GROUP EVIDENCE OF COVERAGE

Preferred Provider Organization (PPO)

Except for Accidental Injury or Medical Emergency treatment, Out-of-Pocket expenses are up to 30% higher when you receive care from a Non-Participating Provider.

Alliant Health Plans, Inc.
A Provider Sponsored Health Care Corporation (PSHCC)
1503 North Tibbs Road
Dalton, GA 30720

HELPFUL MEMBER INFORMATION

Finding Medical Providers, Facilities & Pharmacies:

Web-access (Middle of Home page):	AlliantPlans.com
Customer Service Assistance:	800-811-4793
Chiropractic Network (ActivHealthcare)	ActivHealthcare.com

Important Phone Numbers & Websites:

Customer Service:	800-811-4793
Pre-Certification:	800-865-5922
Navitus[1]:	
Web-access:	AlliantPlans.com
Customer Service:	866-333-2757
PHR*Anywhere*℠ (registration required)	
Web-access:	Alliant Plans.com
Customer Service:	866-262-3881

1 = Not all plans have Prescription benefits

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Make the healthy move with the Alliant Health Plans app

Have all of your health insurance information at your fingertips with the Alliant Health Plans app for your smartphone. No more fumbling for your insurance information; just touch the app to veiw your digital insurance card. Find your favorite Alliant Health Plans physician - do it with just one touch. Download Alliant ID Card Mobile today!

ALLIANT HEALTH PLANS

AlliantPlans.com
Learn more by calling
877-668-1015

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Scan here to download the app now to your smart phone or tablet device.

ARTICLE I – DEFINED TERMS

When used in this Document, any purchased Riders, or your Summary of Benefits the terms listed below will have these meanings:

Accident
A sudden, unforeseen event that causes external or internal trauma to the body.

Child
Child means natural Child(ren), legally adopted Child(ren), Step-Child(ren), and Child(ren) under legal custody (i.e. official court appointed guardianship or custody) of Member or Member's Spouse.

Complaint
A relatively minor verbal or written expression of concern about a condition in the Health Plan's operation which may be resolved on an informal basis by the Member Services Department. Common complaints include Physician or office staff behavior/demeanor, waiting times, adequacy of facilities, or any other concerns similar in scope that affect the accessibility of care.

Contract Year
A period of one (1) year commencing on the Group's effective date (or renewal date) and ending at 12:00 midnight on the last day of the one (1) year period.

Co-Payment
The dollar amount or percentage of costs shown in the Summary of Benefits that a Member must pay directly to the Provider for certain Covered Services.

Co-Insurance
The percentage shown in the Summary of Benefits of Maximum Allowable Costs (MAC) that a Member will be responsible for paying directly to the Provider for Covered Services.

Covered Services
The health care services and items described in this Document, any purchased Riders, and in the Summary of Benefits, for which Alliant provides benefits to Members and which are Medically Necessary.

Custodial Care
Care comprised of services and supplies, including room and board and other institutional services, that is provided to an individual, whether disabled or not, primarily to assist in the activities of daily living.

Deductible
The portion of the bill you must pay before your medical expenses become Covered Services based on your Contract Year.

Emergency or Emergency Services
Health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

In the case of services furnished in a Hospital, Emergency Services are further defined as those which are required to determine, evaluate and/or treat an Emergency medical condition until the condition is stabilized, as directed or ordered by a Physician. Stabilized means with respect to an Emergency medical condition that no material deterioration of the condition is likely, within a reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

Grievance
A more serious written expression of concern about the Health Plan's operation or a Complaint that has not been resolved to the Member's satisfaction. Common Grievances include issue of denial in whole or in part of a health care treatment, service or claim, involuntary disenrollment situations, or any other concerns similar in scope.

Group
Means the Employer.

Hospice Care
Care that is provided by an agency or organization that:

1. Is properly licensed in the state in which it operates;
2. Has Hospice Care available twenty-four (24) hours a day, seven (7) days a week; and
3. Provides or arranges for Hospice Care services or supplies for the terminally ill patient.

Hospital
An institution that:

1. Provides medical care and treatment of sick and injured persons on an In-patient basis;
2. Is properly licensed or permitted legally to operate as such;
3. Has a Physician on call at all times;
4. Has licensed graduate or registered nurses on duty twenty-four (24) hours a day
5. Maintains facilities for the diagnosis and treatment of illness and for major surgery; and
6. Meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations.

In no event will the definition of Hospital include an institution or any part of one that is a convalescent/extended care facility, or any institution that is used primarily as:

1. A rest facility;
2. A facility for the aged; or
3. A place for custodial care.

Illness
A sickness or disease including all related conditions and recurrences. Illness also includes pregnancy and all related conditions.

In-Network
Refers to services provided by Medical Physicians, Facilities and Providers who have contracted with Alliant.

Injury
Any accidental bodily damage or harm sustained while the Member is covered under the Plan and that requires treatment by a Physician.

In-patient
A Member will be considered an In-patient if he or she is treated in a Hospital as a registered bed patient incurring a charge for room and board upon the recommendation of a Physician.

Maximum Allowable Cost (MAC)
The Maximum Allowable Cost is the amount determined by Alliant based on a competitive profile of the usual fees received as reimbursements by similar Physicians or qualified health care Providers within a given geographic area for the procedure performed, according to our records and must not exceed the fees that the Provider would accept from any other payer for the same services.

Medically Necessary
A service or supply must be necessary and appropriate for the diagnosis and treatment of an illness or injury as determined by Alliant based on generally accepted current medical practice.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make that service Medically Necessary.

A service or supply will not be considered as Medically Necessary if:

1. It is provided only as a convenience to the Member;
2. It is not appropriate treatment for the Member's diagnosis or symptoms; or
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment.

Medicare
Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as amended.

Member
The person eligible for coverage by virtue of his/her employment or other similar status, and all of the eligible Dependents including a legal Spouse, natural Child(ren), and adopted Child(ren) who are enrolled in the Plan.

Out-of-Network
Refers to services provided by Medical Physicians, Facilities and/or Providers who do not have a Contract with Alliant Health Plans.

Out-patient
A Member will be considered to be an Out-patient if treated on a basis other than as an In-patient in a Hospital or other covered facility. Out-patient care includes services, supplies and medicines provided and used at a Hospital or other facility under the direction of your Primary Care Physician or pre-approved Specialist for a person not admitted as an In-patient.

Participating Provider
Any Physician, Hospital or other health services Provider who has a Contract with Alliant to provide Covered Services to Members.

Physician
A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Plan
Alliant offered by Alliant Health Plans, Inc.

Preferred Providers
Providers who have a Contract with Alliant.

Pre-authorization or Pre-certification
The approval process, administered by Alliant, through which certain services are reviewed prior to provision as Covered Services except as required by law or regulation. The approval process administered by Alliant is to determine if the proposed services are Medically Necessary and appropriate.

Premium
The monthly charge for the coverage provided by Alliant.

Primary Care Physician (PCP)
A Family/General Practice, Internal Medicine, Pediatric Medicine or OB/GYN Physician.

Provider
A person or organization responsible for furnishing healthcare services, including a:

1. Hospital;
2. Physician;
3. Doctor of Dental Surgery (DDS);
4. Doctor of Podiatry (DPM);
5. Licensed Clinical Psychologist (PhD);
6. Certified Nurse Midwife (CNM) acting within the scope of his or her license, under the direction and supervision of a licensed Physician;
7. Licensed Social Worker (LSW); or

8. Licensed Physical Therapist (LPT); Licensed Occupational Therapist (LOT) or Licensed Speech Therapist (LST) acting within the scope of his or her license, and performing services ordered by a Doctor of Medicine or Doctor of Osteopathy.

Referral
A Primary Care or other Provider's advance written request for the provision of services by a Provider, except when the Summary of Benefits requires Pre-certification from Alliant. Such a request does not determine that services or procedures are Covered Services. Coverage determinations are made by Alliant, as appropriate, based upon the terms of this Evidence of Coverage and other Plan materials.

Room and Board
Charges made by Hospital or other covered facility for the cost of the room, general duty nursing care, and other services routinely provided to all In-patients, not including Special Care Units.

Service Area
The geographic area within which Alliant arranges for the provision of Covered Services.

Skilled Nursing Facility
An institution, other than a Hospital, which meets all of the following requirements:
1. Maintains permanent and full-time facilities for bed care of 10 or more resident patients;
2. Has available at all times the services of a Physician;
3. Has a registered nurse (RN) or Physician on full-time duty in charge of patient care, and one or more other registered nurses (RNs), or licensed vocational nurses (LVNs), or licensed practical nurses (LPNs) on duty at all times;
4. Maintains a daily medical record for each patient;
5. Is primarily engaged in providing continuous Skilled Nursing Care for sick or injured persons during the convalescent stage of their Illness or Injury;
6. Is operating lawfully as a Skilled Nursing Care facility in the jurisdiction where it is located or meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations; and
7. Has a written agreement with at least one other Hospital providing for the transfer of patients and medical information between the Hospital and Skilled Nursing Care Facility.

In no event, however, will Skilled Nursing Care facility include an institution that is primarily:
1. A place for rest;
2. A place for the aged;
3. A place for drug addicts, alcoholics, the blind or deaf;
4. A place for the mentally ill or retarded; or
5. A hotel or similar place.

Special Care Units
A specific Hospital unit that provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention.

Covered charges from Special Care Units include charges for intensive care, coronary care and acute care in a Hospital but do not include care in a surgical recovery or postoperative room. The Special Care Units must meet the required standards of the Joint Commission on Accreditation of Healthcare Organizations for Special Care Units.

Specialist
Any Physician who is not listed as a Primary Care Physician in the above definition is a Specialist.

Summary of Benefits
A Summary of Benefits insert included with this Document provides information on the limits and maximums of the Plan, Deductibles, Co-payments, and Co-insurance amounts that you must pay.

You, Your
The individual to whom this Evidence of Coverage is issued or relating to such individual.

ARTICLE II – IMPORTANT INFORMATION

A. How Alliant Works

This PPO Plan is divided into two sets of benefits: In- Network and Out-of-Network.

If a Member chooses In-Network benefits, the Member must select an In-Network/Participating Provider.

In order to receive In-Network benefits and maximize your benefits, it is your responsibility that you receive care from a Participating Provider and to ensure any Referral or Pre-certifications have been obtained for that care.

Your healthcare will be delivered in the setting that is most appropriate for your symptoms or condition. Your Physician and Alliant work as a team to accomplish this.

