

Certificate of Coverage

Individual /Family Plans





This Contract (Certificate) is between the Subscriber who has executed an Application for Coverage and Alliant Health Plans, Inc. (hereinafter referred to as “Alliant Health Plans”, “Alliant” or “AHP”).

This Contract (Certificate) entitles the Subscriber and eligible Dependents to receive the benefits set forth herein, subject to the terms and conditions of this Contract, and upon payment of the Premium in accordance with Federal and State regulations.

The Contract is duly executed as of the Effective Date confirmed by notice from Alliant Health Plans.

This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously by Alliant.

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

Mark Mixer
Chief Executive Officer



Health Insurance Marketplace

Alliant Health Plans is proud to be a Qualified Health Plan Issuer in the Health Insurance Marketplace.



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IMPORTANT INFORMATION

MEDICAL BENEFITS, CLAIMS & QUESTIONS

Alliant Customer Service	(800) 811-4793 CustomerService@AlliantPlans.com
24-Hour Nurse Advice Line	(855) 299-3087
Alliant Website	AlliantPlans.com
Provider Directory	AlliantPlans.com

*Please have your Member ID number available when you call. This can be found on your Identification Card or an Explanation of Benefits.

PHARMACY BENEFITS, CLAIMS & QUESTIONS

Magellan Rx Customer Service	(800) 424-1799
Magellan Rx Website	MagellanRx.com

PRIOR AUTHORIZATION

Alliant Medical Management (800) 865-5922

Your In-Network Provider or Hospital should call for Prior Authorization before administering services or admission.

You are responsible for obtaining Prior Authorization for out-of-network benefits.

MOBILE ID CARD APP

Coverage at your fingertips! Never forget your ID card again. When you download the 'Alliant ID Card Mobile' app on your mobile device, you gain access to your digital insurance card and Alliant's provider directory – with just one touch. The mobile app is available for Apple and Android operating systems.



THE HEALTH INSURANCE MARKETPLACE

Customer Service	(800) 318-2596
Website	HealthCare.gov

IMPORTANT NOTE

When you see this symbol:  carefully read this section so that you understand how to maximize your benefits.

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.
- Copayments, Coinsurance, 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 and 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 as further defined in this Certificate.
- 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.

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 (800) 811-4793.

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

No agent or other person except an officer of Alliant has authority to do any of the following: (1) waive any condition or restriction of this Contract; (2) extend the time for making Premium; or (3) bind Alliant by making any promises or representations or by giving or receiving any information.

Si necesita ayuda en español para entender este documento, puede solicitarla llamando a nuestro Servicio al Cliente al (800) 811-4793.

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 at (800) 811-4793.

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.

VERIFICATION OF BENEFITS



Verification of benefits is available for Members or authorized health care Providers on behalf of Members. You may call Customer Service with a medical benefits inquiry or verification of benefits during normal business hours.

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 Prior Authorization, please call (800) 865-5922.

PRIOR AUTHORIZATION – IN-NETWORK

(also known as Pre-Certification)

For Prior Authorization call (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 Prior Authorizations can be requested during normal business hours.
- Emergency Medical Services do NOT require Prior Authorization.

PRIOR AUTHORIZATION – OUT-OF-NETWORK

(also known as Pre-Certification)

For Prior Authorization call (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 Prior Authorizations can be requested during normal business hours.
- Emergency Medical Services do NOT require Prior Authorization.

Prior Authorization is NOT a guarantee of coverage in 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.
- Services that are not covered benefits under your benefit plan.

Prior Authorization approvals apply only to services which have been specified in the Prior Authorization and/or prior authorization list available on our website. A Prior Authorization approval does not apply to any other services; other than the specific service being prior authorized. 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.

ELIGIBILITY

If you purchased your coverage through the Health Insurance Marketplace, see “REPORTING LIFE & INCOME CHANGES TO THE MARKETPLACE” at the end of this document for additional information.



COVERAGE FOR YOU

This Certificate describes the benefits you may receive under your health care plan. You are called the Subscriber or Member. Alliant allows child-only policies under this type of plan.

COVERAGE FOR YOUR DEPENDENTS

If you are covered by this plan, you may enroll your eligible Dependents. Your Covered Dependents are also called Members. Enrollment of Dependents can be done during Open Enrollment or upon experiencing a Special Enrollment Period qualifying event. Eligibility requirements apply to Dependents as well.

