SimpleCare

CERTIFICATE OF COVERAGE

Group Health Plans

Alliant Health Plans

Alliant Health Plans is proud to be a Qualified Health Plan Issuer in the Small Business Health Options Program (SHOP) on the Health Insurance Marketplace.

If coverage was purchased by your employer through SHOP on The Health Insurance Marketplace:

- If your employer offers coverage to dependents you may add qualified new Dependents to your Plan by contacting your Plan Administrator or the Health Insurance Marketplace;
    - You must notify the Health Insurance Marketplace of the birth, adoption or placement for adoption and pay the required Premium within the 31-day period or the newborn or adopted child will be treated as a Late Enrollee.
    - Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to the Health Insurance Marketplace. Such confirmation must be furnished at the Member's expense. When the application is processed, the Effective Date will be the first of the month following your Group's Employee waiting period.
- All changes/terminations/removal of dependents are accomplished by notifying the Health Insurance Marketplace.

IF YOUR EMPLOYER PURCHASED THIS PLAN OFF THE HEALTH INSURANCE MARKETPLACE

1. The persons and their eligible family members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by Alliant. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein;
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. Alliant has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family members (if any) as Members of this Group plan.

The Group Master Contract (which includes this Certificate Booklet, and any amendments or riders) constitutes the entire Contract. All rights, which may exist, arise from and are governed by this Group Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all contracts and/or certificates which may have been issued previously by Alliant through the Plan Administrator. In-Network benefits are provided by Alliant.

The words “we,” “us,” and “our” refer to Alliant Health Plans The words “you” and “your” refer to the Member, Subscriber and each covered Dependent.

Mark Mixer
Chief Executive Officer

NOTICE: The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

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Please note:

- Certificate of Coverage is herein referred to as Certificate.
- Alliant Health Plans is herein referred to as Alliant.

Important Phone Numbers / Website

Customer Service

If you have a question related to medical benefits, call:

1-800-811-4793

If you have a question related to pharmacy/prescription services, call:

Navitus Customer Care
1-866-333-2757

24-Hour Nurse Advice Line: (855) 299-3087

Disease Management Program Phone/Fax: (800) 865-5922 / (866) 370-5667

Pre-Certification

Your In-Network Physician or Hospital should call the following number for Coverage Certification prior to admission:

Alliant Medical Management Department
1-800-865-5922

For Out-of-network benefits, you are responsible for obtaining Coverage Certification.

Please have your Alliant ID number available when you call.

Website

For access to all services, including our Provider Directory:

AlliantPlans.com

HealthCare.gov

The Small Business Health Options Program (SHOP)

1-800-706-7893 or healthcare.gov

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

Google play

Available on the iPhone App Store

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

The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

The PPACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms—including mandates, subsidies, and tax credits—to employers and individuals to increase the coverage rate. Additional reforms aim to improve healthcare outcomes and streamline the delivery of health care. The PPACA requires insurance companies to cover all applicants and offer the same rates regardless of pre-existing conditions or sex. The Congressional Budget Office projected that the PPACA will lower both future deficits and Medicare spending.

On June 28, 2012, the United States Supreme Court upheld the constitutionality of most of the PPACA in the case National Federation of Independent Business v. Sebelius.

The PPACA includes numerous provisions to take effect over several years beginning in 2010. There is a grandfather clause on policies issued before then that exempt them from many of these provisions, but other provisions may affect existing policies.

- Guaranteed issue will require policies to be issued regardless of any medical condition, and partial community rating will require insurers to offer the same premium to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tobacco use).
- A shared responsibility requirement, commonly called an individual mandate, requires that all individuals not covered by an employer sponsored health plan, Medicaid, Medicare or other public insurance programs, secure an approved private-insurance policy or pay a penalty, unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service, or waived in cases of financial hardship.
- Health insurance exchanges will commence operation in each state, offering a Health Insurance Marketplace where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy if eligible).
- Low-income individuals and families above 100% and up to 400% of the federal poverty level will receive federal subsidies on a sliding scale if they choose to purchase insurance via an exchange.
- The text of the law expands Medicaid eligibility and simplifies the CHIP enrollment process. In National Federation of Independent Business v. Sebelius, the Supreme Court effectively allowed states to opt out of the Medicaid expansion, and some states (including Georgia) have chosen to exercise their opt-out privilege. States that choose to reject the Medicaid expansion can set their own Medicaid eligibility thresholds, which in many states are significantly below 133% of the poverty line; in addition, many states do not make Medicaid available to childless adults at any income level. Because subsidies on insurance plans purchased through exchanges are not available to those below 100% of the poverty line, this may create a coverage gap in those states.
- Minimum standards for health insurance policies, to include Essential Health Benefits, have been established and annual and lifetime coverage caps are banned.
- Firms employing 50 or more people but not offering health insurance will also pay a shared responsibility requirement if the government has had to subsidize an employee's health care.
- Very small businesses will be able to get subsidies if they purchase insurance through an exchange.

- Co-payments, co-insurance, and deductibles are to be eliminated for select health care insurance benefits considered to be part of an "essential benefits package" for Level A or Level B preventive care.

Alliant Health Plans has complied with every provision of the PPACA and:

- Eliminated Annual and Lifetime Limits;
- Installed a prohibition of rescission in accordance with regulations;
- Implemented zero-cost share preventive health service benefits;
- Extended coverage to dependents to age 26;
- Provides a Summary of Benefits Coverage to each member;
- Implemented an appeals process that complies with federal and state regulations;
- Prohibited pre-existing conditions from being excluded;
- Met the standards for fair premium, limited rating factors and compliant with the “metal” levels established by the Federal Government, where applicable;
- Made its plan(s) available on a guarantee issue basis and implemented a prohibition of discrimination;
- Exceeded the Essential Health Benefit benchmarks set by the Federal Government; to include out-patient prescription drug coverage, habilitative and pediatric vision and pediatric dental coverage; as well as Mental Health Parity.
- Implemented a prohibition on waiting periods that exceed 90-days;
- Provided coverage for participation in Clinical Trials that are approved.
- Employer-sponsored plans cannot discriminate in favor of highly compensated individuals as to eligibility to participate. In addition, the benefits provided under the plan cannot discriminate in favor of highly compensated individuals. Highly compensated individuals include the five highest paid officers, shareholders who own more than 10 percent of the stock, and the highest paid 25 percent of all employees.

IMPORTANT NOTE:
Coverage, eligibility and payments rules may differ based upon where the coverage you have was purchased. Some employers purchase plans through the Health Insurance Marketplace (SHOP) and others from Alliant Health Plans directly.

Plan purchased on The Health Insurance Marketplace may have slightly different rules regarding eligibility and how to make changes to coverage. See page 1 for more information.

In addition, when you see this symbol: 

carefully read this section so that you understand how to maximize your benefits.

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a **medical benefits inquiry** or **Verification of Benefits** during normal business hours (8:00 a.m. to 5:00 p.m. eastern time).

Please remember that a **benefits inquiry** or **Verification of Benefits** is **NOT** a verification of coverage of a specific medical procedure.

- Verification of Benefits is NOT a guarantee of payment.

- If the verified service requires pre-certification, please call 1-800-865-5922.

Pre-Certification – In-Network
(also known as Prior Authorization)

For pre-certification call 1-800-865-5922.

- Required by your Physician or facility for **ALL** in-patient hospital admissions that are In-Network.
- Please notify us by the next business day of an emergency or maternity admission;
- Non-Urgent Care pre- certifications can be requested during normal business hours (8:30 a.m. – 5:00 p.m. eastern time).
- Emergency services do **NOT** require Pre-Certification.

Pre-Certification – Out-of-Network
(also known as Prior Authorization)

For pre-certification call 1-800-865-5922.

- Required by **YOU** for **ALL** in-patient hospital admissions that are Out-of-Network.
- YOU are responsible for notifying us within 1-business day of an emergency or maternity admission, or your claim may be denied.
- Non-Urgent Care pre- certifications can be requested during normal business hours (8:30 a.m. – 5:00 p.m. eastern time).
- Emergency *services* do **NOT** require Pre-Certification.

Pre-Certification is a guarantee of payment for Covered Services; as described in this section (*and Alliant will pay up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned through Coverage Certification)* **except for the following situations:**

- The Member is no longer covered under this Contract at the time the services are received;
- The benefits under this Contract have been exhausted (examples of this include day limits);
- In cases of fraud or misrepresentation.

Pre- Certification approvals apply only to services which have been specified in the pre-certification and/or prior authorization list available on our website under provider resources. A pre-certification approval does not apply to any other services; other than the specific service being pre-certified. Payment or authorization of such a service does not require or apply to payment of claims at a later date regardless of whether such later claims have the same, similar or related diagnoses.

Summary Notice
This Certificate explains your health care benefit plan. This Certificate is written in an easy-to-read language to help you understand your health care benefits.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate carefully. If you have any questions about your benefits as presented in this Certificate, please call our Customer Service at **1-800-811-4793.**

The purpose of this Certificate is to help you understand your coverage.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. *English translation: If you need Spanish-language*

assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID card or in your enrollment booklet.

Eligibility

Coverage for You

This Certificate describes the benefits you may receive under your health care plan. You are called the Subscriber or Member.

- You or the Plan Administrator **must notify us in writing, by completing an enrollment application**. The Plan Administrator is the person named by your employer to manage the plan and answer questions about plan details. Coverage is provided only for those Dependents you have reported to Alliant and added to your coverage by completing the correct application.

Coverage for Your Dependents

If you are covered by this plan, you may have the right to enroll your eligible Dependents. Eligible dependents are determined by the Contract between Alliant Health Plans and your Employer.

Your employer may choose to offer coverage to:

- employee only; or
  - employee and spouse only; or
  - employee and child(ren) only; or
  - employee, spouse and child(ren)

Your Covered Dependents are also called Members.

Your Eligible Dependents May Include *(depending on your employers option of coverage)*:

- Your Spouse; provided you are not legally separated.
- Your Dependent children through the end of the month in which they attain age 26.
- Your legally adopted children from the date you assume legal responsibility, through the end of the month in which they attain age 26,
- Your children for whom you assume legal guardianship and stepchildren, through the end of the month in which they attain age 26,
- Your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree, through the end of the month in which they attain age 26,
- Your children who are mentally or physically handicapped, regardless of age.
  - Eligibility for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract prior to reaching age 26. Certification of the handicap is required within 31 days of attainment of age 26. A certification of the handicap may be required periodically but not more frequently than annually.

Late Enrollees

If you or your Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, you may be eligible for special enrollment as set out below under the Special Enrollment Period section.

Open Enrollment

The Open Enrollment period is defined by your employer, but typically begins no earlier than 30 days prior to the renewal date of an employer's contract.

Please contact your Human Resources Department for more information.

Special Enrollment Periods

Outside of the open enrollment period, the only other time you may change plans or add Eligible Dependents is under a Special Enrollment Period. During the Special Enrollment Period, qualified individuals (including dependents) may enroll in, and/or change, plans.

Plan choices are at the election of the employer. *(For the purpose of this section, "dependent" refers to any individual who is or who may become eligible for coverage because of a relationship to a qualified individual or enrollee).*

Qualifying Life Event	SEP Window	Effective date *(subject to review)*	Additional Information
• Birth • Adoption • Placement for Adoption	May apply 60 days before or after event, but effective date cannot be prior to the event. *For adoption, date of placement is defined as when adopting parents assume legal/financial responsibility.*	The effective date may be either the DOB or the 1st of the month following birth; except in cases of adoption where it is the date upon legal assumption. *(If the child is auto enrolled in a parents plan, the parents plan pays primary and ours secondary; even if the parents plan is with Alliant).*	• Although application can be made prior to the event, the event itself must actually occur and coverage cannot begin prior to the event. • Pregnancy is NOT a QLE, and will not be eligible until after the birth of the child. However, pregnancy may make an individual eligible for Medicaid.
Marriage	May apply 60 days before or after the marriage date.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of the 2nd month if rec'd after the 15th.	• All family members are eligible for the SEP • Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.

Qualifying Life Event	SEP Window	Effective date *(subject to review)*	Additional Information
Involuntary loss of Minimum Essential Coverage (MEC) and/or Loss of employer sponsored health insurance, as a result of: • Termination of employment • Employer reduces work hours to the point where no longer covered by the health plan • Employer's plan decides it will no longer offer coverage to a certain group of individuals for example, those who work part time) • Termination of employer contributions	May apply 60 days before event or up to 60 days after event. The "event" is the date that the coverage is lost.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	An SEP is **not** available in the following circumstances: • Voluntarily quitting other health coverage or being terminated for not paying premiums • Losing coverage that is not considered minimum essential coverage *(example: Limited Benefit Plan).* See separate event for termination of Short-Term-Medical coverage. (See STM below) • Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event. If offered COBRA coverage, individual is not required to take the COBRA coverage. Also see Exhaustion of COBRA
Loss of eligibility for Medicaid or CHIP	May apply 60 days before or after event, but effective date cannot be prior to the event. The event is the last day of coverage.	1st of the following month from a complete application submission.	• Individual must actually have been enrolled in Medicaid or CHIP plan, and are losing coverage. • Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.