Out-of-Network utilization will result in higher expenses when a Member uses Non-Participating Providers. If you are admitted to a network facility under the direction of a non-network Physician, charges related to your confinement shall be paid as Out-of-Network.

When an enrollee, Provider, facility, or Home Health care Provider calls during regular business hours to request verification of benefits, the caller has the clear and immediate option to speak to an employee or agent of Alliant.

Because we require Pre-certification we have sufficient personnel available twenty-four (24) hours a day, seven (7) days a week, to provide such Pre-certifications for all procedures, other than non-urgent procedures; to advise of acceptance or rejection of such request for Pre-certification; and to provide reasons for any such rejection. Such acceptance or rejection of a Pre-certification request may be provided through a recorded or computer generated communication, provided that the individual requesting Pre-certification has the clear and immediate option to speak to an employee or representative of the managed care Plan capable of providing information about the Pre-certification request.

Pre-certification is not a guarantee of benefits.

B. Member Financial Responsibility

Co-Insurance
Co-insurance is the responsibility of the Member. Co-insurance amounts required are shown in the Summary of Benefits.

Co-Payments
Co-payments are the responsibility of the Member. Any Co-payment amounts required are shown in the Summary of Benefits.

Contract or Calendar Year Deductible
A Contract Year begins on the Group's policy effective date. Before this Plan pays benefits, a Member must meet all required Deductibles. Deductible amounts are stated in the Summary of Benefits. A Deductible is the portion of the bill you must pay before expenses become covered.

A Calendar Year begins on January 1st, regardless of when your contract may begin. Before this Plan pays benefits, a Member must meet all required Deductibles for the time period of January 1 through December 31. Deductible amounts are stated in the Summary of Benefits. A Deductible is the portion of the bill you must pay before expenses become covered.

Out-of-Pocket Maximum
The maximum amount of a Member's Co-insurance payments during a given based on your contract type, either a Contract or Calendar year. Such amount does not include Deductible and Co-payment amounts or fees in excess of Providers' reasonable fees. When the Out- of-Pocket Limit is reached, the level of benefits is increased to 100% of Eligible Charges for Covered Services, exclusive of Co-payments and other scheduled fees. The specific Out-of-Pocket Maximum is stated in the Summary of Benefits.

The Out-of-Pocket Maximum benefit does not apply to:

1. Flat dollar Co-pays (Office visits, Emergency Room, Family Planning etc.); or
2. Pharmacy Co-pays

Percentage Payable In-Network and Out-of-Network
Services provided by In-Network Providers are subject to the Deductible. Alliant pays for In-Network Services at the In-Network Co-insurance level shown in the Summary of Benefits, less any Co-payments or Co-insurance shown in the Summary of Benefits for those services provided.

For Out-of-Network benefits, the Contract Year Deductible must be met and Alliant will pay the percentage shown in the Summary of Benefits. After the Member reaches the Out-of-Pocket Maximum, Alliant will pay 100% of the eligible covered expenses for the remainder of the Contract Year. Alliant calculates eligible covered expenses using Alliant's schedule of Maximum Allowable Cost (MAC) charges.

In addition, the Member will be financially responsible for all non-covered services and their related charges.

C. Relationship Between Parties The relationship between Alliant and its' Participating Providers is a contractual relationship between independent contractors. Alliant In-Network Providers are not agents or employees of Alliant, nor is Alliant the agent or employee of any In-Network Provider.

The relationship between your Physician and you is that of a Physician and patient. The Physician is solely responsible for any negligence or omission or other liability on the part of the Participating or non-Participating Provider including, but not limited to, Physicians, Hospitals and pharmacies. All other Providers are solely responsible for the particular services they provide you as well. The Member agrees not to seek redress from Alliant or any of its employees, officers, trustees or agents, for such negligence, omission, or other liability on the part of any Provider.

D. ERISA
If the policy is being purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq, Plan is not the Plan Administrator or named fiduciary of the welfare plan, as those terms are used by ERISA. The Group is the Plan Administrator for purposes of determining eligibility to participate, when coverage begins and when coverage ends. The Group has delegated the responsibility to process and determine claims for benefits by Members to Alliant Health Plans, Inc. The Group has elected to provide medical benefits under the plan on a fully-insured basis by contracting with Alliant Health Plans, Inc., to provide health insurance for such benefits. Alliant also processes all claims under the plan and makes determinations of benefits payable by the plan. Alliant Health Plans address is:

Alliant Health Plans
1503 North Tibbs Road
Dalton, GA 30720

E. Scheduling and Canceling Appointments
When you want to see a Physician call his or her office to schedule an appointment. Always identify yourself as an Alliant Member and state the reason for your call – an Emergency or a request for a routine office visit. If you have never visited the Physician you have chosen (or it has been at least twelve (12) months since your last visit), we recommend that you contact them to review their policies on taking new patients (or updating your patient information).

F. When Out-of-Network Care Is Received
If you receive Out-of-Network healthcare services that have not been Pre-certified by Alliant, except in the event of an Emergency, these services will be covered by Alliant at the Out-of-Network level of benefits. **You will be financially responsible for the additional Deductible(s) and Co-insurance to the Out-of-Pocket Maximums listed in your Summary of Benefits. If you receive treatment and the procedures are determined not to be Medically Necessary, all charges will be ineligible and possibly your financial responsibility.**

G. Case Management
In instances when you are suffering from a complex Illness or Injury that requires ongoing health care, a specially trained Case Manager shall be assigned to monitor that care. Case Management is an interagency standardized process that focuses on coordinating a number of services when needed. It includes a standardized, objective assessment of your needs and the

development of an individual service or care plan that is based on the needs assessment and is goal oriented. The Case Manager shall coordinate services, resources, and information with you, your family, the health care Provider and the insurer.

Case Management is an important part of services of the partnership approach to providing healthcare services. Any time a Pre-certification or Referral is required; your Physician will obtain the necessary approval from the Alliant Medical Management Team. It is recommended that you verify that all approvals have been made through the Alliant Member Services Department since this may affect claim payment.

Your Physician will coordinate the development of your treatment plan and review it, your expected length of stay in the Hospital (if a Hospital admission is required), and other significant aspects of your care with Alliant. This process assures that:

1. The care you receive is appropriate for your situation; and
2. You receive all the benefits to which you are entitled.

Your OB/GYN Physician, in the case of maternity or gynecological services, will handle all communication with Alliant's Medical Management Team.

Pre-Authorization or a Referral is not a guarantee of payment.

Admissions are approved only when the appropriateness of the In-patient setting can be substantiated. Actual payment is based upon eligibility for coverage and the effective date for any Member, and is also dependent upon, but not limited to, specific Plan coverage and the status of the coverage on the date services are rendered. If a Member is admitted to a Hospital and the admission is determined not to be Medically Necessary, no benefits will be provided for the Hospital admission and related Physician charges.

ARTICLE III – WHO CAN JOIN ALLIANT

A. Employee Eligibility

Eligible employee means any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the employer with a normal work week of at least 30 hours, in the employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the employer's business, and they are included as employees under a health benefit plan of the employer, but does not include employees who work on a part-time, temporary, or substitute basis.

Alliant Health Plans may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

Employees may apply for coverage if they meet the definition of eligible employee as listed in this section above and are offered to participate in the group health insurance program by the employer.

Alliant Health Plans must receive applications for all eligible employees and their dependents **within 31 days of their eligibility date**. If new employees do not submit applications within the mentioned period, they will be considered a Late Enrollee.

B. Dependent Eligibility

If dependent coverage is available through your employer, Dependents that enroll must submit (or you must submit on your Dependent's behalf) to Alliant Health Plans, a completed and signed Enrollment Form; and must be one of the following:

1. Your current, legal Spouse.
2. Your Dependent natural or legally adopted Child who is under the age of twenty-six (26). The Child shall continue to be insured up to and including the age of twenty-five (25) so long as the coverage of the insured parent or guardian continues in effect. Alliant shall have the right to request proof from time to time that such Child is a Dependent.
    a. A newborn or an adopted Child(ren) is covered automatically for thirty-one (31) days from the moment of birth or date of assumption of legal responsibility (up to and including the age of twenty-five (25)). If additional Premium is required to continue coverage beyond the thirty-one (31) day period, the Member must notify us of the birth or adoption and pay the required Premium within the thirty- one (31) day period or coverage will terminate.
    b. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered Child(ren). However, for the purposes of this Contract, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you. In addition, Alliant Health Plans does not consider as a Dependent, welfare placement of a foster child under a welfare placement, as long as the welfare agency provides all or part of the child's support.
    c. Mentally retarded or physically handicapped Child(ren) are not eligible under this Contract if they are already twenty-six (26) or older at the time coverage is effective. The mentally retarded, physically handicapped or incapacitated child may remain on the plan after attainment of age twenty-six (26), but must have been covered under this Contract prior to reaching age twenty-six (26). You must give us evidence of your Child's incapacity within thirty–one (31) days of attainment of age twenty-six (26). This proof of incapacity may be required annually by us.

After you are enrolled, you are responsible for informing your Employer of any changes in your personal situation that may affect your Alliant coverage. You must report to your Employer and Alliant must be notified within thirty-one (31) days, of any changes in:

1. Your marital status;
2. The number or eligibility status of your Dependents;
3. Your spouse's Employer or health coverage; or
4. Your residence.

If your family status changes before the next open enrollment period – through marriage or the birth or adoption of a Child, for example – and you want to add any newly eligible Dependent to your own Alliant coverage, you must enroll the eligible Dependent within thirty-one (31) days from the date he or she first becomes eligible. A newly eligible Dependent not enrolled within this time period cannot be enrolled until the next annual open-enrollment period.

Once eligible and upon Alliant's receipt of a properly completed Enrollment Form, coverage for you and your eligible Dependents will begin on:

1. The effective date of the contract between Alliant Health Plans and your employer, or
2. The first of the month following the date you become eligible. Your eligibility date may be set by your Employer based upon a minimum waiting period, or
3. The day after satisfying your waiting period.

ARTICLE IV – WHEN COVERAGE BEGINS

Upon Alliant's receipt of a properly completed Enrollment Form, coverage for you and your eligible Dependents will begin as follows:

A. Initial Group Enrollment

Coverage begins on the effective date of the Contract between your Employer and Alliant.

B. Newly Eligible Employees and Dependents

If the Enrollment Form is received after the effective date of the Contract, and

- During your Employer's annual open-enrollment period, coverage is effective on the next renewal date of the Contract between your Employer and Alliant; or
- Within thirty-one (31) days after first becoming eligible, then coverage is effective on the date of eligibility. Your eligibility date may be set by your Employer based upon a minimum waiting period.

C. Newborns

Refer to Article III, B.

