information

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

Provider

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

Provider Directory

A list of Participating Providers for your plan and the area they serve.

Retired Employee

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

Retrospective Review

A review performed after a claim for benefits is received.

Rider

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

Service Area

The geographic region listed on the Description of Coverage of this Policy that contains the counties within which the Member lives or works.

Small Employer

An employer who employed an average of at least two but not more than 50 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.

Spouse

The person recognized as the covered employee's husband or wife under the laws of the state where the covered employee lives. Your employer may require documentation proving a legal marital relationship.

Substance Abuse

The uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency that develops with continued use and for which treatment is Medically Necessary. The addictive substances included under Substance Abuse are limited to alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

Totally Disabled

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

Urgent Care

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

Usual, Customary and Reasonable

A charge that is not more than the normal level of charges made by Providers of covered services in a geographic area. Health Alliance contracts with a national database for charges by geographic zip code. Charges from Participating Providers are not subject to Usual, Customary and Reasonable charge limitations because of contractual provisions with Health Alliance.

Woman's Principal Health Care Provider

A person licensed to practice medicine in all of its branches under the applicable laws of the state where they provide services, specializing in Obstetrics and/or Gynecology or Family Practice.