Qualifying Life Event	SEP Window	Effective date *(subject to review)*	Additional Information
• Divorce/Legal Separation • Qualified Medical Support Order (QMSO)	May apply 60 days before or after event, but effective date cannot be prior to the event. Divorce: The event is the court ordered date of dissolution.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	• A court order to provide health insurance for a child is **not**, by itself, a QLE. There must be an underlying event like loss of coverage to make the child eligible for an SEP. • Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.
Loss of retiree coverage due to former employer filing for bankruptcy protection	May apply 60 days before or after event, but effective date cannot be prior to the event. The event is the last day of coverage.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.
Death of the policyholder	May apply 60 days before loss of coverage or up to 60 days after loss of coverage. The event date is the loss of actual coverage.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.
Gaining status as a citizen, national or lawfully present individual	60 days after event	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	
Discharge from active military duty	60 days after event	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	

Qualifying Life Event	SEP Window	Effective date *(subject to review)*	Additional Information
Loss of coverage due to a permanent move outside of the plan's service area	May apply 60 days before event or up to 60 days after event.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	• Individual must have lost coverage due to the move. If no coverage in place, a move is not a QLE. • New address must have a different ZIP code to be considered eligible • Individual is eligible even if current coverage is not being cancelled due to the move, or if never had coverage. • Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.
Move to a new service area	May apply 60 days before event or up to 60 days after event.	1st of the following month from a complete application submission if rec'd by the 15th and 1st of 2nd month if rec'd after the 15th.	• Although application can be made prior to the event, the event itself must take place and coverage cannot begin prior to the event.

Loss of coverage does not include voluntary termination of coverage or other loss due to—
(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
(2) Situations allowing for a rescission as specified in45 CFR 147.128.

If dependent coverage is made available by your employer, then Coverage is provided only for those Dependents you have reported to Alliant and added to your coverage by completing a correct and complete application. If you fail to enroll during the time allotted, you will have to wait until the next open enrollment period to enroll in a plan.

Remember, there may be an additional charge for adding additional covered person(s). If a Member does not apply during the allotted time, they will be considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

If your employer offers coverage to dependents, a newborn is covered automatically for 31 days from the moment of birth (or assumption of legal responsibility) in accordance with Georgia regulations. In the event that you choose to enroll your newborn in a different plan; Alliant is still required to cover the newborn under your plan for the first 31-days. In the event there is more than one insurance policy in force; Alliant will not pay more than would be paid under the original plan (the plan where the child is added per the State-of-Georgia required 31-days of coverage).

You must notify Alliant of the birth, adoption or placement by submitting a completed and correct application. You are also required to pay any additional Premium within the allotted time period or the newborn or adopted child will be treated as a Late Enrollee.

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

If your employer offers coverage to dependents, and your employer purchased this coverage outside the Health Insurance Marketplace, then foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to Alliant. Such confirmation must be furnished at the Member's expense. When a complete and correct application is received, the Effective Date will be the first of the month following your Group's Employee waiting period.

An individual who declined coverage must have certified in writing that he or she is covered by another health plan when he or she initially declined coverage under this Group in order to later qualify under this special enrollment. Persons declining coverage will be given notice of the consequences when they originally decline coverage.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child or a child placed for adoption, regardless of whether or not the adoption has become final.
- An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received a MCSO (a "Medical Child Support Order") which has been determined by the employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
- Upon receipt of an MCSO, the employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the employer to provide any type or form of benefit that it is not already offering.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must complete Special Enrollment within the allotted time period of the loss of Medicaid/CHIP or of the eligibility determination.

When Your Coverage Begins

If you apply when first eligible, your coverage will be effective on the date your Group's waiting period has been met. The Effective Date of coverage is subject to any waiting period provision your employer requires (which may not exceed 90-days).

Employee eligibility date
The *employee* is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the *group plan sponsor* and *us*; and
- The *employee* is in an *active status.*

Dependent eligibility date
Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*, or the date the child is legally adopted by the *employee*, whichever occurs first;
- The date the power of attorney is signed and notarized that authorizes grandparents and great grandparents the authority to act on behalf of a dependent grandchild until a copy of a revocation of the power of attorney is received; or
- The date specified in a Qualified Medical Child Support Order (QMCSO), or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

Where dependent coverage is made available, the *employee* may cover his or her *dependents* only if the *employee* is also covered. A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for group coverage under the *master group contract*.

Changing Your Coverage

There is an annual enrollment period during which time Members may elect to change their options. If your employer offers coverage to dependents you may add them during Open Enrollment or if qualified, during a Special Enrollment.

Family and Medical Leave

For groups with 50 employees or greater, if a covered Employee ceases active employment due to an employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage if any contribution is required.

For groups with fewer than 50 employees and not subject to the Family and Medical Leave Act of 1993 (FLMA), coverage will cease when the employee no longer meets the definition of an ‘active at work’ status as defined in the Group Master Contract. The member may have access to certain rights, such as State Continuation.

Changing Your Coverage or Removing a Dependent

When any of the following events occur, notify your employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see “When Your Coverage Terminates”);
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work During Initial Eligibility Period

Initial Enrollees
After a group takeover, if a Member (or a Dependent) had coverage under a prior carrier and is now covered under an extension of benefits provision, the Member (or Dependent) will be enrolled for coverage under this Contract. However, the prior carrier's extension of benefits provision makes the prior carrier responsible for payment of benefits and services relating to disabilities in accordance with the terms of its coverage and state law. To the extent benefits and services are not covered by the prior carrier's extension of benefits provision, payment will be made under this Contract in accordance with the ordinary Contract rules covering such benefits and services.

New Hires
If an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. Active status is generally defined by being paid wages.

Portability Provision
Any newly eligible Employee, Member, Subscriber, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately. The Effective Date of coverage is subject to any waiting period your employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Group Contract.

Certification of Prior Creditable Coverage
If your coverage is terminated, you and your covered Dependents will automatically receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health plan. Certification may be requested within 24 months of losing coverage. If you have any questions, contact Customer Service at the telephone number listed on the back of your Alliant Identification Card.

Eligibility

How Your Benefits Work for You
Whether your employer purchased coverage through the Health Insurance Marketplace or not, there is no difference in the benefits this contract provides.

Note: Terms such as Covered Services, Medical Necessity, In-Network Hospitals and Out-of-Pocket Limit are defined in the Definitions section.

Introduction
All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied. A Member has direct access to primary and specialty care directly from any In-Network Physician.

Physicians and Hospitals participating in our Networks are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement.

You also may receive care from a Physician Assistant (PA) or Nurse Practitioner (see "Definitions" section). For a list of In-Network providers and facilities, please visit AlliantPlans.com or call Customer Service at 1-800-811-4793.

Preferred Provider Option

Your health insurance plan is a comprehensive benefit plan called a "Preferred Provider Plan." This means that you have a choice when you go to a Physician, Hospital or other health care provider. The Contract is divided into two sets of benefits: In-Network and Out-of-network. If you choose Out-of-Network benefits, you will pay more. Each time you visit a provider, you will have that choice to make. That's why it's called Preferred Provider.

By visiting AlliantPlans.com you can choose a provider or practitioner from our network. You also may contact Alliant Customer Service at 1-800-811-4793 and a representative will help you find an In-Network Provider. After selecting a provider, you may contact the provider's office directly to schedule an appointment.

Out-of-Service-Area Provider Coverage

A member who needs a medical provider, physician or facility outside of our service area, can locate an In-Network Provider by contacting Alliant Customer Service at 1-800-811-4793.

Copayment or Out-of-Pocket

Whether you choose In-Network or Out-of-Network benefits, you will be charged a cost-share. Cost-sharing is a Copayment or an Out-of-Pocket amount for certain services, which may be a flat-dollar amount or a percentage of the total charge. Any cost-share amounts required are shown in the **Summary of Benefits and Coverage's**.

If applicable, any emergency room Copayment is waived when a Member is admitted to the Hospital through the emergency room.

The Calendar Year Deductible

Before this plan begins to pay benefits, other than for preventive care, you must meet any **Deductible** required. Deductible requirements are stated in the **Summary of Benefits and Coverage's**.

Carry Over Deductible

When insured by this group health plan, Covered Services during the last three months of a calendar year applied to that year's Deductible can carry over and also apply toward the next year's Deductible. If a change is group plans is made during the last 3-months of a calendar year, the deductible carry-over is restricted to the time period covered under the "newest" group health plan with Alliant Health Plans.

Coinsurance and Out-of-Pocket Limit

The portion which you must pay (the Coinsurance) is stated in the **Summary of Benefits and Coverage's**. After you reach your Out-of-Pocket Limit (including any required Deductible), your Contract pays 100% of the Maximum Allowable Amount for the remainder of the calendar year.

Out-of-pocket Limits are accumulated separately for In-Network and Out-of-Network Providers.

See the Summary of Benefits and Coverage's to determine if you have an In-Network Coinsurance amount and In-Network Out-of-Pocket Limit.

Annual and Lifetime Limits

There is no annual or lifetime dollar limit for Covered Services that are Essential Health Benefits.

Consumer Choice Option **(Please note the following applies only if you purchased the Consumer Choice Option at enrollment; and your employer purchased coverage off The Health Insurance Marketplace)**

The Consumer Choice Option allows you to nominate an Out-of-Network Provider (limited to a physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, licensed marriage and family therapist, chiropractor, qualified athletic trainer (per OCGA 43-5-8), occupational therapist, speech language pathologist, audiologist, dietitian, physician's assistant or Hospital) for specified Covered Services. Such nominated providers must be approved in writing by Alliant and are subject to the normal rules and conditions which apply to a contracted Network Provider. These terms include reimbursement (who we pay and how much), utilization management protocols (pre-certification procedures and our internal procedures enabling us to pay for Covered Services), Prescription Drug Formulary compliance (making sure we pay for drugs on our approved list), Referral to Network or Non-Network Providers, and other internal procedures which Alliant normally follows. All Non-Network Providers must be nominated, agree to participate and be approved. Please remember that, while you may obtain benefits at In-Network levels from an approved, nominated provider, these providers have not gone through Alliant's rigorous credentialing process, and they are not subject to Alliant's quality assurance standards.

The nominated provider is not an In-Network Provider and has not been credentialed by Alliant. The Member alone is responsible for the selection of the nominated provider and Alliant has not undertaken any credentialing or quality assurance measures regarding such nominated provider. Alliant will not undertake to conduct routine quality assurance measures which are used for In-Network Providers. The Member should understand that any and all Physicians, Hospitals and any others who are not In-Network Providers must be nominated by the Member (patient) and approved by Alliant prior to any services being performed by the provider in order for the services to become eligible for reimbursement at In-Network benefit levels. For additional information, please contact your Plan Administrator.

Provider Nomination
Under the Consumer Choice Option, you may nominate any Hospital or provider listed above licensed to practice in the state of Georgia to render specified Covered Services. However, you do **not** have free unrestricted access to non-nominated providers or to providers who have been nominated by you but not yet approved by Alliant.

The nomination process includes several steps:

- You may obtain copies of the nomination form by calling Customer Service at 1-800-811-4793.
- Complete and sign the first section of the nomination form then give to your provider.
- The provider signs the second part of the form, indicating they may be interested in acting as your provider, subject to Alliant's terms and conditions.
- The provider requests authorization for specific procedures (or ongoing medical treatment). The provider submits the form to Alliant.
- Alliant Health Plans verifies the licensure of the provider and notifies the provider of the applicable fee schedule or potential reimbursement.
- The provider, after receiving the notice of the potential reimbursement, signs and returns the form to Alliant.
- Alliant notifies you and your provider if and when the fully completed form has been received and approved.

A decision will be made by Alliant within three days of the receipt of the fully completed nomination form. Please note that approval is made only for the requested procedure. Additional procedures must be requested and approved by Alliant.

It is important to remember that only after all these steps and all other Contract requirements have been followed are Covered Services paid when provided by a Non-Network Provider.

What Your Plan Pays

In order to assist you in understanding the Maximum Allowed Cost (MAC) language as described below, please refer to the definition of In-Network Provider, Out-of-Network Provider and Non-Preferred Provider contained in the Definitions section of this booklet.

Maximum Allowed Cost (MAC) Cost (MAC)

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-network Providers is based on this plan's Maximum Allowed Cost (MAC) Cost (MAC) for the Covered Service that you receive.

The Maximum Allowed Cost (MAC) Cost for this plan is the maximum amount of reimbursement Alliant will pay for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that is provided in accordance with all applicable preauthorization, utilization management (*i.e.*, coverage certification) or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Cost (MAC) Cost to the extent you have not met your Deductible nor have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-network Provider, you may be responsible for paying any difference between the Maximum Allowed Cost (MAC) and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from an eligible Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Cost (MAC). Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Cost (MAC) will be based on the single procedure code rather than a separate Maximum Allowed Cost (MAC) for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, we may reduce the Maximum Allowed Cost (MAC)s for those secondary and subsequent procedures because reimbursement at 100% for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Cost (MAC) may vary depending upon whether the Provider is an In-Network or an Out-of-network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Cost (MAC) for this plan is the rate the Provider has agreed with Alliant to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Cost (MAC) as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Cost (MAC). However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Cost

(MAC) to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit **AlliantPlans.com.**

Providers who have not signed any contract with us and are not in any of our networks are Out- of-Network Providers.

For Covered Services you receive from an Out-of-Network Providers (other than emergency services), the Maximum Allowed Cost (MAC) for this plan will be one of the following as determined by Alliant:

1. An amount based on our Out-of-Network fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Alliant, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
3. An amount negotiated by us or a third- party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Cost (MAC) calculated by using one of the methods described above.

The Maximum Allowed Cost (MAC) for Out-of-Network Emergency Services are calculated as described in the Department of Labor Regulation 29 CFR 2590.715-2719A(b)(3)(i)(A), (B) & (C); with respect to emergency services will calculate cost-sharing as:

1. The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or co-insurance imposed;
2. The amount for the emergency services calculated using the same method as described above for out-of-network services, excluding any in-network copayment or coinsurance imposed; or
3. The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Cost (MAC). You are responsible for paying the difference between the Maximum Allowed Cost (MAC) and the amount the Provider charges. This amount can be significant. Choosing an In-Network provider will likely result in lower out-of-pocket costs to you. Please call Customer Service at **1-800-811-4793** for help in finding an In- Network Provider or visit our website at **AlliantPlans.com.**

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Cost (MAC) as your cost share amount (e.g., Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Summary of Benefits and Coverage's for your cost share responsibilities and limitations, or call Customer Service to learn how this plan's benefits or cost share amounts may vary by the type of Provider you use.