D. Pre-Existing Conditions, Limitations, or Exclusions

Benefits for pre-existing conditions may be limited. "Pre- existing condition" means a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately preceding a person's enrollment date under this Plan. Pre-existing conditions will not be covered until the person has been covered under the Plan for twelve (12) continuous months after his or her enrollment date. Such pre-existing condition exclusion period will be reduced or eliminated by any prior period(s) of Creditable Coverage, as explained below. A pregnancy existing on a person's enrollment date is not a pre-existing condition.

Also, pre-existing condition exclusions will not be applied to a dependent child, or subscriber; who is eligible for coverage and initially enrolls prior to the attainment of age 19.

1. Portability Provision

A period of any pre-existing condition exclusion will be reduced by the aggregate of any periods of continuous Creditable Coverage as defined below which apply to an individual as of his enrollment date under the Plan. The enrollment date is defined as the first day of coverage, or, if there is a waiting period, the first day of the waiting period. Any waiting period required by an Employer for coverage under a Plan will run concurrently with any pre-existing condition exclusion period.

2. Creditable Coverage

Continuous Creditable Coverage is "Creditable Coverage" under one or more Plans with no more than a ninety (90) day break in coverage. "Creditable Coverage" means coverage of an individual under any of the following:

a. Medicare or Medicaid;
b. An Employer based accident and sickness insurance or health benefit arrangement;
c. An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, nonprofit Hospital or nonprofit medical service corporation, health care corporation, or fraternal benefit society;
d. A Spouse's benefits or coverage under Medicare or Medicaid or an Employer based health insurance or health benefit arrangement;
e. A conversion policy;
f. A franchise policy issued on an individual basis to a Member of a true association as defined in subsection (b) of Code 33-30-1;
g. A Health Plan formed pursuant to 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services and for their Dependents);

h. A Health Plan provided through the Indian Health Service or a tribal organization program or both; a state health benefits risk pool;
i. A Health Plan formed pursuant to 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
j. A public Health Plan; or
k. A *Peace Corps Act* Health Benefit Plan.

The following *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) provisions apply to this policy.

3. Late Enrollee

A late enrollee is an employee or eligible Dependent of an employee who does not enroll during:

a. The first period in which he or she is eligible to enroll; or
b. A Special Enrollment Period, as defined below, when there is a change in family status or loss of Group coverage under another Plan.

A late enrollee's coverage will be postponed until the next open enrollment period at which time such late enrollee may be insured, subject to the six (6) month pre-existing condition exclusion. In no event will a Child enrolled more than thirty-one (31) days after the effective date of a qualified medical Child support order issued by a court of competent jurisdiction be considered a late enrollee.

4. Special Enrollment Period Provisions

A Special Enrollment Period will be offered when there has been a loss of coverage or a change in family status. With regard to loss of coverage, a Special Enrollment Period will be allowed if:

a. At the time coverage was declined, the employee stated in writing that coverage was declined because of the existence of other coverage (but only if a written statement was required by the Plan), and the other coverage was lost;
b. Other coverage was lost because:
    i. COBRA coverage has been exhausted;
    ii. Coverage was terminated because of a COBRA qualifying event (whether or not a Group is subject to COBRA);
    iii. Coverage for which Employer contribution was terminated; and
    iv. Employee requests coverage within thirty- one (31) days following loss of other coverage.
c. With regard to a change in family status, employees are allowed to enroll:
    i. New Dependent Child(ren) within thirty- one (31) days of birth or adoption or placement for adoption. Coverage will be effective on the date of birth or adoption or placement for adoption;
    ii. A new Spouse within thirty-one (31) days of marriage with the effective date not later than the first month following election.

A non-enrolled employee can also enroll during any special Enrollment Period created by loss of coverage by a family Member or family status change. Also, an employee's non-enrolled Spouse can enroll when a new Dependent Child, as defined above, is enrolled.

5. Certification and Disclosure of Previous Coverage

Effective October 1, 1996 upon the request of an employee, and effective July 1, 1997 as a matter of practice, a certificate must be provided, without charge, to participants or Dependents that are or were covered under a Group Health Plan upon the occurrence of any of the following events:

a. In the case of a person who is a beneficiary entitled to elect COBRA continuation coverage, a certificate is required to be provided at the time the person would lose coverage under the Plan in the absence of COBRA continuation coverage;
b. In the case of a person who is not a qualified beneficiary entitled to elect COBRA continuation coverage, a certificate is required to be provided at the time the person ceases to be covered under the Plan;
c. In the case of a person who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the person became entitled to elect COBRA continuation coverage), a certificate is to be provided at the time the individual's coverage under the Plan ceases.

Requests for certificates are permitted to be made by, or on behalf of, an individual within twenty-four (24) months after coverage ceases.

6. The certificate must include the following information:

a. The date the certificate is issued;
b. The name of the Group Health Plan that provided the coverage described in the certificate;

c. The name of the participant or Dependent with respect to whom the certificate applies, and any other necessary information for the Plan providing the coverage specified in the certificate to identify the individual;
d. The name, address, and telephone number of the Plan Administrator or issuer required to provide the certificate;
e. The telephone number to call for further information regarding the certificate;
f. The date any waiting period began and the date Creditable Coverage began; or a statement that the person has at least eighteen (18) months of Creditable Coverage, disregarding days of Creditable Coverage before a significant break in coverage; and
g. The date Creditable Coverage ended, unless the certificate indicates that Creditable Coverage is continuing as of the date of the certificate.

E. Requirements of the *Family and Medical Leave Act* of 1993

Your coverage under the Plan continues if you are on a leave of absence that qualifies under the *Family and Medical Leave Act* of 1993. The cost of coverage during such absence will be the same as while you are actively employed. If you cancel your coverage during the leave, upon your return to active employment, your coverage will be reinstated as of the date of your return. You will not be required to satisfy any waiting period or pre-existing condition limitations to the extent they were satisfied prior to your absence. Your Employer will provide you with more detailed information about the *Family and Medical Leave Act* of 1993.

ARTICLE V – WHEN COVERAGE ENDS

A. Your Alliant Group Coverage Ends on the Earliest of

1. The date the Contract between your Employer and Alliant terminates.
2. The date you stop being an eligible employee. However, in the event that you are disabled at the time your Group coverage would otherwise terminate, you will continue to be covered for such disability for up to twelve (12) months. A disability is defined as a medically demonstrable physical or mental disability which renders a person incapable of performing duties necessary for gainful occupation. The date in which you inform your Employer that you no longer desire coverage under Alliant.
3. The date your Alliant coverage began if it is later determined that you intentionally intended to commit fraud or made an intentional material misrepresentation on an Enrollment Form.
4. The date you enter into active duty in the Armed Forces of any country.
5. The date you die. Coverage of your Spouse terminates automatically as of the date of death or divorce. Your Spouse and covered Dependents may be eligible to continue coverage.
6. Your Employer has failed to pay Premiums or contributions in accordance with the terms of the Group Health Insurance Policy or Contract, including any timeliness requirements subject to State law. Your Employer is entitled to a grace period of not less than thirty-one (31) days for the payment of any Premium due, except the first, during which grace period the policy shall continue in force unless your Employer has given Alliant written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. Your Employer shall be liable to Alliant for the payment of a pro-rata Premium for the time the policy was in force during such grace period.

TERMINATION OF GROUP CONTRACT OR PLAN

If the Group Contract or Group Plan terminates while any Group Member or qualifying eligible individual is covered or whose coverage is being continued, the Group Administrator, as prescribed by the insurer, must notify each such Group Member or qualifying eligible individual that he or she must exercise his or her rights within:

a. Thirty (30) days of such notice for Group Members who are not qualifying eligible individuals; or
b. Sixty-three (63) days of such notice for qualifying eligible individuals.

7. The date the Employer has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the Group Health Insurance Policy or Contract.
8. The date the Employer has violated Alliant's minimum Employer contribution or Group participation rules, provided that the insurer submits written notice to each affected Employer and provides each Employer sixty-days in which to bring the Group into compliance prior to cancellation.
9. The date on which none of the Employer's employees or enrollees live, reside, or work in the Service Area of the Provider network unless there is at least one insured employee, Group Member, or enrollee who has agreed to return to the Service Area of Alliant.

10. The date Alliant terminates, cancels, or does not renew all coverage under a particular policy form, provided that:
    a. Alliant provides at least ninety (90) days notice prior to the termination of the policy form to all policy holders and certificate holders;
    b. Alliant offers the Group all other small Group (Employer) or large Group (Employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible.
11. The date Alliant discontinues offering and terminates, cancels, or does not renew all coverage in either the small Employer market or the large Employer market, or both, provided that:
    a. Alliant provides at least one hundred-eighty days notice prior to the discontinuance or non-renewal of a policy or Contract to all policyholders and certificate holders;
    b. Alliant provides at least one hundred-eighty days notice to the Georgia Insurance Commissioner prior to the earliest date of termination or non-renewal related to the discontinuation in the market and indicates in such notice the date described in subparagraph (12)(c); and
    c. Alliant does not issue coverage in such market for five (5) years beginning with the date of the last Health Insurance Policy or Contract in that market not renewed.

Alliant may modify Group policies only at the time of renewal, provided that, for all small Employers covered under a policy, such modifications to that policy are effective on a uniform basis among all small Employers with that policy. Notwithstanding, Alliant may modify a Group policy other than at renewal only if a policyholder elects to modify its coverage at such other time.

Alliant will not terminate your coverage if you move out of the approved Service Area, provided you continue to be an eligible enrollee of the insured Group and agree in writing to return to the approved Service Area for covered medical care.

B. Coverage for Your Dependent Will End on the Earliest of

1. The date your own coverage ends.
2. The date that an eligible Dependent is no longer eligible for coverage, according to the eligibility requirements of your Employer and of Alliant under Article III-B of this Document.
3. The date of expiration of the period covered by your last contribution. Your Employer is entitled to a grace period of not less than thirty-one (31) days for the payment of any Premium due except the first, during which grace period the policy shall continue in force unless your Employer has given Alliant written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. Your Employer shall be liable to Alliant for the payment of a pro-rata Premium for the time the policy was in force during such grace period.
4. The date in which you inform your Employer that you no longer desire coverage under Alliant.
5. The date your Dependent enters into active duty in Armed Forces of any country.