Alliant will not provide any reimbursement for Non-Covered services. You will be responsible for the total amount billed by your Provider for Non-Covered services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Both services specifically excluded by the terms of your policy/plan and those received after benefits have been exhausted are Non-covered services. Benefits may be exhausted by exceeding, for example, day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Cost (MAC) and the Out-of-Network Provider's charge.

Example:
Your plan has a Coinsurance cost share of 20% for In-Network services, and 30% Out-of-Network after the in- or out-of-network deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- *The Out-of-Network anesthesiologist's charge for the service is $1,200. The Maximum Allowed Cost (MAC) for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1,200 and $950. Provided the deductible has been met, your total out of pocket responsibility would be $190 (20% coinsurance responsibility) plus an additional $250, for a total of $440.*

- *You choose an In-Network surgeon. The charge was $2,500. The Maximum Allowed Cost (MAC) for the surgery is $1,500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1,500, or $300. We allow 80% of $1,500, or $1,200. The Network surgeon accepts the total of $1,500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.*

- *You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2,500. The Maximum Allowed Cost (MAC) for the surgery service is $1,500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1,500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1,500, or $1,050. In addition, the Out-of-Network surgeon could bill you the difference between $2,500 and $1500, so your total out of pocket charge would be $450 plus an additional $1,000, for a total of $1,450.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Cost (MAC) and the Out-of-Network Provider's charge.

Please contact Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In- Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Cost (MAC) is $200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and Alliant will be responsible for the remaining $175 of the $200 Maximum Allowed Cost (MAC).

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Cost (MAC) of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

Coverage Certification

Certification

Some benefits require certification. To certify a benefit or service, your provider should call the Utilization Management Department at 1-800-865-5922. Certifications are given for services based on Medical Necessity, see "Definitions". Alliant also applies key utilization management procedures such as pre-service review, urgent concurrent review and post-service review.

If you have questions about how a certain service is approved, call Alliant at 800-865-5922. If you are deaf or hard of hearing, dial 711 for the National Relay Service. We will be happy to send you a general explanation of how that type of decision is made or send you a general explanation of the overall approval process if you request it.

	Timeframe for Decision
Urgent Care Service	As soon as possible, but no more than 72 hours after receipt of the request for service. If more information is needed to make a decision, Alliant will notify you within 24 hours of the request for service of the needed information. Alliant will make a decision within 72 hours of receipt of the request for services decision Alliant will regardless of the receipt of the requested additional information. *(Alliant will provide oral notification of its decision within 72 hours of the initial request)*
Pre-Service Certification	Within 15 days. Alliant may extend the 15-day period for an additional 15-days because of matters beyond Alliant's control. If this is necessary Alliant will let you know in writing within the first 15 days. If the delay is because Alliant needs more information to make a decision, you will have up to 45-days to provide the needed information.

Concurrent Services Certification	Within 24 hours of request for services involving Urgent Care Services. For other requests a decision will be made within 15 days.
Post-Service Certification	Within 15 business days for electronic claims and 30 calendar days for paper claims. Alliant may extend the initial time periods for an additional 15-calendar days because of matters beyond Alliant's control. If this is necessary Alliant will let you know in writing within the first 15 business days or 30 calendar days. If the delay is because Alliant needs more information to make a decision, you will have up to 45 calendar days to provide the needed information.

For purposes of this Coverage Certification section, "Urgent Care Services" means any medical care or treatment with respect to which the application of the time periods for making non-Urgent Care Services determinations (A) could seriously jeopardize your life or health or your ability to regain maximum function or (B) in the opinion of the attending Provider, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the certification.

A listing of the benefits requiring Pre-Certification can be found on our website: AlliantPlans.com or by calling Customer Service at 1-800-811-4793. The Pre-Certification list is subject to change.

Benefits

All Covered Services must be Medically Necessary, whether provided through In-Network or Out-of-network Providers**.**

Allergy Conditions

Benefits are provided as stated in the **Summary of Benefits and Coverage's**.

Ambulance Service

Benefits are for local service to the nearest appropriate facility in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance to the nearest appropriate facility is covered subject to Medical Necessity.

Anesthesia Services for Certain Dental Patients

Pre-certification is required. General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

- Patients age seven or younger, or developmentally disabled.
- An individual for whom a successful result cannot be expected by local anesthesia due to a neurological disorder.
- An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Assistant Surgery

If Medically Necessary, services rendered by an assistant surgeon are covered in conjunction with a surgery which has been coordinated by the Member's surgeon, or for Out-of-Network Care which has been Pre-Certified by Alliant.

Autism

Autism means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

This Contract shall provide benefits for the diagnosis of autism in accordance with the conditions, schedule of benefits, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost-sharing arrangements and copayment requirements which exist in this contract for neurological disorders.

This contract provides for habilitative or rehabilitative services (including applied behavior analysis) and other counseling or therapy services necessary to develop, maintain, and restore the functioning of an individual with ASD who is six years of age or under. There is an annual cap of $30,000 on claims paid for applied behavior analysis for the purpose of treating a person with ASD when applying the benefits required by Georgia House Bill 429. This cap only applies to applied behavior analysis and does not apply to the other treatments (such as counseling or therapy services) which may be required by HB 429.

Breast Cancer Patient Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member. Additional charges may apply. Mastectomy bras are covered; up to 2 per calendar year.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas

Cardiac Rehabilitation

Programs require prior authorization and individual case management.

Chiropractic Care

One of the Covered Services is for In-Network Spinal Manipulation. There is a limit to the number of visits. Call Customer Service at 800-811-4793 to verify any limitations.

Clinical Trial Programs for Treatment of Children's Cancer

Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and benefits to Members who are Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. "Routine patient care costs" means those pre-certified as Medically Necessary costs as provided in Georgia law (OCGA 33-24-59.1)

Clinical Trial Programs Required by PPACA

Covered Services include routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without your consent. To qualify for such coverage you must:

- Be a Member,
- Be diagnosed with cancer or other life threatening disease or condition,
- Be accepted into an approved clinical trial (as defined below),
- Be referred by an Alliant doctor who is a Participating Provider,
- Receive Coverage certification from Alliant.

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is

conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and (1) the study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (3) the study or investigation is a drug trial this is exempt from having such an investigational new drug application.

If you qualify, Alliant cannot deny your participation in an approved clinical trial. Alliant cannot deny, limit or place conditions on its coverage of your routine patient costs associated with your participation in an approved clinical trial for which you qualify. You will not be denied or excluded from any Covered Services based on your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, cost sharing (*i.e.*, Deductible, Coinsurance and Copayments) will apply the same as if the service was not specifically related to an approved clinical trial. In other words, you will pay the cost sharing you would pay if the services were not related to a clinical trial.

Colorectal Cancer Examinations and Laboratory Tests

Covered Services include colorectal cancer screening examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening; which are not considered investigational or experimental

Complications of Pregnancy

Benefits are provided for Complications of Pregnancy (see “Definitions”) resulting from conditions requiring Hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Benefits for a normal or difficult delivery are not covered under this provision. Such benefits are determined solely by the maternity section of this Contract.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.

Diabetes

Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Dialysis Treatment

Dialysis treatment is covered if care has been Pre-Certified by and coordinated through your Physician. If services are rendered Out-of-Network, dialysis treatment is covered when Pre-Certification has been obtained from Alliant. If an out-of-network provider is elected, then out-of-network benefits are applied. This benefit will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

This plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity and applicable Pre-Certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. We may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patient's physical disorder.

Emergency Room Services / Emergency Medical Services

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for an emergency medical condition or serious Accidental Injury which requires immediate medical care. If you require emergency care, go to the nearest Emergency Room or call 911.

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

A Copayment may be required for In-Network and Out-of-Network care. Any applicable Copayment is waived if the member is admitted to the Hospital through the emergency room. The Copayment and/or percentage payable are shown in the Summary of Benefits and Coverage's and is the same for both In-Network and Out-of-Network care.

Eye Care

A Member who seeks c o v e r e d eye care may obtain such service directly from a participating ophthalmologist or optometrist who is licensed to provide eye care. Care is limited to medical conditions only, not routine vision care (except for children under age 19).

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure that is a Covered Service. Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are also covered.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Habilitative Services

We cover Medically Necessary habilitative services. Habilitative services are defined as healthcare services and devices that are designed to assist individuals acquiring, retaining or improving self-help, socialization, and adaptive skills and functioning necessary for performing routine activities of daily life successfully in their home and community based settings. These services include physical therapy, occupational therapy, speech therapy, and durable medical equipment.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits and Coverage's**. A visit consists up to four hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician.

Some special conditions apply:

- The Physician's statement and recommended program must be Pre-Certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note:
- Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Contract.
- A Member must be essentially confined at home.

Covered Services**:**

- Visits by an RN or LPN-Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Administration of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health do not include:

Food, housing, homemaker services, sitters, home-delivered meals; Home Health Care services which are not Medically Necessary or of a non-skilled level of care. Services and/or supplies which are not included in the Home Health Care plan as described.

- Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
- Any services or supplies not specifically listed as Covered Services.
- Routine care of a newborn child.
- Dietitian services.
- Maintenance therapy.
- Private duty nursing care.

Hospice Care Services

Hospice benefits cover inpatient and outpatient services for patients certified by a Physician as terminally ill.

Your Contract provides Covered Services for inpatient and outpatient Hospice care under certain conditions as stated in the **Summary of Benefits and Coverage's**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by Alliant;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
    - Provides an organized system of home care;
    - Uses a Hospice team; and
    - Has around-the-clock care available.

The following conditions apply:

- To qualify for Hospice care, the attending Physician must certify that the patient is not expected to live more than six months.
- The Physician must design and recommend a Hospice Care Program; and
- The Physician's statement and recommended program should be Pre-Certified.

Hospital Services

For In-network Care, your Physician must arrange your hospital admission. Your Contract provides Covered Services when the following services are Medically Necessary.

Inpatient

Inpatient Hospital Services

- Inpatient room charges. Covered Services include semiprivate room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Covered Services are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Covered Services are based on the Hospital's prevalent room rate. Pre-Certification is required for all Hospital admissions.

Services and Supplies

- Services and supplies provided and billed by the Hospital while you are an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient

Outpatient Services

- Your Contract provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require Pre-Certification.

Medical Emergency Care

- Care or treatment for a Medical Emergency is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life-threatening Medical Emergency. See "Definitions."
- The emergency room cost-share may be required for initial services for Medical Emergencies rendered in the emergency room of a Hospital. Physician notification, if not completed prior to emergency room visit, should occur within 48 hours of seeking emergency room care.
- Use of the emergency room for conditions that are not Medical Emergencies is **not** covered.

- A Member is responsible for the required cost-share, if applicable to your plan benefits. If a copayment is applicable, it is waived if the Member is admitted to the Hospital through the emergency room.
- Covered Services for Medical Emergencies include Medically Necessary mental health emergency care provided in the emergency room. Emergency care coverage includes care related to Medical Emergencies associated with substance abuse.

How to Obtain Care After Normal Office Hours

If you need medical attention after normal office hours because you need Urgent or Emergency Care, you can find an In-Network facility by contacting Customer Service or visiting AlliantPlans.com.

Urgent Care" means any medical care or treatment of a medical condition that (A) could seriously jeopardize your life or health or your ability to regain maximum function or (B) in the opinion of the attending Provider, would subject you to severe pain that cannot be adequately managed without care or treatment. Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital; and is not considered an emergency.

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are generally limited to one daily visit for each Physician during the covered period of confinement.

Licensed Mid-Level Providers

Benefits are also payable for Covered Services provided by licensed mid-level providers. Such providers include, but are not limited to, Nurse Practitioners (NP), Physician Assistant (PA), and Physician Assistant Anesthetists (PAA).

Licensed Speech Therapist Services

The visits must be Pre-Certified by Alliant. Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits and Coverage's.** Developmental Delay will be covered when it is more than two standard deviations from the norm as defined by standardized, validated developmental screening tests such as the Denver Developmental Screening Test. Services will be covered only to treat or promote recovery of the specific functional deficits identified.

Maternity Care (Pre and Post Natal Care)

Covered Services include Maternity Care on same basis as for any other type of care, subject to your Contract's Copayment and/or Deductible provisions.

Maternity benefits are provided for a female Employee and any eligible female Dependent. Routine newborn nursery care is part of the mother's maternity benefits. Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name (see "Changing Your Coverage" to add coverage for a newborn).

Under federal law, the Contract may not restrict the length of stay to less than the 48/96-hour periods or require Pre-Certification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

For In-Network Physician's care for prenatal care visits, delivery and postpartum visit(s), only one Copayment (if applicable) will be charged.

Medical and Surgical Care

Benefits include general care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Mental Health Care and Substance Abuse Treatment

Hospital Inpatient Mental Health Care & Substance Abuse Treatment

There are also benefits for Hospital and Physician Inpatient charges. These benefits are listed for each Member are stated in the Summary of Benefits and Coverage's**.**

Hospital Inpatient Alcohol and Drug Detoxification

There are benefits for acute alcohol and drug Detoxification. These benefits are listed for each Member in a Network Hospital are stated in the **Summary of Benefits and Coverage's**.

Benefits for professional fees for Inpatient Physician treatment of acute alcohol and drug Detoxification for each Member when administered by a Network Provider are stated in the **Summary of Benefits and Coverage's**.

Professional Outpatient Mental Health Care and Substance Abuse Treatment

Benefits for outpatient charges for each Member (50-55 minute sessions or their equivalent) are stated in the **Summary of Benefits and Coverage's**.

Other Medical Care Covered Services include:

- Professional care in the outpatient department of a Hospital;
- Physician's office visits;
- Services within the lawful scope of practice of a licensed approved Provider.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level Provider such as a licensed clinical social worker, mental health clinical nurse specialist, a licensed marriage and family therapist, or a licensed professional counselor.

Members can select a Mental Health Care provider or Substance Abuse Treatment provider from Alliant's network. Some benefits require pre-certification. Please have your provider call Alliant Health Plans Medical Management at 800-865-5922

Nutritional Counseling

Nutritional counseling related to the medical management of certain disease states (subject to Pre-Certification by Alliant).

Nutritional Counseling for Obesity

Covered Services for obesity include nutritional counseling visits when referred by your Physician. There may be limitations. To verify, please contact Customer Service at 800-411-8793. Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

Oral Surgery

Pre-Certification is required. To obtain the highest level of benefits, Pre- Certification from an In-Network Physician is required. If out-of-network, the member must obtain pre-certification.

Covered Services include only the following:

- Bony Impacted teeth
- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure.
- Oral surgery precipitated or caused by TMJ.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this Certificate Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (Donor Costs), post-operative care (including anti-rejection drug treatment, if Prescription Drugs are covered under the Contract) and transplant related chemotherapy for cancer limited as follows.

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- Removed from and replaced in the same person's body (called a self-donor).

A covered transplant means a Medically Appropriate transplant.

Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.

- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
- Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
- Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
- Neuroblastoma, Stage III or Stage IV;
- Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have HLA-compatible
- donor available for allogenic bone marrow support;
- Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
- Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed
- following response to first-line treatment;
- Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:

- Aplastic anemia;
- Acute leukemia;
- Severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
- Infantile malignant osteoporosis;
- Chronic myelogenous leukemia;
- Lymphoma (Wiscott-Aldrich syndrome);
- Lysosomal storage disorder;
- Myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- Medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- Preserving it; and
- Transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as non-transplant related under the terms of the Contract.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except Donor Costs and antirejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by Alliant.

"Professional Provider Transplant Services" means All Medically Necessary services and supplies provided by a professional Provider in connection with a covered transplant except donor costs and antirejection drugs.

Benefits for Antirejection Drugs

For antirejection drugs following the covered transplant, Covered Services will be limited to Prescription Drugs, if any, otherwise covered under the Contract.

Pre-Certification Requirement

All transplant procedures must be Pre-Certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by Alliant. To Pre-Certify, call the Alliant office using the telephone number on your Identification Card.

The Pre-Certification requirements are a part of the benefit administration of the Contract and are not a treatment recommendation. The actual course of medical treatment the Member chooses remains strictly a matter between the Member and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at an Alliant-approved Transplant Center. The donor, donor recipient, and the transplant surgery must meet required medical selection criteria as defined by Alliant.

If the transplant involves a living donor, benefits are as follows:

- If a Member receives a transplant and the donor is also covered under this Contract, payment for the Member and the donor will be made under each Member's Coverage.

- If the donor is not covered under this Contract, payment for the Member and the donor will be made under this Contract but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Member is the donor and the recipient is not covered under this Contract, payment for the Member will be made under this Contract limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Contract for the recipient.

Please see the "Limitations and Exclusions" section for Non-Covered Services.

Osteoporosis

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting Alliant's criteria.

Other Covered Services

Your Contract provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, when provided by a covered Physician
- Oxygen, blood and components, and administration
- Use of operating and treatment rooms and equipment

Outpatient Services

See the **Summary of Benefits and Coverage's** for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Outpatient services include facility, ancillary, facility use, and professional charges when given as an outpatient at a Hospital, Hospital freestanding facility, Retail Health Clinic, or other Provider as determined by us. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by us.

Outpatient Surgery

Hospital outpatient department or Freestanding Ambulatory Facility charges are covered at regular Contract benefits as shown in the **Summary of Benefits and Coverage's**. Some procedures require Pre-Certification or prior approval.

Ovarian Cancer Surveillance Tests

- Covered Services are provided for at risk women 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 clusters of women relatives with breast cancer,
        - (iii) of nonpolysis
        - colorectal cancer; or
    - (b) testing positive for BRCA1 or BRCA2 mutations.

- Surveillance tests means annual screening using:
    - (a) CA-125 serum tumor marker testing,
    - (b) transvaginal ultrasound, and
    - (c) pelvic examinations.

Physical Therapy, Occupational Therapy, Speech Therapy or Services of Athletic Trainers

Services by a Physician, a registered physical therapist (R.P.T.), or licensed occupational or speech therapist (O.T. and/or S.T.), limited to a combined total maximum visits per calendar year as outlined in the Summary of Benefits and Coverage's.

Out-of-Network care includes services for a licensed chiropractor (D.C.) or qualified athletic trainers. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from an In-Network or Out-of-Network Physician except where indicated. However, payment is significantly reduced, or not covered, if services are received from an Out-of-Network Physician. Such services are subject to applicable Deductible and Out-of-Pocket requirements.

As an Alliant member you can choose a provider from within our network by visiting AlliantPlans.com. You also may contact Alliant Customer Service at 1-800-811-4793 and a representative will help you locate an In-Network Provider or Practitioner. After selecting a provider you may contact the provider's office to schedule an appointment.

Preventive Care

Preventive Care services include outpatient services and office services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the diagnostic services benefit.

In-Network

Preventive care services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no Deductible, Co-payments or Co-insurance from the Member when provided by an In-Network Provider. That means Alliant pays 100% of the Maximum Allowed Cost (MAC). These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

   You may call Customer Service using the number on your ID card for additional information about these services. Information is also available at these federal government web sites:

   - http://www.healthcare.gov/center/regulations/prevention.html; or
   - http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/

Covered Services also include services required by state and federal law as outlined in the **Summary of Benefits and Coverage's**.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement for product years which begin one year after the date the recommendation or guideline is issued or on such other date as required by the Affordable Care Act. The product year, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Alliant may impose reasonable coverage limits on such preventive care as long as they are consistent with the Affordable Care Act and applicable Georgia law. These coverage limitations also are applicable to the preventive care benefits listed below.

Out-of-Network

The following services are covered Out-of-Network, subject to your Out-of-Network Deductible, Co-insurance and Out-of-Pocket requirements.

- Routine Mammograms;
- Pap Smear;
- Prostate Antigen Test;
- Annual Chlamydia Screening Test;
- Child Wellness Services - from birth through age five. These services are not subject to the calendar year Deductible. Covered Services are based on the standards for preventive pediatric health care published by the American Academy of Pediatrics. Child wellness services include:
  - Periodic Health Assessments (includes a medical history and appropriate physical exam);
  - Development assessment of the child;
  - Age appropriate immunizations; and
  - Laboratory testing.

Note: Preventive care services are not paid at 100% when utilizing out-of-network providers. They are paid as any other service, subject to deductibles and co-insurance.

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

The following items related to prosthetic devices include artificial limbs and accessories, artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s), arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal. Ankle, foot orthotics are covered to the extent that the orthotic extends from the foot to above the ankle.

The following items are **excluded:** corrective shoes, shoe inserts; night-splint; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic

injuries; bite-plates, oral splints ; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; or implants for cosmetic purposes except for reconstruction following a mastectomy.

Pulmonary Rehabilitation

Programs require prior authorization and Individual Case Management.

Reconstructive Surgery

Pre-Certification is required. Reconstructive Surgery does not include any service otherwise excluded in this Certificate Booklet. (See "Limitations and Exclusions")

Reconstructive Surgery is covered only to the extent Medically Necessary:

- To restore a function of any bodily area which has been altered by disease, trauma, Congenital/developmental Anomalies or previous therapeutic processes;
- To correct congenital defects of a Dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Registered Nurse First Assistant

Covered services are provided for eligible registered nurse first assistants. Benefits are payable directly to a registered nurse first assistant if such services are payable to a surgical first assistant and such services are performed at the request of a Physician and within the scope of a registered nurse first assistant's professional license. No benefits are payable to a registered nurse first assistant who is employed by a Physician or Hospital.

Second Medical Opinion

Covered Services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or, when Pre-Certified by Alliant, any medical care that is a Covered Service.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Summary of Benefits and Coverage's**. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this program pays the amount of the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a- day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for chronic brain syndromes for which no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Specialist Physician (Specialty Care)

A Member has direct access to specialty care directly from any In-Network Physician. A Member may access specialty care directly from a Specialist Physician; no PCP Referral is needed. You can locate a Specialist Physician on AlliantPlans.com or by calling Customer Service. Some services provided by a Specialist Physician may require Pre-Certification.

Telemedicine

The practice of telemedicine, by a duly licensed Physician or healthcare Provider, by means of audio, video or data communications (to include secured electronic mail) is a covered benefit.

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute telemedicine service and is not a covered benefit.

The use of telemedicine may substitute for a face-to-face "hands on" encounter for consultation. To be eligible for payment, interactive audio and video telecommunications must be used, permitting real-time communications between the distant Physician or practitioner and the Member/Patient. As a condition of payment, the patient (Member) must be present and participating.

The amount of payment for the professional service provided via telemedicine by the Physician or practitioner at the distant site is based on the current Maximum Allowed Cost (MAC) for the service provided. The patient (Member) is subject to the applicable Deductible and Coinsurance based upon his or her in-network benefits.

Urgent Care Services

Covered Services rendered at contracted Urgent Care Centers are covered as outlined in the **Summary of Benefits and Coverage's.**

Out-Patient Prescription Drug Program

[Be aware that large group plans are not required to offer out-patient prescription drug benefits; so verify coverage with your Human Resources Department if you are a member of a large group account).

This Plan uses a Pharmacy Benefits Administrator (PBM) for the administration of out-patient prescription drug benefits. Navitus is Alliant Health Plans PBM. Contact information for Navitus can be found on your plan ID card or simply call 1-866-333-2757.

The Navitus pharmacy network includes local and retail pharmacies throughout the United States. Members may obtain prescription drug and pharmacy assistance by calling the Navitus Customer Service team at 1-866-333-2757.

The Plan will provide coverage for drugs; supplies; supplements and administration of a drug (if such

services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a participating pharmacy. The Plan uses a Preferred Drug List, or formulary, which is a list of Prescription Drugs that are covered by the Plan. The Preferred Drug List includes drugs for a variety of disease states and Conditions. If you have questions regarding the Preferred Drug List or regarding your Outpatient Prescription Drug benefits, call the Customer Care Center for assistance, or visit our website at AlliantPlans.com to view the Preferred Drug List. Additional information regarding Prescription Drug Limitations and Exclusions can be found in the Exclusions section of this Evidence of Coverage document.

Covered Services are stated in the Summary of Benefits and Coverage's. All In-Network prescriptions must be written by either your Physician, a Network Physician designated by your Physician to provide services in his/her absence, an emergency room Physician (if your condition is a Medical Emergency), or a specialist who is a Network Provider.

Your benefit design as shown in the **Summary of Benefits and Coverage's** will determine the Copayment or Coinsurance of your Prescription Drug program for preferred formulary drugs and non-preferred drugs that are listed on the Drug Formulary as well as non-formulary drugs. For prescription drugs and diabetic supplies rendered by a pharmacy, the Maximum Allowed Cost (MAC) is the amount determined by us using prescription drug cost information provided by the pharmacy benefits manager.

At the time the prescription is dispensed; present your Identification Card at the Participating Pharmacy. The Participating Pharmacist will complete and submit the claim for you. If you do not go to a Participating Pharmacy, you will need to submit the itemized bill to be processed.

Benefits

The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug benefit when accompanied by a prescription.

This program allows for refills of a prescription within one year of the original prescription date, as authorized by your Physician.

A limited number of Prescription Drugs require Pre-Authorization for Medical Necessity. If Pre-Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Pre-Authorization, please call Customer Service.

Covered Services May Include:

Retail prescription medications that have been prescribed by a Network Provider and obtained through a Participating Pharmacy. Retail Prescription Drugs shall, in all cases, be dispensed according to the Drug Formulary for prescriptions written and filled In-Network and Out-of-Network. Only those Prescription Drugs included in the Drug Formulary, as amended from time to time by Alliant, may be Covered Services, except as noted below or otherwise provided in the Drug Formulary.

Specialty Drugs

Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require Pre-Authorization. You may obtain the list of Specialty Drugs and contracted Network Specialty Pharmacies by contacting Customer Service or online at AlliantPlans.com.

You or your Physician may order your Specialty Drugs from our Network Specialty Pharmac(ies). The first time a Specialty Drug is ordered for home use you will be asked to complete a Patient Profile

questionnaire. To obtain a Specialty Drug for home use, you must have a prescription for the drug which is signed by a Physician and which states the drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address. If the Specialty Drug is ordered via telephone, any Copayment or Coinsurance due can be paid by credit card or debit card. When submitting a paper prescription, a completed order form is required along with your Coinsurance or Copayment payable by check, money order, and credit or debit card.

Network Specialty Pharmacies will deliver your Specialty Drug prescriptions via common overnight carrier and are shipped directly to you or, if necessary, to a Network Provider for administration. Your treatment plan and specific prescription will determine where administration of the drug will occur and by whom.

Additionally, your Copayment and/or Coinsurance may be prorated to support the method of distribution and treatment. If a Network Provider charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the medication. Charges for drug administration are considered medical services which are subject to the Copayment, Coinsurance and percentage payable provisions as explained in the **Summary of Benefits and Coverage's**.

Specialty Pharmacies provide dedicated patient care coordinators to help you manage your condition and provides toll-free 24-hour access to nurses and registered pharmacists to answer questions regarding your medications. You or your doctor can order your Specialty Drug direct from the specialty pharmacies by simply calling 1-877-977-9118. We will work with you and your Physician to obtain prior authorization and to coordinate the shipping of your medication directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your prescription.

Tier Assignment Process

We have either established or delegate responsibility to a Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, step-therapy protocols, drug profiling initiatives and the like. Some of these programs will require additional information from your doctor in order to meet requirements. For more information about these programs and how Alliant Health Plans administers them, please contact Customer Service. When delegated, there will be a P&T Oversight Committee at the health plan level that has the responsibility of overseeing activities and decisions by the delegated entity.