C. Termination of Marital Relationship

Upon the death of the insured or the entry of a valid decree of divorce between the insured parties, the surviving or divorced Spouse and covered Dependents shall have the right to continuation coverage as described in Article XIV. When such continuation coverage expires, the surviving or divorced Spouse shall be entitled to have issued to him or her, an individual or family policy without evidence of insurability, upon application made to the company within thirty-one (31) days of the expiration of such coverage and upon the payment of the appropriate Premium. Any and all probationary or waiting periods set forth in such an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy. If the Spouse is at least age sixty (60) at the time of the death or divorce, the Spouse may also be entitled to the special continuation coverage.

You have the right to appeal any termination or cancellation through the Grievance Procedure.

ARTICLE VI – COVERED SERVICES

The following services are covered by Alliant and are applicable to In-Network and Out-of-Network benefits unless specifically noted as otherwise. Coverage is provided subject to the Co-payments, Deductibles, Co-insurance, Limitations and Exclusions that are specified in this Document, your Summary of Benefits or any purchased Riders. Your Co-payments, Deductibles, and Co-insurance may be further limited as set forth in your Summary of Benefits to an annual amount.

A. Preventive Care Services

Alliant Health Plans shall, at a minimum, provide coverage for and shall not impose any cost sharing requirement for;

a. No less than once per year, evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
c. With respect to infants, children, and adolescents, evidence–informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
d. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention shall be considered the most current other than those issued in or around November 2009.

B. Diagnostic and Out-patient Services

1. Prescribed X-ray and laboratory tests, services and materials, e.g., diagnostic X-rays, X-ray therapy, chemo-therapy, fluoroscopy, electrocardiograms (EKGs), electroencephalograms (EEGs), and therapeutic radiology services.
2. Medically Necessary surgical procedures and anesthesia.
3. Office visits to medical or surgical Specialists.
4. Urgent Care Services other than Hospital Emergency Room visits. Please note that Urgent Care Services may require a Co-payment at the time of service. For further Co-payment information please refer to your Summary of Benefits. Urgent Care Services generally pertain to minor health problems that occur when your Physician's office is closed that require immediate attention but are not Emergencies; examples include:
    a. Minor cuts and abrasions;
    b. Minor burns;
    c. Sprains;
    d. Earaches or stomach aches;
    e. Minor/simple bone fractures; and
    f. Other minor injuries.
5. Allergy testing and treatment.
6. Short-term rehabilitative services (physical, occupational and speech therapies). Such therapies shall be performed or rendered at a Hospital or facility. (Refer to the Summary of Benefits for further details and limitations.)
7. Laboratory screening test for Chlamydia.
8. Coverage is provided for qualified individuals for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis.
9. Coverage is provided for Medically Necessary equipment, and Out-patient self-management, training and education, including medical nutrition therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by a Physician.
    a. Diabetes Out-patient self-management training and education as indicated in this section shall be provided by a Provider who is certified and registered; or a
    b. Licensed health care professional with expertise in diabetes.

    Self-management training and education services shall conform to the standards established by the American Diabetes Association and must have prior authorization by Alliant.

Insulin and other pharmacological agents and supplies are not covered unless purchased by the Employer through a separate prescription drug Rider.

10. Coverage is provided for approved clinical trial programs for treatment of children's cancer meaning a Phase II and III prescription drug clinical trial program in this state, as approved by the Federal Food and Drug Administration or the National Cancer Institute, for the treatment of cancer that generally first manifests itself in Child(ren) under the age of nineteen (19.) Coverage is limited to those under age nineteen (19) and who are not otherwise eligible for payments or reimbursements from any other third party payers or other similar sources.

C. In-patient Hospital Services

The following acute In-patient services are provided at In-Network or Out-of-Network Hospitals and Skilled Nursing Facilities when, except in the case of Emergency admissions, they are ordered by the admitting Physician and Alliant gives prior written Authorization. Payment will be in accordance to In-Network or Out-of-Network benefits as outlined in the Summary of Benefits.

1. Room and board for semi-private accommodations, including use of operating room, intensive and coronary care units, recovery room & special treatment rooms. Private accommodations and special diets will be covered if Medically Necessary, as determined by Alliant's Medical Director in consultation with your admitting Physician.

2. General nursing care. Private duty nursing when Medically Necessary. (Refer to the Summary of Benefits for Limitations.)

3. Diagnostic and interventional radiology services, clinical laboratory and other diagnostic tests, anesthesia, oxygen services, radiation, encephalography, cardiography, nuclear medicine and chemotherapy.

4. Non-experimental drugs, medications and biologicals which have been Pre-Authorized by Alliant.

5. Physical, speech, occupational and respiratory therapies.

6. Administration of blood and blood products. The cost of these products is not covered when a volunteer re-placement program is available.

7. Pre- and post-Hospital planning and referral to community and social welfare resources.

8. Heart, heart/lung, kidney, liver, pancreas, cornea, bone marrow, and other non-experimental transplants are covered if, and only if:
   a. Services are rendered in an institution Pre-authorized by Alliant;
   b. Specific clinical indications are present; and
   c. Pre-authorization is obtained from Alliant in advance of transplant, and confirmed in writing.

D. Coverage For Emergency Services

1. In the event of an Emergency, go to the nearest Hospital. An Emergency is defined as those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in:
   a. Placing the patient's health in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part.

   Emergency treatment for a condition that meets the definition presented above does not have to be referred by a Physician. However, you must inform Alliant about your Emergency treatment within forty-eight (48) hours of receiving that care, or as soon thereafter as medically possible. You will be charged a Co-payment for Emergency Services, but this Co-pay may be waived if you are admitted to the Hospital.

1. Follow-Up Care for Emergency Services Rendered by In-Network Providers
   All follow-up care should be provided by your Participating Alliant Physician.

2. Follow-Up Care for Emergency Services Rendered by Out-of-Network Providers
Follow-up care after the Member is stable will be covered at the Out-of-Network benefit level.

If after review, Alliant determines that the Emergency Services provided were not Medically Necessary, the Member may be responsible for all charges incurred.

E. Other Services

1. Ambulance Transportation
Alliant covers charges for Emergency transportation to the nearest Hospital or if transportation is Pre-certified to preserve life or limb. This transportation must be provided by a professional ambulance service. Certified air ambulance transportation will be covered if Medically Necessary to preserve life or limb and approved by Alliant.

2. Dental Services
Dental Services are not covered by Alliant. Certain limited oral surgical procedures are covered when Pre-certified. In-patient services require specific Alliant Pre-certification. Only the following oral surgical procedures are eligible for coverage:
   a. Initial first aid treatment received within forty- eight (48) hours of an accidental injury to sound natural teeth, the jawbones, or surrounding tissues. This includes only extraction of teeth and repair of soft tissue. Replacement and restoration of teeth are not covered;
   b. Medically Necessary orthognathic surgery. This type of surgery is intended to correct skeletal mismatches. That is, when one jawbone is too large, too small, too far forward or too far back in relation to the cranial base (the bones which house and protect the brain);
   c. Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   d. Extraction of bony impacted wisdom teeth;
   e. Medically Necessary oral surgery to repair fractures and dislocations;
   f. Medically Necessary surgical or nonsurgical treatment for the correction of temporomandibular joint dysfunction by Physicians professionally qualified by training and experience, with written Pre-Authorization by Alliant, and subject to the limitations listed in your Summary of Benefits;
   g. General anesthesia services and associated Hospital and ambulatory surgical facility charges for anesthesia used for dental procedures if such Member is:
      i. Seven (7) years of age or younger or is developmentally disabled;
      ii. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Member; or
      iii. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by Workers' Compensation insurance.

3. Durable Medical Equipment and Prosthetic Devices
The rental or purchase, a Alliant's discretion, of Medically Necessary Durable Medical Equipment, oxygen, respiratory equipment, medical appliances and prescriptions is covered when ordered by your Physician and Pre-certified by Alliant Medical Management Team. To be covered by Alliant, Durable Medical Equipment must be on Medicare's approved list.

Alliant covers an initial Prosthesis if the illness or injury occurs while insured under the Plan or as Pre-Authorized by Alliant. To be covered by Alliant, Prosthetic Devices must be on Medicare's list of approved Prosthetic Appliances.

Deluxe versions of Durable Medical Equipment or Prosthetic Devices will not be covered.

4. Home Healthcare Services

Home Healthcare Services are covered upon the order of your Physician and when Pre-certified in writing in advance by Alliant. Home Healthcare Service benefits which are in lieu of In-patient hospitalization and are coordinated through Case Management include:

a. Physician services;
b. Skilled Nursing Care;
c. Physical, occupational and other related therapies;
d. Administration of medications and IV therapy; and
e. Supplies and equipment as determined by Alliant.

Convalescent and custodial services are not covered. Personal comfort and convenience items and services, such as meals and housekeeping, are not covered.

5. Hospice Care

The following Hospice Services are covered:

a. In-patient and Out-patient Hospice Services, including care provided by an appropriately licensed Hospice, for treatment directed at controlling pain, relieving other symptoms; and
b. Such other supportive services as are regularly provided by the Hospice in support of terminally ill patients.

Covered Services must be upon the order of your Physician and Pre-certified in writing in advance by Alliant.

Homemaker, volunteer and spiritual counseling services, if other than palliative, curative treatment or services, food or home-delivered meals and custodial care, rest care or care for someone's convenience are not covered.

6. Infertility Diagnosis and Treatment

Alliant provides coverage for treatment relating to an Infertility Diagnosis and surgical treatment. Alliant does not cover drug therapy, medications and procedures to induce pregnancy (artificial insemination, in vitro fertilization and embryo transplants) or reversals of tubal ligation and vasectomy procedures.

7. Maternity Care

Maternity services provided to you or your covered Spouse is covered effective on the date that Alliant's Medical Management Team is notified of the anticipated delivery date. Maternity services include the following:

a. Hospital and Physician charges related to your pregnancy, including use of delivery room and nursery and postpartum care; Members are allowed to stay in the Hospital up to forty-eight (48) hours when delivery is considered a normal vaginal delivery and up to ninety-six (96) hours when delivery is considered Cesarean;
b. One (1) ultrasound performed during each pregnancy;
c. Pre- and post-natal care;
d. Coverage of your newborn Child(ren);
e. Administration of anesthesia and injectibles and X-ray and laboratory services;
f. Treatment for complications of pregnancy, child- birth and any obstetrical disorder; injury or condition arising from childbirth; when the pregnancy is not terminated, conditions requiring Hospital stays which are not directly related to pregnancy but are caused or adversely affected by the pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, preclampsia, missed abortion and similar medically diagnosed conditions; or when the pregnancy is terminated; it includes non-elective Cesarean section, ectopic pregnancy, miscarriage and abortion which are Medically Necessary to save the life of the mother. A complication of pregnancy is treated as a sickness separate from pregnancy. This service is also available to eligible Dependents.