The determinations of tiers is made by based upon clinical decisions provided by the P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternative; and where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

First-Tier, Second-Tier, Third-Tier, Fourth-Tier and Fifth-Tier Drugs

The amount you will pay for a Prescription Drug depends on whether the drug you receive is a first-tier, second-tier, third-tier, and fourth-tier or fifth-tier drug. Refer to your **Summary of Benefit and Coverage's** to determine your Copayment, Coinsurance and Deductible (if any) amounts. Prescription Drugs will always be dispensed as ordered by your Physician. You may request, or your Physician may order, the Brand Name Drug. However, if a Generic Drug is available, you will be responsible for the difference in the allowable charge between the Generic and Brand Name

Drug, in addition to your generic Copayment. The difference you will be charged between the two drug costs not including the copayment. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.

- **First-tier** drugs generally have the lowest cost-share. This tier will contain low-cost or preferred medications. This tier may include generic, single-source brand drugs, or multi-source brand drugs.
- **Second-tier** drugs will have a higher cost-share than first-tier drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single-source, or multi-source brand drugs.
- **Third-tier** drugs will have a higher cost-share than second-tier drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single- source brand drugs, or multi-source brands drugs.
- **Fourth-tier** drugs will have a higher cost-share than third-tier drugs. This tier will contain specialty medications. This tier may include generic, single-source brand drugs, or multi-source brands drugs.
- **Fifth-tier** drugs will not have cost sharing. This tier will contain drugs covered under the Preventive Guidelines of the Patient Protection and Affordable Care Act. This tier may include generic, single-source brand drugs, or multi-source brands drugs.

Note: Some plans may have fewer tiers than the five listed above.

Drug Formulary

A Member or prospective Member shall be entitled upon request, to a copy of the Drug Formulary Guide, available through the Member Guide, our website: AlliantPlans.com or as a separate reprint.

Alliant Health Plans offers several formularies. When seeking information, be sure that you are reviewing the formulary that is attached to your plan.

Alliant may only modify the Drug Formulary for the following reasons:

- Addition of new drugs, including generics, as they become available.
- Removal of drugs from the marketplace based on either FDA guidance or the manufacturer's decision.
- Re-classification of drugs from formulary preferred to formulary non-preferred or vice versa.
- All drug reclassifications are overseen by an independent Physician review committee.

Changes can occur:

- Based on new clinical studies indicating additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient;
- When multiple Similar Drugs are available such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma
- inhalers;
- When a Brand Name Drug loses its patent and generics become available; or

- When Brand Name Drugs become available over the counter.
- Re-classification of drugs to non-formulary status when Therapeutic/Clinically Equivalent drugs are available including over the counter drugs.

Similar Drugs mean drugs within the same drug class or type. Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

You will be notified in writing of drugs changing to non-formulary status at least 30 days prior to the Effective Date of the change if you have had a prescription for the drug within the previous 12 months of coverage under this plan. Drugs considered for non-formulary status are only those with Therapeutic/Clinically Equivalent alternatives.

You may use the prior authorization process to request a non-formulary drug. If your prior approval request is denied, you may exercise your right to appeal. For information regarding either the prior authorization or appeals process, please call the customer service number on your Identification Card. Georgia law allows you to obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Drug Formulary when:

- You have been taking or using the non-formulary prescription drug prior to its exclusion from the formulary and we determine, after consultation with the prescribing Physician, that the Drug Formulary's Therapeutic/Clinically Equivalent is or has been ineffective in the treatment of the patient's disease or condition; or
- The prescribing Physician determines that the Drug Formulary's Therapeutic/Clinically Equivalent drug causes, or is reasonably expected to cause, adverse or harmful reactions in the patient.

Special Pharmacy Programs

From time to time we may initiate various programs to encourage Members to utilize more cost-effective or clinically-effective drugs including, but not limited to, Generic Drugs, over-the-counter items (OTC), or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

Off-Label Drugs

When prescribed for an individual with a life-threatening or chronic and disabling condition or disease benefits are provided for the following:

- Off-Label Drugs
- Medically Necessary services associated with the administration of such a drug.

An Off-Label Drug is one that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration.

Other Program Provisions

Should the Member, on his or her own accord, choose a Brand Name Drug over a Generic Drug, regardless of whether a Generic equivalent is available and even if the Physician orders the drug to be "dispensed as written," the Member will pay the Copayment for the Generic Drug as outlined in the **Summary of Benefits and Coverage's, PLUS the difference in the cost of the two drugs.** The difference you will be charged between the two drug costs will not exceed $200 per prescription, not including the copayment.

The following are not Covered Services under this Contract:

- Prescription drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule;
- Prescription Drugs received through an Internet pharmacy provider or mail order provider except for our designated mail order provider;
- Newly approved FDA drugs that have not been approved for at least 180-days.
- Non-legend vitamins;

- Over-the-counter items;
- Cosmetic drugs;
- Appetite suppressants;
- Weight loss products;
- Diet supplements;
- Syringes (for use other than insulin) except when in coordination with an approved injectable;
- Non-contraceptive injectables (except with pre-certification);
- The administration or injection of any Prescription Drug or any drugs or medicines;
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued;
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order;
- Prescription Drugs for which there is no charge;
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use;
- Prescription Drugs for use as an Inpatient or outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients;
- Charges for delivery of any Prescription Drugs;
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs (except insulin);
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs;
- Prescription Drugs which are not Medically Necessary or which we determine are not consistent with the diagnosis (See Off-Label Drugs for exceptions);
- Prescription Drugs which we determine are not provided in accordance with accepted professional medical standards in the United States;
- Any services or supplies, which are not specifically listed as covered under this Prescription Drug program;
- Prescription Drugs which are Experimental or Investigational in nature as explained in the "Limitations and Exclusions" section;
- Prescription medicine for nail fungus except for immunocompromised or diabetic patients;
- Non-formulary drugs except as described in this Prescription Drug Program section.

Pediatric Vision Benefits

[Be aware that large group plans do have this benefit).

This section describes the services and supplies available to Covered Persons under age 19 only. These services and supplies must be provided and billed by Providers and must be Medically Necessary unless otherwise specified.

The following Routine Vision Care Services are covered:

Vision Examinations - Alliant will cover comprehensive examination components as follows:

- a case history
- general patient observation
- clinical and diagnostic testing and evaluation
- inspection of conjunctivae and sclera
- examination of orbits
- test visual acuity
- gross visual field testing

- ocular motility
- binocular testing
- examination of irises, cornea(s), lenses, and anterior chambers
- examination of pupils
- measurement of intraocular pressure (tonometry)
- ophthalmoscopic examinations
- determination of refract status
- color vision testing
- stereopsis testing
- case presentation including summary findings and recommendations including prescribing Lenses

Lenses and Frames - Alliant will cover the following services only when performed to obtain prescribed Lenses and Frames:

- facial measurements and determination of interpupillary distance
- assistance in choosing Frames
- verification of Lenses as prescribed
- after-care for a reasonable period of time for fitting and adjustment.

Contact Lens Evaluations and Follow-up - Alliant will cover contact lens compatibility tests, diagnostic evaluations, and diagnostic lens analysis to determine a patient's suitability for contact lenses or a change in contact lenses. Appropriate follow-up care is also covered.

Pediatric Vision Coverage is not provided for (in addition to those non-covered items listed in the "Exclusions" section of this Certificate):

1. For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
2. For Lenses which are not prescribed.
3. For the replacement of Lenses or Frames except as specified in the Schedule of Benefits.
4. For safety glass and safety goggles.
5. That Alliant determines are special or unusual; such as orthoptics, vision training and low vision aids.
6. For tints other than Number One or Two.
7. For tints with photosensitive or antireflective properties.
8. For progressive lenses.
9. For spectacle lens treatments or "add-ons", except for tints Number One or Two.
10. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).
11. For non-covered services or services specifically excluded in the text of this Certificate.

Pediatric Oral (Dental)

[Be aware that large group plans do have this benefit).

Pediatric oral (dental) benefits are available for members under age 19. This pediatric coverage is for a number of routine dental care procedures. For each evaluation you pay a $25 copayment when using in-network providers and Alliant Health Plans takes care of the rest. In order to receive benefits, you must

use a Preferred dentist, except if dental care is required due to an accidental injury. Below is a complete list of the covered procedures and fee schedule amounts. Any service not listed is not covered.

Clinical Oral Evaluations

Services	Alliant Pays	Member Pays
Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation*	All charges in excess of your $25 copayment	$25 copayment per evaluation

Dental Radiology

Services	Alliant Pays	Member Pays
Intraoral complete series, including bitewings (limited to 1 complete series every 3 years) Bitewing — single film** Bitewings — two films** Bitewings — four films**	All charges in excess of your $25 copayment	$25 copayment per evaluation

Preventive

Services	Alliant Pays	Member Pays
Prophylaxis — adult*** Prophylaxis — child*** Topical application of fluoride (prophylaxis not included) — child*** Sealant — per tooth, first and second molars only (once per tooth for children up to age 16 only)	All charges in excess of your $25 copayment	$25 copayment per evaluation
Not covered: Any service not specifically listed above	Nothing	All charges

* Benefits are limited to a combined total of two evaluations per person per calendar year.
** Benefits are limited to a combined total of four films per person per calendar year.
*** Benefits are limited to a combined total of two services per person per calendar year.

General Limitations and Exclusions

What Is Not Covered

Your coverage does not provide benefits for:

- **Abortion** and care for abortion are not covered.
- **Acupuncture** - Acupuncture and acupuncture therapy.
- **Allergy Services** - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- **Beautification Procedures** - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of

asymmetry, except when determined to be Medically Necessary by Alliant, is not covered.
- This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries
- when performed within two years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
- The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum.
- This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this Certificate Booklet.

- **Before Coverage Begins** - Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
- **Behavioral Disorders** - Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to, hyperkinetic syndromes, , learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
- **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.
- **Care, Supplies, or Equipment** - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
- **Complications** - Complications of non-covered procedures are not covered.
- **Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- **Court-Ordered Services** - Court-ordered services, or those required by court order as a condition of parole or probation.
- **Covered Services** - Any item, service, supply or care not specifically listed as a Covered Service in this Certificate Booklet.
- **Crime** - Injuries received while committing a crime as long as any injuries are not the result of a medical condition or an act of domestic violence.
- **Daily Room Charges** - Daily room charges while the Contract is paying for an Intensive Care, cardiac care, or other special care unit.
- **Dental Care** - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other

periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this booklet. Coverage for pediatric dental may be available based on eligibility circumstances.

- **Disposable Supplies** - Supplies, equipment or personal convenience items including, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags, unless Medically Necessary.
- **Drugs** - Any drug or other item which does not require a prescription.
- **Durable Medical Equipment** - The following items related to Durable Medical Equipment are specifically *excluded*:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports and orthopedic or corrective shoes; shoe inserts; orthopedic or correct shoes; shoe molds; and support stockings.
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - TENS units;
    - Sequential stimulators;
    - Conductive garmets;
    - Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment; light-box therapy for SADS;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which Alliant feels do not meet the listed criteria.
    - Duplicate medical equipment.
- **Employer-Run Care** - Care given by a medical department or clinic run by your employer.
- **Experimental or Investigational** - Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in Alliant's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- **Failure to Keep a Scheduled Visit** - Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
- **Foot Care** - Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
- **Foreign Travel** – Benefits do not include non-emergent care when traveling outside the United States. Benefits do include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. We cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange.
- **Free Services** - Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

- **Government Programs** - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- **Hair** - Hair transplants, hairpieces or wigs wig maintenance, or prescriptions or medications related to hair growth
- **Hearing Services** - Hearing aids, hearing devices and related or routine examinations and services.
- **Homes** - Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- **Hypnotherapy**
- **Ineligible Hospital** - Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
- **Ineligible Provider** - Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
- **Infertility** - Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.
- **Injury or Illness** - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness.
- **Inpatient Mental Health** - Inpatient Hospital care for mental health conditions when the stay is:
    - determined to be court-ordered, custodial, or solely for the purpose of environmental control;
    - rendered in a home, halfway house, school, or domiciliary institution;
    - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations.
- **Inpatient Rehabilitation** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Participant has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
- **Maximum Allowed Cost (MAC) –** Expenses in excess of the Maximum Allowed Cost (MAC) as determined by Alliant.
- **Medical Reports** - Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- **Medicare** - Services paid under Medicare or which would have been paid if the Participant 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 Participant has enrolled in Medicare Part B.
- **Methadone** - Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Contract has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
- **Miscellaneous Care** - Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital.

Ambulance transportation from the Hospital to the home is not covered.

- **Non-covered Services -** Services that are not Covered Services under the Contract.
- **Non-Physician Care** - Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.
- **Not Medically Required** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
- **Obesity** – 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 counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).
- **Orthoptics** - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- **Outpatient Therapy or Rehabilitation** - Services for outpatient therapy or rehabilitation other than those specifically listed in this Certificate Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, clinic changes and/or which are performed as a treatment for acne, services and supplies.
- **Personal Comfort Items** - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **Private Room** - Private room, except as specified as Covered Services.
- **Private Duty Nursing**
- **Provider** (Close Relative) - Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- **Routine Physical Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.
- **Safe Surrounding** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- **Sclerotherapy** - Sclerotherapy performed for cosmetic purposes and that is not medically necessary.
- **Self-Help** - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- **Sexual Modification/Dysfunction Treatments** - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
- **Shoes** - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

- **Skilled Nursing Facility** - Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
- **Telehealth** - Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.
- **Thermograms** - Thermograms and thermography.
- **Transplants** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
  - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
  - Transportation, travel or lodging expenses for non-donor family members;
  - Donation related services or supplies associated with organ acquisition and procurement;
  - Chemotherapy with autologous, allogenic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
  - Any transplant not specifically listed as covered.
- **Transportation** - Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered.
- **Treatment (Outside U.S.)** - Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
- **Vision** - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. This exclusion does not apply to vision for pediatric members under the age of 19.
- **Vision (Surgical Correction)** - Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- **Waived Fees** - Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, Alliant will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
- **War** - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- **Workers' Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Alliant does not pay for care of any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. The State Board of Workers' Compensation in Georgia requires that workers' compensation benefits are required if your employer has at least three or more employees. As many as five officers may waive coverage on themselves. If waived, Alliant may request a copy of the WC-10 as proof of waiver. If a member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another Alliant group plan, Alliant plan, any other group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under this Contract will be coordinated with the benefits payable under the other program/plan. The total benefits paid by us will not exceed 100% of the Allowable Expense, the per diem negotiated fee or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the programs/plans covering the person for whom the claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- Automobile Insurance
  Medical benefits available through automobile insurance coverage will be determined before that of any other program if the automobile coverage has either no order of benefit determination rules or it has rules which differ from those permitted under applicable Georgia Insurance Regulations.
- Non-Dependent/Dependent
  The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced
  Except as stated below, when this plan and another plan cover the same child as a Dependent of different persons, called "parents":
  - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that Year.
  - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

- Dependent Child/Parents Separated or Divorced
  If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child; and
  - finally, the plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the company has that actual knowledge.
- Joint Custody
  If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."
- Active/Inactive Employee
  The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- Longer/Shorter Length of Coverage
  If none of the above rules determine the order of benefits, the benefits of the plan which covered an Employee or Member longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this plan is a secondary plan to one or more other plans. In that event the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" below.

Reduction in this plan's benefits

The benefits of this plan will be reduced when the sum of:

- The benefits that would be payable for The Allowable Expenses under this plan in the absence of this provision; and
- The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this program will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Miscellaneous Rights

- Right to Receive and Release Necessary Information
  Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts needed to pay the claim.
- Facility of Payment
  A payment made under another plan may include an amount which should have been paid under this plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again.
- Right of Reimbursement
  If the amount of the payment made by us is more than it should have paid under this provision, we may recover the excess from one or more of:
  - the persons we have paid or for whom we have paid,
  - insurance companies, or
  - other organizations.

Right of Recovery

- If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this plan, we shall have a right of recovery. Our right of recovery shall be limited to the amount of any benefits paid for covered medical 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. Our right of recovery shall include compromise settlements. You or your attorney must inform Alliant of any legal action or settlement discussion, ten days prior to settlement or trial. We will then notify you of the amount we seek, and the amount of your legal expenses we will pay.
- Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 12 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final

determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

We have oversight responsibility for compliance with Provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

General Information

Member Rights and Responsibilities

Your rights as an Alliant Member

As a Member, you have the right to:

- Recommend changes to the Member's Rights and Responsibilities policy**.**
- Receive information about the Plan, its services, its Providers, and about your Rights and Responsibilities as a Member.
- Choose your Physician from the Plan's network directory listing In-Network Providers.
- Receive considerate and courteous service with respect for personal privacy and human dignity through the Plan in a timely manner.
- Expect the Plan to implement policies and procedures to ensure the confidentiality of all your personal health information.
- Understand where your consent is required and you are unable to give consent, the Plan will seek your designated guardian and/or representative to provide this consent.
- Participate in full discussion with your Provider concerning the diagnosis, appropriate or Medically Necessary treatment options, and the prognosis of your conditions, regardless of whether or not the information represents a covered treatment or benefit.
- Receive and be informed about where, when, and how to obtain all benefits to which you are entitled under your Contract including access to routine services, as well as after-hours and emergency services.
- Be informed of your Premiums, Deductibles, Copayments, and any maximum limits on Out-of-Pocket expenses for items and services.
- Receive Plan rules regarding Copayments and Pre-Certification including, but not limited to, Pre-Certification, concurrent review, post-service review, or post-payment review that could result in your being denied coverage of a specific service.
- Participate with Providers in the decision-making process concerning your health care.
- Refuse treatment and be informed by your Physician of the medical consequences.
- Receive specific information, upon your request, from Network Providers including, but not limited to, accreditation status, accessibility of translation or interpretation services, and credentials of Providers of direct care (limited to contracted Providers). Alliant encourages
- Network Providers to disclose such information upon Member request.
- Receive, upon request, a summary of how Physicians, Hospitals and other Providers are compensated using a variety of methodologies, including capitation, fee-for-service, per diem, discounted charges and global reimbursement.
- Express your opinions, concerns, or complaints about the Plan and the care provided by

Network Providers in a constructive manner to the appropriate people within the Plan and be given the right to register your complaints and to appeal Plan decisions.
- Receive, upon request, a summary of the number, nature and outcome of all formally filed grievances filed with the Plan in the previous three years.
- Receive timely access to medical records and health information maintained by the Plan in accordance with applicable federal and state laws.

Your responsibilities as an Alliant Member

As a Member, you have the responsibility to:
- Maintain your health and participate in the decisions concerning treatment.
- Ask questions and make certain that you understand the explanations and instructions you are given by your Physician, and comply with those conditions.
- Identify yourself as a Member when scheduling appointments or seeking specialty care, and pay any applicable Physician office Copayments at the time of service and Coinsurance or Out-of Pocket Limits in a timely manner.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Furnish information regarding other health insurance coverage.
- Treat all In-Network Physicians and personnel respectfully and courteously as partners in good health care.
- Permit Alliant to review your medical records as part of quality management initiatives in order to comply with regulatory bodies.
- Provide, to the extent possible, information that the Plan and its Providers need in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your Physician(s).

Financial Incentives

Utilization Management decision making is based only on the appropriateness of care and services, and the existence of coverage at the time the care was rendered. Alliant does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM staff or agents do not encourage decisions that result in underutilization.

Proof of Loss, Payment of Claims

In-network Providers

When services are provided by an In-Network Provider, claims will be filed by that Provider. You are not responsible for filing any claims when services are rendered by an In-Network Provider.

In-Network Providers are Providers who have signed a Network Contract with Alliant to provide Covered Services to Members covered under an Alliant contract.

It is anticipated that a Member will make payment to a Physician or Provider providing services under this Contract only to comply with those Copayments, Deductible, and Out-of-Pocket requirements outlined in the **Summary of Benefits and Coverage's**. We are authorized by you or the Group to make payments directly to the Provider of Covered Services.

Out-of-Network Providers

When Covered Services are rendered Out-of-Network, services are performed by Out-of-Network or Non-Preferred Providers. Each person enrolled through the Group's Contract receives an Identification Card. When admitted to an Alliant In-Network Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by your Group Contract. The Hospital will bill us directly for Covered Services.

For health care expenses other than those billed by an In-Network Hospital or licensed health care

Provider, your Provider should submit an itemized bill to Alliant. The claim should include your name, Member and Group ID numbers exactly as they appear on your Identification Card. Make certain the bills are itemized to include dates, places and nature of services and/or supplies. Be sure to keep a photocopy of all forms and bills for your records.

Balance Billing

In-Network Providers are prohibited from balance billing. In-Network Providers have signed an agreement with us to accept our determination of the Maximum Allowed Cost (MAC) for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of the Maximum Allowed Cost (MAC), except what is due under the Contract, e.g., Copayments, Deductibles or Coinsurance.

Filing and Payment of Claims

You are responsible for giving your provider your correct health insurance policy information so claims can be filed properly. Always make certain you have your Identification Card with you. Be sure Hospital or Physician's office personnel copy your name, Group and Member numbers accurately when completing forms relating to your coverage. Based on the health coverage information you provide, your provider will submit claims to us for payment.

If you are hospitalized outside Georgia, the claim for Hospital services is usually handled in the same manner as within the state and the Hospital files the claim through to Alliant Health Plans. It may, however, be necessary for you to pay the Hospital or attending Physician for his or her services and then submit an itemized statement to us when you return home.

If you need to submit a claim to Alliant Health Plans for services by an out-of-network provider or reimbursement for services you had to pay, you must submit a claim form to Alliant Health Plans. You can obtain a blank claim form by calling Customer Service at 1-800-811-4793.

- You have 90 days from the date of service to submit a properly completed claim form with any necessary reports and records.
- Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required to obtain incomplete or missing information. In which case, we will notify you within 15 working days of receipt for electronic claims and 30-calendar days of receipt for paper claims of the reason for the delay and list all information needed to continue processing your claim.
- After this information is received by us, claims processing will be completed during the next 15 working days for electronic claims and 30-calendar days for paper claims.
- We shall pay interest at the rate of 12% per year to you or your assigned Provider if we do not meet these requirements.

Processing Your Claim

You are responsible for submitting your claims for Covered Services not billed by and payable to a Hospital or Physician. Always make certain you have your Identification Card with you. Be sure Hospital or Physician's office personnel copy your name, Group and Member numbers accurately when completing forms relating to your coverage.

If you are hospitalized outside the service area, the claim for Hospital services is usually handled in the same manner as within the state and the Hospital files the claim through to Alliant Health Plans. It may, however, be necessary for you to pay the Hospital or attending Physician for his or her services and then submit an itemized statement to us when you return home.

Timeliness of Filing and Payment of Claims (Out-of-Network)

In the event you submit a claim to receive benefits, a properly completed claim form with any necessary reports and records must be filed by the Member within 90 days of the date of service.
Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, we will notify you within 15 working days of receipt for electronic claims and 30-calendar days of receipt for paper claims of the reason for the delay and list all information needed to continue processing your claim. After this information is received by us, claims processing will be completed during the next 15 working days for electronic claims and 30-calendar days for paper claims. We shall pay interest at the rate of 12% per year to you or the assigned Provider if we do not meet these requirements.

Physical Examinations

If you have submitted a claim and we need more information about your health, we can require you to have a physical examination. We would pay the cost of any such examination.

Non-Discrimination

Alliant does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, health status, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

Unauthorized Use of Identification Card

If you permit an Alliant Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or the Alliant Customer Service Department. Be sure to always give your Member ID number. If you wish to get a full copy of the Utilization Review plan procedures, contact the Customer Service Department.

Write

Alliant Health Plans
Customer Service Department
1503 N. Tibbs Rd
Dalton, GA 30720

When asking about a claim, give the following information:

- Member ID number;
- Patient name and address;
- Date of service;
- Type of service received; and
- Provider name and address (Hospital or doctor).

We Want You to be Satisfied

We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

Complaints about Alliant Health Plans Service

As an Alliant Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that we give our fullest

attention to your concerns. Please utilize it to tell us when you are displeased with any aspect of services rendered.

1. Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
2. If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will, hopefully bring the matter to a satisfactory conclusion for you.

Summary of Grievances

A summary of the number, nature and outcome results of grievances filed in the previous three years is available for your inspection. You may obtain a copy of any such summary at a reasonable cost from us.

Complaints about Provider Service

If your complaint involves care received from a Provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

We provide the benefits described in this booklet only for eligible Members. The health care services are subject to the limitations, exclusions, Copayments, Deductibles and percentage payable requirements specified in this booklet. Any Group Alliant Contract or Certificate which you received previously will be replaced by this Contract.

Benefit payment for Covered Services or supplies will be made directly to In-Network Providers. A Member may assign benefits to a provider who is not an In-Network Provider, but it is not required. If a Member does not assign benefits to an Out-of-Network Provider, any payment will be sent to the Member.

We do not supply you with a Hospital or Physician. In addition, we are not responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person.

In order to process your claims, we may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by an Alliant employee is not legally binding. Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying us of your new address.

General Information

Fraudulent statements on Subscriber application forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Both parties to this Contract (the employer and Alliant) are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, etc.

We will adhere to the employer's instructions and allow the employer to meet all of the employer's responsibilities under applicable state and federal law. It is the employer's responsibility to adhere to all applicable state and federal laws and we do not assume any responsibility for compliance.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Care Received Outside the United States

Non-emergency care is not a covered service outside the United States. You will receive Contract benefits for only emergency care and/or treatment received outside the United States. Contract provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. We will reimburse you directly. Payment will be based on the Maximum Allowed Cost (MAC). Assignments of benefits to foreign Providers or facilities cannot be honored.

Medicare

Any benefits covered under both this Certificate Booklet and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate Booklet provisions and federal law.

Except when federal law requires Alliant to be the primary payor, the benefits under this Certificate Booklet for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or
D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members, to the extent Alliant has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, Alliant will calculate benefits as if they had enrolled. For Medicare Part D, Alliant will calculate benefits upon receipt of the Member's Explanation of Medicare Benefits (EOMB) or Part D payment data obtained from an authorized Prescription Benefit Manager (PBM).

Governmental Health Care Programs

If you are enrolled in a group with fewer than 20 employees, your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program.

Under federal law, for groups with 20 or more employees, all active employees (regardless of age) can remain on the group's health plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active employees can remain on the group's health plan and receive group benefits as primary coverage.

When Your Coverage Terminates

A. Termination of Coverage (Group)

Alliant may cancel this Contract in the event of any of the following:

1. The Group fails to pay Premiums in accordance with the terms of this Contract.
2. The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
3. The Group has fallen below our minimum employer contribution or Group participation rules. We will submit a written notice to the Group and provide the Group 60 days to comply with these rules.
4. We terminate, cancel or non-renew all coverage under a particular policy form, provided that:
   - We provide at least 180 days' notice of the termination of the policy form to all Members;
   - We offer the Group all other small group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
   - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

B. Termination of Coverage (Individual)

Your coverage ceases if:

- your employment ends, or
- if you no longer meet eligibility requirements, or
- if the Group Contract ceases, or
- if you fail to make any required contribution (determined by your employer) toward the cost of your coverage.

Coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases automatically at the end of the month in which the child attains age 26.

Coverage of a handicapped child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of the spouse of a Member terminates automatically as of the date of divorce or death.

A rescission of your coverage means that the coverage may be legally voided all the way back to the day your coverage began, just as if you never had coverage under this Contract. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Group plan.

Alliant will give you 30 days written notice prior to the effective date of the termination.