Group Health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. In any case, Plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

8. Skilled Nursing Facilities

Medically Necessary care in a Skilled Nursing Facility is covered if admitted within three (3) days following Hospital discharge when prescribed by your Physician and Pre-certified by Alliant. (Refer to the Summary of Benefits.)

9. Kidney Disease and Dialysis
   All Medically Necessary services for hemodialysis for renal disease and for kidney transplants; subject to all federal and state requirements regarding end- stage renal disease including equipment, training, and medical supplies required for home dialysis. Should you qualify for Medicare benefits for End- Stage Renal Disease (ESRD), Alliant will coordinate benefits as prescribed for by Medicare standards and guidelines.

10. Cardiac Rehabilitation
    Cardiac Rehabilitation programs (both in-patient and out- patient) are covered when Pre-certified.

11. Sterilization
    Vasectomies and tubal ligations are covered when Pre-authorized. Reversals of Sterilization procedures are not covered.

12. Podiatric Services
    Services provided by Podiatrists are covered, excluding routine foot care.

13. Specialty Clinics
    Treatment in participating Specialty Clinics and Centers and programs for pain control and sleep disorders are covered if Pre-certified.

14. Breast Reconstruction from Covered Mastectomy
    In consultation with the appropriate Physician, coverage will be provided in connection with a covered mastectomy for:
    a. Reconstruction of the breast on which the mastectomy was performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
    d. Up to (3) mastectomy prosthesis bras per Contract Year.

    In addition, the Plan shall provide coverage for Medically Necessary In-patient care following a mastectomy or lymph node dissection until the completion of the appropriate period of Medically Necessary In-patient care. Coverage shall also be provided for an appropriate number of follow-up visits.

15. Transplantation Services
    Covered Services for transplants when ordered by a Physician and authorized in advance by Alliant. Transplantation Services must be Medically Necessary as determined in advance by Alliant and rendered in accordance with Alliant's policies for Transplantation Services and not be an experimental, investigational or unproven service.

16. Treatment for Mental Health/Substance Abuse Services
    a. Hospital In-patient Care
       Benefits for In-patient Hospital and Physician charges are subject to the Deductible, Co- insurance requirements.

    b. Professional Out-patient Care
       These services are subject to the Contract Year Deductible and percentage payable; or co-payment provisions stated in the Summary of Benefits. Covered Services include:
       i. Professional care in the Out-patient Department of a Hospital;
       ii. Physician's office visits; and
       iii. Services within the lawful scope of practice of an approved licensed psychiatrist or a licensed clinical psychologist.

17. Ovarian Cancer Surveillance Tests
    Covered Services are provided for at-risk women thirty-five (35) years of age and older. At-risk women are defined as:
    a. Having a family history;
        i. With one or more first or second-degree relatives with ovarian cancer;
        ii. Of cluster of women relatives with breast cancer;
        iii. Of nonpolysis colorectal cancer; or
    b. Testing positive for BRCA1 or BRCA2 mutations.

    Surveillance tests mean annual screening using:
    a. CA-125 serum tumor marker testing;
    b. Transvaginal ultrasound; and
    c. Pelvic examinations.

18. Colorectal Cancer Examinations and Laboratory Tests
    Covered Services include coverage for screenings or tests that receive a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

ARTICLE VII – EXCLUSIONS FROM COVERAGE

A. Some services are specifically referenced in this Document as Covered Services and are noted in (B) below when relevant.

B. Unless specifically referenced as Covered Services, the following services and/or supplies are not Covered Services and, therefore, are excluded from coverage:

1. Any court-ordered testing, treatment, or hospitalization.
2. Care rendered to self or a Dependent by a relative, or rendered by Providers with the same legal residence as the Member.
3. Services rendered before coverage began or after coverage ended, except those services which are subject to continuation coverage.
4. Skilled Nursing Facility services, except as specifically provided in this Document. Intermediate care and Custodial Care Services are not covered.
5. Examinations, reports and immunizations for the purpose of obtaining or maintaining employment, insurance, governmental licensure, visas and passports; Employer requested annual physical exams; court-ordered or forensic evaluations; for premarital purposes; exams for schools, athletic activities, and summer camps.
6. Cosmetic or plastic treatments/surgery/procedures including, but not limited to, cosmetic or plastic surgery, pharmacological regimens and nutritional procedures or treatments except as Medically Necessary for:
    a. Repair of anatomical impairment to improve or correct functional disability;
    b. Breast reconstruction following a covered mastectomy; or
    c. Plastic surgery following an accidental Injury up to twelve (12) months after the date of the injury. This exclusion includes no coverage for sagging skin or extra skin. Also excluded is augmentation or reduction procedure (e.g. mammoplasty) unless Medically Necessary; liposuction, phinoplasty and rhinoplasty done in conjunction with covered nasal or covered sinus surgery. Complications of such surgery are covered only if Medically Necessary and otherwise not covered. Remedial work is not covered.
7. Dental Care, except for Medically Necessary oral surgery incidental to fracture, dislocation and tumor or as otherwise provided in this Document. Exclusions include, but are not limited to:
    a. Treatment on or to the teeth;
    b. Extraction of teeth, except the extraction of bony impacted wisdom teeth;
    c. Treatment of dental abscess or granuloma;
    d. Placement, removal or replacement of implants of the teeth and alveolar ridge;
    e. Treatment of periodontal disease and abscess;
    f. Root canal; or
    g. Braces, retainers and bite plates.
8. Treatment for mental retardation and mental deficiency; care for chronic mental illness, chronic alcoholism and chronic drug addiction. The determination regarding chronic illness rests with Alliant or its designated representative. Examples of chronic illness include, but are not limited to, the following:

a. Treatment for mental illness diseases or illnesses that, according to generally accepted professional standards, are not usually amenable to favorable modification;
b. Treatment for mental illness that has not responded positively to reasonable treatment procedures. The following criteria will be used to review response to treatment:
    i. Number of psychiatric/substance abuse hospitalizations;
    ii. Degree of disability as indicated by comparison to standard established criteria; and
    iii. Member's degree of cooperation and compliance with treatment plans.
c. Treatment, therapy, teaching or programs relating to remedial education, rehabilitation or training intended to overcome, improve or compensate for any learning impairment.

9. Except for counseling provided under the Patient Protection and Affordability Act, any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional or obesity counseling), including:
    a. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding;
    b. Food supplements;
    c. Services of In-patient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education;
    d. Any services or supplies that involve weight reduction as the main method of treatment, including medical or psychiatric care or counseling;
    e. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature; and
    f. Procedures including but not limited to liposuction, gastric balloons, lap bands, jejunal bypasses, and wiring of the jaw.
10. Long-term psychiatric medicine and long-term rehabilitative services for chronic conditions.
11. Refractive surgery; contact and corrective lenses and eyeglasses and supplies including but not limited to lenses and frames; all manner of contact lenses or corrective lenses and refractions; eye exercises, visual training, vision therapy, or porthoptics (except for convergence insufficiency and amblyopia penalization for Child(ren).) Refractive surgery includes LASI, Laser Thermal Keratoplasty, Ortheratology, Standard Keratomeleusis, Astigmatic Keratotomy, Photoreactive Keratomy, Radial Keratotomy, Epikeratoplasy, Keratophakia and Keratolileusis.
12. Personal comfort items such as television, telephone, private rooms (except as Medically Necessary) in a Hospital or Skilled Nursing Care Facility; housekeeping services and meal services as a part of home Healthcare; travel, transportation, or living expenses; rest cures, travel, recreational, or diversional therapy.
13. Investigational or experimental medical, surgical, or other health procedures, including investigational or experimental drugs as determined by Alliant. Alliant will make this determination based on the recommendation of the Medical Management Committee and the most recent DATTA (Diagnostic and Therapeutic Technology Assessment) reports published by the American Medical Association. Pharmaceuticals and devices which have not received FDA approval.
14. Care for conditions that state or local law requires to be treated in a public facility or for which you have no legal obligation to pay; care rendered while in custody of state, federal, or local prison systems or authorities. Care that results from an injury resulting from being in the custody of state, federal or local prison systems or authorities including injuries resulting from community service performed as a result of a judgment issued by a state, federal or local judicial system.
15. Any services received in a military or veteran's health care facility, or services for which any government payer is primarily responsible.
16. Medical equipment, appliances and supplies for home use other than as set forth in this Document; duplicate medical equipment and repairs to equipment; exercise equipment, support devices (shoes, shoe molds and inserts, and support stockings); bite plates; disposable medical supplies and TENS units.
17. Routine foot and nail care and treatment of conditions such as weak, strained, flat, unstable or unbalanced feet; treatment of superficial lesions on the feet such as corns, calluses or hyperkeratoses, tarsalgia, metarsalgia or bunion except surgery which involves exposures of bone, tendon or ligament; toenail, except removal of the nail matrix; and arch supports, heel wedges, lifts, the fitting or provision of orthotics or orthopedic shoes.
18. In-vitro fertilization, infertility drugs, embryo transplant services, artificial insemination, gamete intrafallopian transfer (GIFT) procedures and reversal of voluntary sterilization and any related procedures.
19. Abortions.
20. Physical therapy and occupational therapy, except as provided in this Document; non-medical services such as vocational rehabilitation, work hardening, employment counseling and psychological counseling; training and educational therapy for remaining disabilities and all long-term rehabilitation; speech therapy, except as provided in this Document; testing for intelligence, aptitude, or interests.
21. Chiropractic services unless provided through a separate Rider.

22. Prescription drugs except those provided on an In-patient basis unless provided through a separate Rider.
23. Hypnosis, biofeedback, acupuncture, hypnotherapy.
24. Services or supplies related to occupational Injury or illness. Alliant shall determine if injuries are work related. Care for any condition or injury recognized as a loss through any Worker's Compensation, occupational disease or similar law. This applies if the Member's rights have been waived or qualified and whether or not a Worker's Compensation claim has been filed.
25. Counseling for marital or relationship conflicts; employment counseling; vocational rehabilitation counseling services; sex therapy and treatment of sexual dysfunction; religious counseling; except for counseling provided under the Patient Protection and Affordability Act.
26. Transsexual surgery and related services. Any procedure or treatment designed to alter the physical characteristics of a Member from the Member's biological sex to those of the opposite sex regardless of the diagnosis of gender role or psychosexual orientation problems.
27. Blood, blood plasma, or blood derivatives when a volunteer replacement program is available. The cost of securing the services of professional donors is not covered. The collection or storage of blood or the cost of securing the services of blood donors is also not covered.
28. Hearing aids.
29. Penile implants.
30. Charges for completion of forms and reports.
31. Experimental organ transplants; for non-experimental transplants except for heart; any expenses related to procurement of an organ or tissue; transplant donor costs, including harvesting, transport and maintenance of organ or tissue. Coverage does not begin for non-experimental transplants until presentation to the recipient occurs.
32. Alliant shall not be liable for any loss for which a contributing cause was the insured's commission of, or attempt to, commit an illegal act or be engaged in an illegal occupation. Alliant shall not be liable for any loss sustained or contracted in consequence of the insured being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
33. Any health service or supply that is not Medically Necessary.
34. Any services or supplies not within the scope of the authorized practice of the Provider rendering the service or supplies; any services or supplies provided by a practitioner not recognized by this policy.
35. Care or treatment of sickness or injury as a result of or caused by:
    a. War, declared or undeclared;
    b. Service in the armed forces or auxiliary units, including the National Guard or Military Reserve active duty. If coverage ceases due to entry into the armed forces on a full-time basis, any unearned Premiums shall be refunded on a pro-rated basis upon written notification to Alliant of entry into such service.
36. Services received outside the United States except for Emergency treatment for onset of Illness or Injury while traveling for business, recreational purposes or vacation, for up to ninety (90) days from date of departure.
37. Health Services and associated expenses for Out-patient Hospital and Hospital Emergency Room services obtained during normal Physician office hours unless necessary because of an Emergency.
38. Maternity services for Dependent Child(ren).
39. All enteral feedings, equipment required for feedings and other over-the-counter nutritional and/or electrolyte supplements.
40. Any charge or portion thereof, in excess of the Reasonable and Customary or specified limitation.
41. Cost of duplicating and mailing medical records.
42. Claims filed one hundred-eighty (180) days after services are rendered.
43. Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) an Out-of-Pocket amount, we will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
44. Services rendered or supplies provided before coverage begins, i.e. before a Member's effective date, or after coverage ends, subject to the Continuation of Alliant Coverage.
45. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to End Stage Renal Disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B.
46. Expenses in excess of the Maximum Allowable Cost (MAC) as determined by Alliant. Any charges that are in excess of the MAC are the Member's responsibility.
47. Non-Emergency treatment of chronic illnesses received outside the United States and performed without Pre-authorization.
48. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.

49. Health services otherwise covered related to any and all conditions when a Member refuses to comply with or has terminated the scheduled service or has not followed a treatment against medical advice.
50. An adopted newly born infant's initial Hospital stay if the natural parent has coverage available for infant's care.
51. Autopsies.
52. Custodial Care, domiciliary care, long-term care, maintenance care, adult care or rest care and cures. Room, board, nursing care or personal care which is rendered to assist a Member who, in Alliant's opinion has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
53. Improper use of an Emergency Room or Emergency admissions. Routine care and treatment for conditions that Alliant determines are not medical Emergencies when received in an Emergency Room. Follow-up care provided at a Hospital Emergency Room is excluded.
54. When Medicare is the primary payer, Covered Services are provided only to the extent not covered by Medicare.
55. No show charges. If a Provider charges a fee for a missed appointment, you are responsible for the payment of the fee.
56. No coverage is available outside the United States if the Member traveled out of the country to obtain medical treatment, drugs, or supplies. In addition, there is no coverage for treatment, drugs, or supplies that are unavailable or illegal in the United States.
57. The following are excluded as diabetic services and supplies: services and supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet clubs, or plans for the purpose of losing weight even if recommended by the Member's Physician or qualified health professional; any counseling or courses in diabetes management other than described in this Evidence of Coverage; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diet aids and supplements related to dieting.
58. Home Health Care benefits are limited to the amount of visits shown on your Summary of Benefits.
59. Private or special duty nursing. Private room.
60. Services not specifically listed as covered.

ARTICLE VIII – CLAIMS

A. The Usual Procedure

When utilizing In-Network providers, all you need to do is make your required Co-payment while at your doctor's office. In-Network Providers will file claims directly to Alliant on your behalf. **Services that require Deductibles, Co-payments and Co-insurance, and the amounts of those Deductibles, Co-payments and Co-insurance are listed in your Summary of Benefits.** Alliant will generally pay the Provider of care directly; you will not receive any checks. If you utilize an Out-of-Network Provider, you may be asked to pay the entire charges at the time of service. Alliant will only pay Out-of-Network Providers directly if an appropriate assignment of benefits has been signed by the Member and is on file with the Provider.

B. When Deductibles, Co-Payments, and Co-Insurance Apply

Within the Alliant program, certain services are subject to Deductibles, Co-payments or Co-insurance. These services and their corresponding amounts or percentages are listed in your Summary of Benefits.

For example, a Co-payment associated with office visits to your Participating Provider as specified on the Summary of Benefits will be paid at the time services are rendered. On the other hand, if you receive a Covered Service that involves a significant Co-insurance the Provider will submit a claim to Alliant and we will pay the Provider the Co-insurance level that applies.

To ensure that you will always have access to basic health care services, your Deductibles and Co-insurance have limitations, as set forth in your Summary of Benefits. The annual Out-of-Pocket Maximum will depend on which benefit option your Employer chose. This limitation does not include Co-payments.

Services provided by Out-of-Network Providers are not subject to Co-payments. All Out-of-Network services are subject to the annual Deductible and Co-insurance amounts listed in your Summary of Benefits.

Eligible charges that are applied to your Deductible during the last three (3) months of a Plan year may also be applied to the following year's Deductible.

C. Additional Information

For Out-of-Network Emergency Services the following claims procedures apply:

1. Written notice of sickness or Injury must be given to Alliant within forty-eight (48) hours after the date of sickness or Injury occurred. Failure to give notice within that time shall neither invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give notice and that notice was given as soon as was reasonably possible.
2. All benefits payable under this policy will be payable upon receipt of written proof of loss within fifteen (15) working days. If all necessary information in order to process the claim is not available then Alliant shall have fifteen (15) working days to send a letter stating reasons for non-payment of proof of loss and requesting any necessary information.
3. When all necessary information has been received, Alliant will have fifteen (15) working days within which to process and either pay or deny the claim in whole or in part and give reasons as to why the claim was denied in whole or in part.
4. Failure to comply with the above specifications for payment of claims will result in Alliant being responsible for an interest penalty on the proceeds or benefits due.
5. Alliant, at Alliant's expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim and shall also have the right to perform an autopsy in case of questionable death and/or circumstances.
6. No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty-days after written proof of loss has been furnished in accordance with the requirements of the policy, and no action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

ARTICLE IX – RECEIPT AND RELEASE OF INFORMATION

Alliant must have your Authorization to receive and release information about the medical services provided to you or your covered Dependents in order to administer your health benefits coverage. You give Alliant this Authorization when you sign your Enrollment Form. You may be asked to update this Authorization at later intervals.

By enrolling in Alliant, you authorize any healthcare Provider, any insurance company, any third-party administrator, and any payer to release information regarding any claim or the delivery of medical care – on behalf of yourself or your covered Dependents – to Alliant. You also authorize Alliant to release any information regarding any claim or delivery of medical care - on behalf of yourself or your covered Dependents – to any other person or organization that may be responsible for providing or paying for your medical care. Where confidentiality or privilege laws require other processes, Alliant will utilize such other processes.

ARTICLE X – COMPLAINT PROCEDURE

An adverse benefit determination eligible for internal claims and appeals processes includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

The amount of time Alliant Health Plans will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 24 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 24 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for pre-service claims and 30 days for post-service claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims.

Failure to make a payment in whole or in part includes any instance where a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

Under these interim final regulations, an adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions (26 CFR 54.9815–2712T(a)(2), 29 CFR 2590.715–2712(a)(2), and 45 CFR

147.128(a)(2)), whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Rescissions of coverage must also comply with the requirements of the regulations restricting rescissions.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

1. The specific reasons for the denial;
2. The specific references in the plan documentation on which the denial is based;
3. A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
4. The steps to be taken to submit your claim for review;
5. The procedure for further review of your claim; and
6. A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claim Administrator.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

A. Level one appeal

If you disagree with a claim determination after following the above steps, you can contact us in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

1. The patient's name and the identification number from the ID card.
2. The date(s) of medical service(s). The provider's name.
3. The reason you believe the claim should be paid.
4. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial. During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by Alliant Health Plans in considering the claim; and that demonstrates Alliant Health Plans' processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by Alliant Health Plans. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. Alliant Health Plans may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

B. Level two appeal

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted within 60 days from receipt of first level (level one) appeal decision.

- For appeals of pre-service claims, the second level appeal will be conducted and you will be notified within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims, the second level appeal will be conducted and you will be notified within 30 days from receipt of a request for review of the first level appeal decision.

C. Urgent Care claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call Customer Service as soon as possible. You will be provided a written or electronic determination within 24 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

D. Claims or Suits

You should follow your Appeal Procedures to its conclusion before filing any sort of claim or suit in court.

E. ERISA Rights

The Plan is maintained pursuant to a federal statute designed to protect the rights of employees with respect to certain Health Plans. The formal name of the statute is the "Employee Retirement Income Security Act of 1974," as amended or "ERISA." ERISA requires that you be provided with certain information about the Plan including the following statement concerning your ERISA rights.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other principal Employer facilities, all Plan Documents, including copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions;
- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator, for which the Plan Administrator may make a reasonable charge; and
- Receive a summary of the Plan's annual financial report, which is required by law to be furnished to you.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For example, you may file suit in federal court to enforce any rights you feel were not granted. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you still have questions about the matters discussed or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Pension and Welfare Benefits Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

F. Independent Review

In the event of a benefit denial, you may be eligible to request an independent review.

If you meet the eligibility requirements, the Georgia Department of Community Health will coordinate an independent review on your behalf with an Independent Review Organization (IRO). The IRO will ensure that you have access to an objective third party review, which is not influenced by or affiliated with the health plan. Your right to an independent review is limited by specific eligibility guidelines:

1. You must have exhausted all levels of internal appeals
2. The cost of the services in question must exceed $500
3. Benefit denial must relate to a denial of coverage based on medical necessity or an experimental/investigational procedure

Alliant Health Plans will notify you if you are eligible for an independent review. If you have any questions about your right to an independent review, please contact the Customer Service phone number listed on your member ID card.

ARTICLE XI – COORDINATION OF BENEFITS

A. Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to pay health expenses when a person is covered by more than one Plan. Alliant follows rules established by Georgia law to decide which Plan pays first and how much the other Plan must pay. The objective is to make sure the combined payments of all Plans are no more than your actual bills.