C. Continuation of Coverage (Georgia Law)

Any Employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Contract, or this and its immediately preceding health insurance contract, you may elect to continue Group health coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation, independently.

Cost

These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the Group's Plan Administrator within 60 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance. This continuation benefit is not available if:

- Your employment is terminated for cause; or Your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
  Your health plan enrollment is terminated and replaced without interruption by another group contract; or
- Health insurance is terminated for the entire class of Employees to which you belong; or
- The Group terminates health insurance for all Employees.

Termination of Benefits

Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other group insurance or Medicare.

D. Continuation of Coverage (Federal Law-COBRA)

If your coverage ends under the plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three month's continuation benefit described above, you may elect from 18-36 months of continuation benefits, regardless of whether the Group is insured or self-funded.

Qualifying Events for Continuation Coverage Under Federal Law (COBRA)

COBRA continuation coverage is available when your Group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and Group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Employee during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	**Length of Availability of Coverage**
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months

For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second Qualifying Event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the plan's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the

end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.

Continuation of Coverage (Federal Law – USERRA)
Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Contract, and if he or she becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under this Contract. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Member and his or her Dependents can elect to continue coverage under this Contract for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Member returns to work, if the Member meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Member did not elect COBRA continuation. These requirements are (i) the Member gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five years, except in unusual or extraordinary circumstances) and the Member must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Member must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). You may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Member upon reemployment, as well as to any Dependent who has become covered under this Contract by reason of the Member's reinstatement of coverage.

Trade Adjustment Act Eligible Individual
If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out-of-pocket.

E. When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing

condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA;
- The Group terminates all of its group welfare benefit plans.

F. Continuation of Coverage (Age 60 and Over)

An Employee (and eligible Dependents), insured in Georgia under a company welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Employee was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements, which must be met:
- You must have been covered under a group plan which covers 20 or more employees; and
- You must have been continuously enrolled for at least six months under this Contract.

This continuation benefit is not available if:
- Your employment is terminated voluntarily for other than health reasons;
- The health plan enrollment was terminated because you failed to pay a Premium or Premium contribution;
- The health plan enrollment is terminated and replaced without interruption by another group contract;
- Health insurance is terminated for the entire class of Employees to which you belong;
- The Group terminated health insurance for all Employees;
- Your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (Chapter 8 of Title 34 “Employment Security Law”).

The following eligibility requirements apply:
- You must have been 60 years of age or older on the date coverage began under the
- continuation provision;
- Your Dependents are eligible for coverage if you meet the above requirements;
- Your spouse and any Covered Dependent children whose coverage would otherwise
- terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (Premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal Group Member. You must pay the first Premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:
- The date you fail to pay any required Premium when due;
- The date the Group Contract is terminated; (If the Group Contract is replaced, coverage will continue under the new Group plan.)
- The date you become insured under any other Group health plan;
- The date you or your divorced or surviving spouse becomes eligible for Medicare.

G. Extension of Benefits in Case of Total Disability

If the Group Contract is terminated for non-payment of subscription charges, or if the Group terminates the Contract for any reason, or if the Contract is terminated by us (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

Contract benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to 12 months from the date of termination of the Group Contract.

NOTE: We consider total disability a condition resulting from disease or Injury where:

- The Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- The Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

H. Extended Benefits

If a Member's coverage ends and he or she is totally disabled and, under a Physician's care Alliant extends major medical benefits for that Member under this Contract as explained below. This is done at no cost to the Member.

Alliant only extends benefits for Covered Services due to the disabling condition. The Covered Services must be incurred before the extension ends. What Alliant pays is based on all the terms of this Contract.

Alliant does not pay for charges due to other conditions. Alliant does not pay for charges incurred by other Covered Dependents.

The extension ends on the earliest of: (a) the date the total disability ends or (b) one year from the date the Member's coverage under this Contract ends. It also ends if the Member has reached the payment limit for his or her disabling condition.

NOTE: Alliant considers total disability a condition resulting from disease or Injury where:

- The Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- The Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

Definitions

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. It does not include injuries for which benefits are provided under any Workers' Compensation, employer's liability or similar law.

After-Hours Office Visit

Care rendered as a result of a condition that has an onset after the Physician's business hours.

Applicant

The corporation, partnership, sole proprietorship, other organization or Group which applied for this Contract.

Application for Enrollment

The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Application may take the form of an electronic submission.

Autism

means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

This Contract shall provide benefits for the diagnosis of autism in accordance with the conditions,

schedule of benefits, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost-sharing arrangements and copayment requirements which exist in this contract for neurological disorders.

This Autism contract provides for habilitative or rehabilitative services (including applied behavior analysis) and other counseling or therapy services necessary to develop, maintain, and restore the functioning of an individual with ASD who is six years of age or under. There is an annual cap of $30,000 on claims paid for applied behavior analysis for the purpose of treating a person with ASD when applying the benefits required by Georgia House Bill 429. This cap only applies to applied behavior analysis and does not apply to the other treatments (such as counseling or therapy services) which may be required by HB 429.

Benefit Period

One year, January 1 – December 31 (also called year or calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Brand Name Drugs

A drug item which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: drugs that are produced by only one manufacturer and do not have a generic equivalent available.
- Multi-Source Brand: drugs that are produced by multiple pharmaceutical manufacturers and do have a generic equivalent available on the market.

Centers of Expertise (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

The network of health care professionals that entered into Contracts with Alliant Health Plans to provide transplant or other designated specialty services.

Certificate

A short written statement which defines our legal obligation to the individual Members. It is part of this Certificate Booklet.

Chemical Dependency Treatment Facility

An institution established to care for and treat chemical dependency, on either an Inpatient or Outpatient basis, under a prescribed treatment program. The institution must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The institution must be licensed, registered or approved by the appropriate authority of the State of Georgia, or must be accredited by the Joint Commission on Accreditation of Hospitals.

Coinsurance

If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Limit. Compare to Copayment.

Combined Limit

The maximum total of In-Network and Out-of-Network Benefits available for designated health services in the **Summary of Benefits and Coverage's**.

Complications of Pregnancy
Complications of pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, cesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly
A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Contract
If your employer purchased this coverage outside of the Health Insurance Marketplace, then this Certificate Booklet in conjunction with the Group Master Contract, the Group Master Contract Application, the Alliant Formulary, any amendments or riders, your Identification Card and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate Booklet or the Group Master Contract and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate Booklet and the Group Master Contract, the Group Master Contract shall control.

Contract Year
A period of one year commencing on the Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claim payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment
A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Summary of Benefits and Coverage's** for an office visit. The Member is usually responsible for payment of the Copayment at the time health care is rendered. Typical Copayments are fixed or variable flat amounts for Physician office visits, Prescription Drugs or Hospital services.

Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered. Copayments may be collected by the Provider of service.

Cosmetic Surgery
Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth

defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

If your employer purchased this coverage outside of the Health Insurance Marketplace then if eligible, any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Certificate Booklet, has enrolled in Alliant's healthcare Plan, and is subject to Premium requirements set forth in the Group Master Contract.

Covered Services

Those charges for Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Member's Contract, (b) not excluded under such Contract, (c) not Experimental or Investigational and (d) provided in accordance with such contract.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 90- day gap in coverage 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; (d) a spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or similar coverage as defined in OCGA 33-30-15.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non- infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of Alliant can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill you must pay before your medical expenses become reimbursable. It usually is applied on a calendar year basis.

Dependent

The spouse; and all children until attaining age 26. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. 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 does not consider as a Dependent, welfare placement of a foster, as long as the welfare agency provides all or part of the child's support.

Mentally or physically handicapped children remain covered no matter what age. You must give us evidence of your child's incapacity within 31 days of attainment of age 26. This proof of incapacity may be required annually by us. Such children are not eligible under this Contract if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

Direct Access

A Member has direct access to primary and specialty care directly from any In-Network Physician. This is called Direct Access.

Drug Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals by us that may include but not be limited to (1) a listing of preferred and non-preferred prescription medications that are covered and/or prioritized in order of preference by us, and are dispensed to Members through pharmacies that are Network Providers, and (2) Pre-Certification rules. This list is subject to periodic review and modification by us, at our sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Drug Formulary.

Durable Medical Equipment

Equipment, as determined by us, which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

For individuals who join this Group after the first enrollment period, the Effective Date is the date we approve each future Member according to our normal procedures.

Elective Surgical Procedure

An elective surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Services

- A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

- Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

  The term "**stabilize**" means, with respect to an emergency medical condition:

- To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee
A person who is engaged in active employment with the Group and is eligible for Group coverage with us under the employment regulations of the Group.

Enrollment Date
The date of enrollment of the individual in the health plan or if earlier, the first day of the waiting period for such enrollment.

Essential Health Benefits
Benefits* defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

*Pediatric dental care may be separately provided through a stand-alone dental plan that is offered to you by your employer.

Exchange
See "Health Insurance Marketplace".

Experimental or Investigational
Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961(t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute,
- National Academy of Sciences, Health Care Financing Administration, and any National
- board recognized by the National Institutes of Health for the purpose of evaluating the

medical value of health services; or
- It meets the Technology Assessment Criteria as determined by us as outlined in the "Definitions" section of this Certificate Booklet.

Frame
Standard eyeglasses excluding the Lenses.

Freestanding Ambulatory Facility
A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and Registered Nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Generic Drugs
Prescription Drugs that are not Brand Name Drugs but which are made up of equivalent ingredients.

Group
The Subscriber's employer. The Group shall act only as an agent of Members who are Subscribers of the Group and their eligible Dependents.

Health Insurance Marketplace
Known as the Health Insurance Marketplace. A marketplace that allows individuals and small businesses to shop for coverage in a way that permits comparison of available plan options and to find out if they are eligible for tax credits and/or cost-sharing reductions.

Home Health Care
Care, by a state-licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency
A Provider which renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital
An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians

duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. “Hospital” does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Identification Card

The latest card given to you showing your Member and Group numbers, the type of coverage you have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Pre-Admission Certification was not obtained. Such charges are not eligible for payment.

Ineligible Hospital

A facility which does not meet the minimum requirements to become an In-Network Hospital. Services rendered to a Member by such a Hospital are not eligible for payment.

Ineligible Provider

A Provider which does not meet the minimum requirements to become an In-Network Provider or with whom Alliant does not directly contract. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Group (or one of that person’s eligible Dependents) on the original Effective Date of the group health plans coverage between Alliant and the Group or currently enrolled through the Group under an Alliant Contract.

Injury

Bodily harm from a non-occupational accident.

In-Network Care

Covered Services provided to Members by their Physician through Network Hospital and Network Providers. A Member has direct access to primary and specialty care directly from any In-Network Physician.

In-Network Hospital

A Hospital which is a party to a written agreement with, and in a form approved by, Alliant to provide services to its Members.

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In-Network Provider

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies in the Service Area that has a Network Provider Contract with us to provide Covered Services to Members.

Inpatient
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a Hospital that: 1) treats patients with serious illnesses or Injuries; 2) can provide special life-saving methods and equipment; 3) admits patients without regard to prognosis; and 4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees means Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Contract: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Contract, but only as long as the Member requests enrollment for such Dependent within sixty (60) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to us that coverage was declined because other coverage existed.

Lenses
Clear plastic single vision, bifocal or trifocal corrective materials which are ground as prescribed by a licensed Provider.

Long Term Acute Care
Long Term Acute Care requires a Hospital Environment which provides the patient with daily Physician visits, a critical care and medical/surgical experienced nursing staff, a complete respiratory department (24 hours a day, 7 days a week), an in-house rehab department, case management, social services, an in-house pharmacy, radiology, an operating room, an ICU, and a complete health care system designed to meet the needs of highly acute patients. This acute care environment promotes timely and effective responses to maximize the recovery potential of the patient, and prevents the need for discharge when complications arise. Such care differs from skilled nursing facility/subacute facility care because that care is limited in the range and frequency of services provided and does not offer a complete health care delivery system.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Contract.

Maximum Allowed Cost (MAC)
The Maximum Allowed Cost (MAC) is the maximum amount of reimbursement Alliant will pay for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That is provided in accordance with all applicable Pre-Authorization, utilization management *(i.e*., coverage certification) or other requirements set forth in your Plan.

MCSO-Medical Child Support Order
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a Group health plan participant or requires health benefit coverage of such child in such plan,

and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group health plan.

Medical Facility
Any Hospital, ambulatory care facility, chemical dependency facility, skilled nursing care facility, home health agency or mental health facility, as defined in this Certificate Booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by us.

Medical Necessity or Medically Necessary
We reserve the right to determine whether a health care service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

We consider a health care service Medically Necessary if it is:
- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- Compatible with the standards of acceptable medical practice in the United States;
- Not provided solely for your convenience or the convenience of the doctor, health care Provider or Hospital;
- Not primarily Custodial Care; and
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Member
The Subscriber and each Dependent, as defined in this booklet, while such person is covered by this Contract.

Mental Health Disorders
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or chemical dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Care Provider
An institution such as a Hospital or ambulatory care facility established for the diagnosis and treatment of mental illness. The facility must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The facility must be operated in accordance with the laws of the State of Georgia, or accredited by the Joint Commission on Accreditation of Hospitals.

Minimum Essential Coverage
The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

New Hire
A person who is employed by the Group after the original Effective Date of the Group health plan coverage.

Non-Covered Services
Services that are not benefits specifically provided under the Contract, are excluded by the Contract, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Nurse Practitioner (NP)
An individual duly licensed by the State of Georgia to provide primary nursing and basic medical services.

Out-of-Network Care
Care received by a Member from an Out-of-Network Provider.

Out-of-Network Provider
A Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies, that does not have a Network Provider Contract with Alliant.