When you or your family members are covered by another Group Plan in addition to this one, we will follow Georgia "Coordination of Benefits" rules to determine which Plan is primary and which is secondary. The Plan that has the first obligation to pay or provide services is called the primary Plan. Any other Plan that covers you is called secondary. You must submit all bills first to the primary Plan. The primary Plan must pay its' full benefits as if you had no other coverage. If the primary Plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary Plan.

Alliant pays for health care only when you follow our rules and procedures. If our rules conflict with those of another Plan, it may be impossible to receive benefits from both Plans, and you will be forced to choose which Plan to use.

An Allowable Expense means a Medically Necessary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. Dental care, vision, and hearing corrective devices are not Allowable Expenses. Also, when benefits are reduced under a primary Plan because you have not complied with the provisions of the primary Plan, the amount of such reduction is not considered an Allowable Expense.

Once you have provided Alliant with the information about other Contracts that cover you, Alliant will handle this coordination. This will be done according to the order of benefit determination explained below:

1. COB affects benefits in the following manner when you are covered by more than one Plan:
    a. If the total benefits of all Contracts exceed the Covered Services you receive, the benefits Alliant provides will be determined according to this provision;
    b. When Alliant is primary, benefits will be paid without regard to any other Contract; and
    c. When Alliant is secondary, benefits paid may be reduced and will not exceed the Allowable Expense remaining after payment by the other Contract.
2. Alliant will determine when we are primary or secondary according to the following order:
    a. The other Contract with no COB provision is always primary;
    b. The Contract covering the Member as an Employee, Member, or Subscriber other than as a Dependent is primary;
    c. When a Dependent is covered by more than one Contract of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the Contract that covered the parent longer will be primary and the Contract which covered the other parent for a shorter period is secondary. If a Dependent is covered by two Contracts of insurance and the other Contract does not have this COB rule, the rule of the other Contract will determine the primary and secondary Contract. If the parents are separated or divorced, the following rules apply:
        i. If the parent with custody has not remarried, his or her coverage is primary;
        ii. If the parent with custody has remarried, his or her coverage is primary, his or her Spouse's coverage is secondary and the coverage of the parent without custody is last;
        iii. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary from the date of decree.
3. When a Contract covers you as an Actively-at-Work Employee or a Family Dependent of such Employee and the other Contract covers you as a laid-off or retired Employee or as a Family Dependent of such person, the Contract that covers the Member as an Actively-at-Work Employee or Family Dependent of such Employee is primary.
4. When the rules above do not apply, the Contract that has covered you longer is primary.
5. If a Member or Dependent is entitled to, but not enrolled in Medicare, Alliant benefits are determined as if the person were covered under Medicare Parts A and B. Alliant benefits are determined as if the full amount that would have been payable under Medicare was actually paid.
6. If coverage under this Agreement is primary, benefits will be paid as if you have no other coverage. However, if the coverage is secondary, our payment will be calculated by subtracting the primary Plan's benefits for the services and supplies covered under this Agreement from our allowances for the services and supplies. If a person is hospitalized upon becoming a Member, any other Contracts covering the Member at the commencement of the Hospital admission will be primary for that Hospital confinement only.

7. By accepting coverage under Alliant's Plan, you agree to do two things to enable Alliant to coordinate benefits. First, when requested, you will supply us with information about other Contracts that cover you. Second, if Alliant makes a payment and later finds that the other coverage should have been primary, you will return the excess amount to us. By accepting coverage under the Alliant Plan, you have given us the right to obtain information needed from others to coordinate benefits.

B. Right of Recovery

If you or your covered Dependents have a claim for damages or a right to recover damages from a third party or parties for any Illness or Injury for which benefits are payable under this Plan, Alliant may have a right of recovery. Our Right of Recovery shall be limited to the recovery of the reasonable cash value of any services provided or benefits paid for identical covered medical services or expenses under this Plan but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Alliant's Right of Recovery may include compromise settlements.

You or your attorney must inform Alliant of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. Alliant will then notify you of the amount it seeks to recover for covered benefits paid. Alliant's recovery may be reduced by the pro-rata share of your attorney fees and expense of litigation.

ARTICLE XII – CONTINUATION OF ALLIANT COVERAGE

A. Group Continuation Coverage for Members of Groups with Fewer Than Twenty (20) Employees

Under certain circumstances, if you cease to meet eligibility requirements under Article III of this Document, you may be eligible for Group continuation coverage under your Group's Health Benefits Plan. Except where federal or state continuation coverage rules apply and provide to the contrary, Group continuation coverage will **not** be available if:

1. Your employment was terminated for cause;
2. Your coverage was immediately replaced by similar Group coverage;
3. If the Group Contract was terminated in its entirety or was terminated with respect to a class to which you belong; or
4. You were terminated because you failed to pay any required contribution.

ELIGIBILITY FOR CONTINUATION OF COVERAGE

5. Group Member and Dependents of Groups of Fewer than Twenty (20) Employees
    a. Has been a Group Member for at least six (6) months;
    b. Is an insured certificate holder or Subscriber;
    c. Employment was not terminated for Cause;
    d. Coverage was not terminated because of Member's failure to pay required contributions;
    e. Group coverage was not immediately replaced by similar coverage; and
    f. Group Contract was not terminated in its entirety or terminated with respect to the class to which Member belonged.

6. Other Qualifying Eligible Individuals of Groups of Fewer than Twenty (20) Employees
    a. Does not qualify as a Group Member;
    b. Has an aggregate of eighteen (18) months of creditable medical coverage with various Plans;
    c. Coverage was not terminated for failure to pay contributions or for acts of fraud or intentional misrepresentation; and
    d. Is not currently eligible for COBRA, Medicaid, and Medicare or under replacement Group coverage.

7. Group Members and Eligible Individuals continuously covered for six (6) months immediately prior to termination are entitled to have his/her coverage and coverage for Dependents continued as follows:
    a. For three (3) full months plus any fraction of the current month remaining after the date of termination;
    b. Payment of Premium must be made in advance of when such Premium becomes due during the coverage period (by cash, certified check or money order at option of Employer.) For continuation coverage the Premium may not exceed the amount of Premium paid by the Employer;
    c. Premium must include portion paid by Employer (if Employer no longer pays any of the Premium.)

B. Group Continuation Coverage Under Federal Law (Applies to Groups with Twenty (20) or More Employees)

On April 7, 1986, a Federal Law was enacted (Public Law 99-272, Title X referred to as "COBRA") requiring most Employers sponsoring Group Health Plans to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at Group rates in certain instances where coverage under the Plan would otherwise end. COBRA requires the Employer to notify you of certain rights and obligations you have under COBRA when you initially become covered by the Plan. This notice is intended to serve as the initial COBRA notice and to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA.

1. If you are an employee covered by the Plan, you have the right to choose continuation coverage for yourself and your Dependents if you lose Group Health coverage for the following reasons:
    a. Your termination of employment (for reasons other than gross misconduct); or
    b. A reduction in the hours of employment.

2. If you are the Spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose Group Health coverage under the Plan for any of the following reasons:
    a. The death of your Spouse;
    b. A termination of your Spouse's employment (for reasons other than gross misconduct);
    c. Reduction in your Spouse's hours of employment;
    d. Divorce or legal separation from your Spouse; or
    e. Your Spouse becomes entitled to Medicare.

3. In the case of a Dependent Child of an employee covered by the Plan, he or she has the right to continuation coverage if Group Health coverage under the Plan is lost for any of the following reasons:
    a. The death of a parent;
    b. A termination of a parent's employment (for reasons other than gross misconduct);
    c. Reduction in the parent's hours of employment;
    d. Parent's divorce or legal separation;
    e. A parent becomes entitled to Medicare; or
    f. The Dependent ceases to be a "Dependent" under the Plan.

4. Under COBRA, the employee or a family Member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a Child losing Dependent status under the Plan within sixty (60) days of the date of the event. If the employee or family Member does not provide the required notice within sixty days, COBRA coverage is not available. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and Dependents if the Employer commences a bankruptcy proceeding and these individuals lose coverage.

5. When the Plan Administrator is notified that one of these events has happened, the Plan Administrator, or its delegate, will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have sixty (60) days from the later of:
    a. Date you lose coverage because of one of the events described above; or
    b. The date of the notice informing you of the event and termination of coverage, to inform the Plan Administrator that you want continuation coverage.

    If you do not choose continuation coverage during this sixty (60) day period, your Group Health insurance coverage under the Plan will end.

6. If you choose continuation coverage during the election period, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. However, you will be charged the applicable COBRA Premium rate for the coverage, not to exceed more than 2% above the Premium rate for the Employer. Alliant will offer Group continuation coverage to you and your covered Dependents entitled to such coverage under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA), 29 U.S.C. § 1161-67, for the period of time COBRA requires that continuation coverage be provided:
        a. Eighteen (18) months if your employment terminates for any reason other than gross misconduct or you are not considered to be in active full time employment of the Employer as specified in Article III of this Document. The continuation coverage period will be a maximum of twenty-nine (29) months (rather than eighteen (18) months) if:

i. You or your covered Dependent is determined for purpose of Title II or Title XVI of the *Social Security Act* to be disabled as of the date your employment is terminated or your hours are reduced;
ii. The disabling condition continues for that period; and
iii. If notice of the determination of disability is provided within eighteen (18) months of the date of termination or reduction in hours and no more than sixty (60) days from the date of determination.

In addition, as to your Dependent, the eighteen (18) month period will be extended to a maximum of thirty-six (36) months if a second event (other than the Employer's bankruptcy) occurs during the initial eighteen (18) month continuation period;

b. Thirty-six (36) months if your Dependent becomes ineligible for coverage due to your death or enrollment in Medicare benefits, divorce, legal separation, or the loss of Dependent Child status. The thirty-six (36) month period will be measured from the date of the above-listed event unless you become enrolled in the Medicare program. In that case, the continuation coverage period for your Dependent begins on the date on which you became enrolled in the Medicare program (or, if applicable, the date of an earlier event) and extends for thirty-six (36) months from the date of enrollment. In the event of a divorce or legal separation or Dependent Child no longer qualifying for coverage as a Dependent, you or your Dependent will be responsible for notifying the Plan Administrator within sixty days after the date of the event;

c. A Child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary for the remainder of the COBRA coverage period. In accordance with the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption;

d. Coverage is subject to your and the Group's compliance with all COBRA requirements and with this Agreement. Group continuation coverage will cease upon termination of the Agreement. Unless otherwise by COBRA, Group continuation coverage under this section will also cease if:
i. You or your Dependents become covered (as an employee or otherwise) under a Group Health Plan that has no limitations or exclusions with respect to any pre-existing conditions that you or your Dependents may have;
ii. You or your Dependents become eligible in the Medicare program;
iii. You or your Dependents fail to pay the Premium for this coverage on time;
iv. The Employer no longer provides Group Health Plan coverage to any of its employees; or
v. The qualified beneficiary extends coverage for up to twenty-nine (29) months due to your disability and there has been a final determination that the individual is no longer disabled.