Out-of-Pocket Limit
(May apply to In-Network or Out-of-Network—Refer to **Summary of Benefits and Coverage's**) The maximum amount of a Member's Co-payment and Coinsurance payments during a given calendar year. Such amount does not include Deductible amounts, charges for non-covered services or fees in excess of the Maximum Allowed Cost (MAC). When the Out-of-Pocket Limit is reached, the level of benefits is increased to 100% of the Maximum Allowed Cost (MAC) for Covered Services.

Periodic Health Assessment
A medical examination that provides for age-specific preventive services that improve the health and well-being of a patient being examined. This examination is provided through the network by

Physicians. The frequency and content of the health assessment are determined by established guidelines and the Member's personal history.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care. This service could be provided or prescribed, overseen and billed for by the Physician, or given by a physiotherapist on an Inpatient basis on the orders of a licensed Physician and billed by the Hospital.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D.) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

Physician Assistant (PA)
An individual duly licensed by the State of Georgia to provide basic medical services under the supervision of a licensed Physician.

Physician Assistant Anesthetist (PAA)
An individual duly licensed by the State of Georgia to provide anesthesia services under the supervision of a licensed Physician specializing in anesthesia.

Plan Administrator
The person named by your employer to manage the plan and answer questions about plan details.

PPACA
Patient Protection and Affordable Care Act

PPO Network
A limited panel of Providers as designated by Alliant known as a preferred provider organization.

PPO Network Provider
A Provider that is included in a limited panel of Providers as designated by Alliant and for which the greatest benefit will be payable when one of these Providers is used.

Premium
The amount that the Group or Member is required to pay us to continue coverage.

Prescription Drug
A drug which cannot be purchased except with a prescription from a Physician and which must be dispensed by a pharmacist.

Primary Care Physician (PCP)
A licensed Physician who is an In-Network Provider trained in general family practice, pediatrics, obstetricians and gynecologists, or internal medicine, and has entered into an agreement to coordinate the care of Members.

Your Primary Care Physician provides initial care and basic medical services, assists you in obtaining Pre-Certification of Medically Necessary Referrals for Specialist and Hospital care, and provides you with continuity of care.

Professional Ambulance Service
A state-licensed emergency vehicle which carries via the public streets injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Provider
Any Physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a Hospital, clinical laboratory, freestanding ambulatory surgery facility, Retail Health Clinic, Skilled Nursing Facility, long term acute care facility, or Home Health Care Agency holding all licenses required by law to provide health care services.

Psychiatric Services within a General Hospital Facility
A general hospital facility that provides Inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a Physician.

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes a right of a child who is recognized under the order as having the right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a

reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Qualified Health Plan
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Referral
Specific instructions from a Member's Physician, in conformance with our policies and procedures, that direct a Member to an In-Network Provider for Medically Necessary care.

Respite Care
Care furnished during a period of time when the Member's family or usual caretaker cannot, or will not, attend to the Member's needs.

Retail Health Clinic
A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

Semiprivate Room
A Hospital room which contains two or more beds.

Service Area
Includes counties listed in the appropriate Service Area map. (Please refer to your Provider Directory.)

Similar Drugs
Similar Drugs are those within a certain therapeutic class such as insomnia drugs, oral contraceptives, seizure drugs, etc.

Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by us to meet the reasonable standards applied by any of the aforesaid authorities.

Specialty Drugs
High-cost, injectable, infused, oral or inhaled medications that typically require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require Pre-Authorization.

Specialty Pharmacy
A pharmacy which dispenses biotech drugs for rare and chronic diseases via scheduled drug delivery either to the Member's home or to a Physician's office. These pharmacies also provide telephonic therapy management to ensure safety and compliance.

Spinal Manipulation
Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Subscriber
The individual who signed the Application for Enrollment and in whose name the Identification Card is issued.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation
Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans.

Substance Abuse Residential Treatment Center
A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Substance Abuse Services within a General Hospital Facility
A general Hospital facility that provides services, on an inpatient, 24-hour basis, for medical detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Technology Assessment Criteria
Five criteria all procedures must meet in order to be Covered Services under this Contract.
- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Telehealth Services
A health care service, other than a telemedicine service, delivered by a licensed or certified health professional, acting within the scope of the healthcare professional's license or certification, who does not perform a Telemedicine Medical Service, that requires the use of advanced telecommunications technology, other than by telephone or facsimile including:
- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Telemedicine Medical Service
A health care medical service initiated by a Physician or provided by a health care professional, diagnosis, treatment or consultation by a Physician, or the transfer of medical data that requires the

use of advance communications technology, other than by telephone or facsimile including:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine.

Therapeutic / Clinically Equivalent

Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Therapeutic / Clinically Equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutic / Clinically Equivalent determinations are based on industry standards and reviewed by such organizations as The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

Urgent Care

"Urgent Care" means any medical care or treatment of a medical condition that (A) could seriously jeopardize your life or health or your ability to regain maximum function or (B) in the opinion of the attending Provider, would subject you to severe pain that cannot be adequately managed without care or treatment. Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital; and is not considered an emergency. Benefits provided for Urgent Care Services are outlined in the **Summary of Benefits and Coverage's**.

Urgent Care Center

A facility, appropriately licensed and meeting Alliant standards for an Urgent Care Center, with a staff of Physicians and health care professionals that is organizationally separate from a Hospital and whose primary purpose is providing urgently needed medical procedures. Services are performed on an outpatient-basis and no patients stay overnight. A Physician's office does not qualify as an Urgent Care Center.

Statement of ERISA Rights

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls:

- all plan documents, including insurance contracts,
- collective bargaining agreements and copies of all documents filed by this plan with the U.S.
- Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits 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 claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Certificate Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Alliant. In addition to this information, if this *plan* is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you; they will apply in place of any similar claim procedure rules included in this Certificate Booklet.

COMPLAINTS & APPEALS

We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

COMPLAINTS ABOUT ALLIANT HEALTH PLANS

As an Alliant Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that we give our fullest attention to your concerns. Please utilize it to tell us when you are displeased with any aspect of services rendered.

1. Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
2. If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will, hopefully bring the matter to a satisfactory conclusion for you.

SUMMARY OF GRIEVANCES

A summary of the number, nature and outcome results of grievances filed in the previous three years is available for your inspection. You may obtain a copy of any such summary at a reasonable cost from us.

COMPLAINTS ABOUT PROVIDER SERVICE

If your complaint involves care received from a Provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

DEFINITIONS FOR APPEALS

The capitalized terms used in this appeals section have the following definitions:

Adverse Benefit Determination

- A denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit;
- Any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet Alliant's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness; or
- Based in whole or in part on medical judgment, includes the failure to cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.
- A decision by Alliant to deny coverage based upon an initial eligibility determination.

An Adverse Benefit Determination is also a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required Premiums or contributions toward cost of coverage.

The denial of payment for services or charges (in whole or in part) pursuant to Alliant's contracts with network providers, where you are not liable for such services or charges, are not Adverse Benefit Determinations.

Authorized Representative

An individual authorized in writing by you or state law to act on your behalf in requesting a health care service, obtaining claim payment, or during the internal appeal process. A health care provider may act on behalf of you without your express consent when it involves an Urgent Care Service.

Final Adverse Benefit Determination

An Adverse Benefit Determination that is upheld after the internal appeal process. If the time period allowed for the internal appeal elapses without a determination by Alliant, then the internal appeal will be deemed to be a Final Adverse Benefit Determination.

Post-Service Claim

An Adverse Benefit Determination has been rendered for a service that has already been provided.

Pre-Service Claim

An Adverse Benefit Determination was rendered and the requested service has not been provided.

Urgent Care Services Claim

An Adverse Benefit Determination was rendered and the requested service has not been provided, where the application of non-urgent care appeal timeframes could seriously jeopardize:

- Your life or health or your unborn child's; or
- In the opinion of the treating physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

INTERNAL APPEAL

You, or your Authorized Representative, or a treating Provider or facility may submit an appeal. If you need assistance in preparing the appeal, or in submitting an appeal verbally, you may contact Alliant for such assistance at (800) 811-4793. You may submit appeals to the following addresses, dependent upon the type of appeal:

Claims Appeals:	Alliant Health Plans PO Box 1247 Dalton, GA 30722
Medical Appeals (Level I & II):	Alliant Health Plans Attn: UM Appeals Department 9601 Amberglen Blvd Ste 225 Austin, TX 78729 Phone: (800) 865-5922 Fax: (866) 370-5667
Pharmacy Appeals (Level I):	Navitus Health Solutions Attn: Grievance and Appeals Coordinator PO Box 999 Appleton, WI 54912-0999 Fax: (920) 735-5347
Pharmacy Appeals (Level II)	Alliant Health Plans Attn: RX Grievance and Appeals Department 1503 North Tibbs Road Dalton, GA 30720 Fax: (866) 634-8917

If you are Hearing impaired you may also contact Alliant via the National Relay Service at 711.
You (or your Authorized Representatives) must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination.
SPANISH (Español): Para obtener asistencia en Español, llame al (800) 811-4793.

Within five business days of receiving an appeal (or 24 hours for appeals involving an Urgent Care Services Claim), Alliant will contact you (or your Authorized Representative) in writing or by telephone to inform you of any failure to follow Alliant's internal appeal procedures.

The appeal will be reviewed by personnel who were not involved in the making of the Adverse Benefit Determination and will include input from health care professional in the same or similar specialty as typically manages the type of medical service under review.

TIMEFRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIMEFRAME FOR DECISION**
EXPEDITED APPEALS	WITHIN 72 HOURS or 3 CALENDAR DAYS
PRE-SERVICE AUTHORIZATION APPEALS (LEVEL I & II)	WITHIN 15 DAYS
POST-SERVICE AUTHORIZATION (LEVEL I & II)	WITHIN 30 DAYS

EXHAUSTION OF PROCESS

The foregoing procedures and process are mandatory and must be exhausted prior to establishing litigation or arbitration or any administrative proceeding regarding matters within the scope of this Complaint and Appeals section.

EXTERNAL APPEAL

You may have the right to have our medical or pharmacy decision to deny a request or claim based on a

determination of medical necessity, experimental/investigation status of the recommended treatment, the condition being considered or a health care coverage rescission reviewed externally after you have exhausted the internal appeals rights provided by AHP. You must file a request for an external review within 123 days after you receive notice of the denial of the claim or appeal.

How do I request external review?

You can request an external appeal by calling 888-866-6205 to request an external review request form. The form can be faxed to 888-866-6190. You may also send an external appeal in writing by sending an email to ferp@maximus.com or by mail:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

If you have any questions or concerns during the external appeal process, you (or your Authorized Representative) can call the toll-free number 888-866-6205 or visit www.externalappeal.com.

How do I request an expedited external review?

In some cases, you may ask for an expedited (faster than usual) external review. An expedited review may be requested when:

1. You have asked for an expedited internal appeal and want an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place your life, health or ability to regain maximum function in danger.

   OR

2. You have completed an internal appeal with the plan and the decision was not in your favor, and:
   a. The timeframe to do a standard external review (45 days) would place your life, health or ability to regain maximum function in danger, or
   b. The decision is about admission, care availability, continued stay, or emergency health care services where you have not been discharged from the facility.

When requesting an expedited external review, a person must provide the following information:

- Name and Address
- Phone
- Email address
- Whether the request is urgent
- Patient's signature if person filing the appeal is not the patient
- A brief description of the reason you disagree with your plan's denial decision

You may use an HHS Federal External Review Request Form to provide this and other additional information.

An expedited external review happens faster if you ask for it by calling the toll-free telephone number 888-866-6205. The 72-hour timeframe for an expedited request begins when the phone call ends.

Instructions for Sending Your Expedited External Review Request:

You may also ask for an expedited external review by faxing to (888) 866-6190 or mail to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

The 72-hour timeframe for expedited requests sent by mail or fax begins when the request is received.

ERISA RIGHTS

If you are enrolled in a private employer plan, then you may also have the right to bring a civil action under Section 502 (a) of ERISA following the full internal review of your compliant by AHP.

Other Resources to Help You

You or your authorized representative may request an external appeal or complaint by notifying the Georgia Department of Insurance Consumer Services Division by phone at (800) 656-2298. You or your authorized representative may also file a request for external appeal by completing the required forms available at www.oci.ga.gov and submitting them directly to the address noted below. Alliant will also provide the forms upon request.

Georgia Department of Insurance
Consumer Services Division
2 Martin Luther King Jr. Drive
Suite 716 West Tower
Atlanta, Georgia 30334
Fax: (404) 657-8542
Website: www.oci.ga.gov; select Consumer Complaint Portal

Once an eligible request for external review is complete, the matter will be investigated by the Georgia Department of Insurance. There will be no charge to you for the investigation. The Georgia Department of Insurance will notify you and your authorized representative of its decision.

General Rules and Information

General rules regarding Alliant's Complaint and Appeal Process include the following:

- You must cooperate fully with Alliant in our effort to promptly review and resolve a complaint or appeal. In the event you do not fully cooperate with Alliant, you will be deemed to have waived your right to have the Complaint or Appeal processed within the timeframes set forth above.
- Alliant will offer to meet with you by telephone. Appropriate arrangement will be made to allow telephone conferencing to be held at our administrative offices. Alliant will make these telephone arrangements with no additional charge to you.
- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.
- Alliant will provide you with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Alliant to send any new medical information to review directly so you have an opportunity to review the claim file.

Telephone Numbers and Addresses

You may contact an Alliant Complaints and Appeals Coordinator at the number listed on the acknowledgement letter or notice of Adverse Benefit Determination or Final Adverse Benefit Determination. Below is a list of phone numbers and addresses for complaints and appeals.

Alliant Health Plans
Appeals Department
PO Box 1247
Dalton, GA 30722
(800) 811-4793

Alliant Health Plans
Complaints Coordinator
1503 N. Tibbs Rd.
Dalton, GA 30721
(800) 811-4793

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Summary of Benefits and Coverage's.**

If you would like more information on WHCRA benefits, call your Plan Administrator.