7. The *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA") restricts the extent to which Group Health Plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rules with these new limits as follows: If you become covered by another Group Health Plan and that Plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other Plan's pre-existing condition rule does not apply to you by reason of HIPAA's restriction on pre-existing condition clauses; the Plan may terminate your COBRA coverage.

8. You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage as described above. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

9. As mentioned above, under COBRA, you must pay the full Premium for your continuation coverage. The Administrator of COBRA must receive your first Premium payment, which includes all amounts due since the loss of coverage, within forty-five (45) days of the date you sign the election form. There is a thirty (30) day grace period for payment of the regularly scheduled premium. COBRA also says that at the end of the eighteen (18) month or thirty-six (36) month continuation coverage period.

C. Disability

Under federal law, you may be required to pay up to 150% of the Premium after the eighteenth (18th) month of COBRA continuation coverage if you are disabled under Title II or XVI of the Social Security Act at the time of the termination of employment or reduction in hours.

D. State Continuation for Members, Surviving/Divorced Spouses Age Sixty (60) Years or Older Following COBRA Termination

1. If a Member is age sixty (60) or older and the Member's coverage ceases due to termination of the Subscriber's employment with the Group, then the Member may have such coverage continue under this Evidence of Coverage.
2. If a Subscriber dies and his/her Spouse is age sixty (60) years or older at the time of the Subscriber's death, then the Spouse may continue coverage under this Evidence of Coverage for the Spouse and any other Family Dependent whose coverage would end because of the Subscriber's death.
3. If coverage of a Family Dependent who is the Spouse of a Subscriber ends due to divorce and the Spouse is age sixty (60) years or older at the time of the divorce, then the Spouse may continue coverage under this Evidence of Coverage for the Spouse and any other Family Dependents whose coverage would end because of the Subscriber's divorce.
4. The monthly Premium for the continuation will be no more than 120% of the total amount that would be charged if the eligible Member, divorced or surviving Spouse were a current Group Member.

This will **not** apply if:

1. The Subscriber has not been continuously covered under the Group Contract, or any other Group Health Plan that it replaced, for at least six (6) months prior to the date coverage would end.
2. Termination of employment is voluntary for other than health reasons.
3. Termination of coverage occurred because the Subscriber's employment was terminated for reasons which would cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the Employment Security Law.
4. Coverage ended due to the Subscriber's failure to make any Premium contribution when due.
5. Coverage is immediately replaced by a similar health care policy.
6. The Group Contract is terminated in its entirety or with respect to a class to which the Subscriber belongs.
7. The Subscriber is a Member of a Group with less than twenty (20) employees.

E. Special Continuation for Employees and Other Eligible Individuals Age Sixty (60) or Older

1. If you are age sixty (60) or older and your continuation coverage is terminated for any reason other than:
    a. Failure to make any required contributions;
    b. Cancellation of coverage for the class in which you belong;
    c. Reasons which would cause forfeiture of unemployment compensation; or
    d. Voluntary employment termination other than for health reasons; and
    e. If you have been covered by the Plan for at least six (6) consecutive months, you may continue the coverage by paying the required Premium to Alliant.
2. In no event will the continuation coverage extend beyond the earliest date below:
    a. The last day of the period for which the required contribution has been timely paid;
    b. The date that you become covered under another Group Plan;
    c. The date the Group policy is cancelled; or
    d. The date you become eligible for Medicare.
3. If your Dependent Spouse's and Child(ren)'s coverage would otherwise cease because of your death or because of your divorce or legal separation, and if, at the time of your death, divorce or legal separation your Dependent Spouse is sixty (60) years of age or older, your surviving or former Spouse may continue Dependent medical benefits for himself or herself and any Dependent Child(ren) subject to the provisions set forth above. In no event will the continuation coverage extend beyond the earliest of:
    a. The last day of the period for which the required contribution has been timely paid;
    b. The date that your surviving or former Spouse becomes covered under another Group Plan or eligible for Medicare;
    c. The date the Group policy is cancelled; or
    d. For any one Dependent, the date that Dependent ceases to qualify as a Dependent.
4. When you (or the Spouse or Dependent) elects regular continuation coverage, you (or the Spouse or Dependent) will be deemed to have elected this special continuation coverage after the regular continuation coverage terminates without any further action, assuming you (or the Spouse or Dependent) are eligible for the special continuation coverage on the date you elect regular continuation coverage. At the time the special coverage begins, the Premium

may be increased to 120% of the regular Premium charged to active Members and is due at the same time as Premium payments under regular continuation coverage.

ARTICLE XIII – ENTIRE CONTRACT

This Group Evidence of Coverage, Group Contract including the Endorsements, Riders, Application, Summary of Benefits and the attached papers if any, constitute the entire Contract of Insurance. No change in this policy shall be valid until approved by an executive officer of Alliant and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Clerical error within this Document shall not deprive an individual of Coverage under the Plan or create a right to additional benefits.

ARTICLE XIV – MEMBERS' RIGHTS AND RESPONSIBILITIES

MEMBERS' BILL OF RIGHTS

As a Member of Alliant, you probably have certain expectations. Your expectations no doubt include issues like service, care, and confidentiality. And you are correct. All of these are things to which you are entitled. They are your Rights as a Member of our Health Plan. Along with these Rights come Responsibilities. For your information and reference we have listed the Rights and Responsibilities below:

1. Available and accessible service that can be secured as promptly as appropriate for the symptoms presented in a manner that assures continuity and when Medically Necessary the right to Emergency Services available twenty-four (24) hours a day, seven (7) days a week.
2. Receive information regarding your health problems, treatment alternatives, and associated risks sufficient to assure an informed choice.
3. Privacy of your medical and financial records that will be maintained by Alliant or any Participating Provider in accordance with applicable law.
4. File a Complaint and/or Grievance according to the procedure as set forth in the appropriate Benefit Plan Documents if you experience a problem with Alliant or any Participating Provider.
5. Be treated privately, with respect and dignity.
6. Participate in decisions regarding your health care.
7. Access your medical records in accordance with applicable law.
8. Be provided with information about the Managed Care Organization, its services, the Practitioners providing care, and Members' Rights and Responsibilities.
9. Have a family member or designated person facilitate any care when you are unable to do so.

MEMBERS' RESPONSIBILITIES

1. Read the Benefit Plan Documents* and Member materials in their entirety and comply with the rules and limitations as stated.
2. Contact the Participating Providers to arrange for medical appointments as necessary.
3. Notify Participating Providers in a timely manner of any cancellation of an appointment.
4. Pay Deductibles, Co-payment or Co-insurance as stated in the Summary of Benefits at the time service is provided.
5. Coordinate or receive Pre-authorization or Pre-certification for services, when required, and comply with the limits of the authorization.
6. Carry and use your Alliant identification card and identify yourself as an Alliant Member prior to receiving medical services.
7. Use Participating Providers consistent with the applicable Benefit Plan.
8. Use Participating Providers for services that do not require written Pre-authorization.
9. Provide, to the extent possible, information needed by professional staff in caring for the Member.
10. Follow instructions and guidelines given by those providing health care services.

*Benefit Plan Documents include the Group Evidence of Coverage, Summary of Benefits and any applicable Rider(s).

IN-NETWORK SPINAL MANIPULATION RIDER

I. Definitions:

"Spinal Manipulation" – means detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of a related to distortion, misalignment or subluxation of or in the vertebral column.

II. Benefits:

A. Coverage will be provided for Spinal Manipulation, including diagnosis and related services, and limited to:

1. A per visit co-pay, equal to your PCP Office Co-payment (see your summary of benefits for details) *(Note: High Deductible Health Plans = subject to deductible and co-insurance)*

2. One visit and treatment per day

Eligible expenses will be paid at the stated percentage level as indicated on the Benefit Plan Summary for services rendered by participating providers. Co-pay's do not apply toward the annual maximum out-of-pocket.

THIS RIDER PROVIDES FOR SPINAL MANIPULATION HEALTH SERVICES TO THE EXTENT HEREIN LIMITED AND DEFINED

Issued by Alliant Health Plans, Inc.

In-Network Providers for this benefit can be found at:
http://www.activhealthcare.com

THIS CONTRACT PROVIDES FOR COMPREHENSIVE HEALTH CARE TO THE EXTENT HEREIN LIMITED AND DEFINED

Issued By

Alliant Health Plans, Inc.

A Provider Sponsored Health Care Corporation Certified Under The Applicable Laws of the State of Georgia

EVIDENCE OF COVERAGE

This Contract is between the Member who has executed an application for enrollment and Alliant Health Plans, Inc. (hereinafter referred to as "Alliant").

This Contract entitles the Member and Eligible Dependents to receive the benefits set forth herein, subject to the terms and conditions of this Contract, and upon payment of the Premium.

The Contract is duly executed as of the effective date confirmed by notice from Alliant.

Mark Mixer,
Chief Executive Officer

Obligations of Alliant and In-Network Providers

In accordance with the agreement between Alliant and its In-Network Participating Providers, In-Network Providers may not seek compensation from you for any of the Covered Services and supplies described in this Document or your Summary of Benefits except for Deductibles, Co-payments and Co-insurance.

If you are suffering from and receiving active health care services for a chronic or terminal illness or are an In-patient, you shall have the right to continue to receive health care services from that Physician for a period of up to sixty (60) days from the date of the termination of the Physician's Contract. If you are pregnant and receiving treatment in connection with a pregnancy at the time of the termination of that your Physician's Contract, you shall have the right to continue receiving health care services from that Physician throughout the remainder of that pregnancy, including six-weeks´ post delivery care. During such continuation of coverage period, the Physician shall continue providing such services in accordance with the terms of the Contract applicable at the time of the termination, and the Carrier, Plan, Network, Panel, and all agents thereof shall continue to meet all obligations of such Physician's Contract. You shall not have the right to the continuation provisions if the Physician's Contract is terminated because of the suspension or revocation of the Physician's license or if the Carrier, Plan, Network, Panel, or any agent thereof determines that the Physician poses a threat to your health, safety, or welfare.

A list of In-Network Participating Providers which is updated at least every thirty (30) days is published on our website at www.alliantplans.com