YOUR ELIGIBLE DEPENDENTS MAY INCLUDE:

- Your Spouse, provided you are not legally separated. Domestic partners are not considered eligible Dependents except when State or Federal law supersedes this Contract.
- Your Dependent children through the end of the year in which they attain age 26;
- Your legally adopted children from the date you assume legal responsibility,
- Your children for whom you assume legal guardianship and stepchildren,
- Your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree.
- Your children who are mentally or physically handicapped and totally dependent on you for support, regardless of age.
 - To be eligible 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.

Please note: For the purpose of this Contract, a spouse is the Subscriber’s legal spouse as recognized by the state in which the Subscriber lives.

If the wrong date of birth of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or Alliant.

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 the federal government. This enrollment period applies whether purchasing through the Health Insurance Marketplace or directly from Alliant Health Plans.

SPECIAL ENROLLMENT PERIODS

Consumers can qualify for a Special Enrollment Period (SEP) to enroll for health insurance coverage if they meet certain eligibility criteria. Below is a list of the categories of SEPs currently available.

1. Loss of qualifying health coverage.
2. Change in household size.
3. Change in primary residence.
4. Enrollment or plan error.

Loss of coverage does not include voluntary termination of coverage or other loss due to:

- Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
- Situations allowing for a rescission as specified in 45 CFR 147.128.

WHEN YOUR COVERAGE BEGINS

Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is determined by Alliant Health Plans. No benefits will be provided for services, supplies or charges incurred before your Effective Date.

CHANGING YOUR COVERAGE

There will be an annual re-enrollment period during which time Members may elect to change their options.



CHANGING YOUR COVERAGE (adding a dependent)

You may add new Dependents to your Plan, during Open Enrollment or a Special Enrollment Period, by contacting Customer Service.

If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace.

If you purchased outside the Health Insurance Marketplace, you must notify us in writing. Coverage is provided only for those Dependents you have reported to Alliant and added to your coverage by completing the correct application during a time they are eligible.



Marriage and Stepchildren

A Member may add a spouse and eligible stepchildren within thirty-one (31) days of the date of marriage. The Effective Date will be the date of marriage. In most cases, there is an additional charge for adding additional covered person(s).

If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace.

If you purchased outside the Health Insurance Marketplace, you must notify Alliant in writing by submitting an enrollment application.

If a Member does not apply for coverage to add a spouse and stepchildren within thirty-one (31) days or as otherwise provided by the Marketplace of the date of marriage, the spouse and stepchildren are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Newborns

A newborn shall be covered for the first thirty-one (31) days from date of birth. For Coverage to continue beyond the first thirty-one (31) days, an application form to add the child as a Dependent and a payment of any applicable Premium must be received by us within thirty-one (31) days from the date of birth. The Premium shall include the first thirty-one (31) days of coverage. If the application and Premium are not received by us within thirty-one (31) days from the date of birth, Coverage will terminate at the end of the thirty-one (31) day period. If the application and Premium are received by us after the thirty-one (31) day period, but within sixty (60) days from the date of birth, Coverage will be reinstated retroactively with no break in Coverage.



If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace.

In the event you enroll your newborn in a different plan; Alliant is still required to cover the newborn under your plan for the first thirty-one (31) days. If you do not wish to have the required coverage under this plan for the thirty-one (31) days, you must sign a waiver. Please contact Customer Service at (800) 811-4793 to obtain a

Newborn Coverage Waiver Form.

In the event there is more than one insurance policy in force; there is no Coordination of Benefits for individual/family plans (such as this one).

Adopted Children

Adopted children are considered eligible from the date of assumption of legal responsibility. The adopted child is not automatically added to your policy. For Coverage to begin, an application form to add the child as a Dependent and a payment of any applicable Premium must be received by us within thirty-one (31) days from the date of legal assumption. The Premium shall include the first thirty-one (31) days of coverage. If the application and Premium are not received by us within thirty-one (31) days from the date of birth, Coverage will terminate at the end of the thirty-one (31) day period. If the application and Premium are received by us after the thirty-one (31) day period, but within sixty (60) days from the date of legal assumption, Coverage will be reinstated retroactively with no break in Coverage.



If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace

In the event there is more than one insurance policy in force; there is no Coordination of Benefits for individual/family plans (such as this one).

Foster Children

Foster children are children whose natural 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. 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.

Foster Children are not automatically added to your policy. For Coverage to begin, an application form to add the child as a Dependent and a payment of any applicable Premium must be received by us within thirty-one (31) days from the date of legal assumption. The Premium shall include the first thirty-one (31) days of coverage. If the application and Premium are not received by us within thirty-one (31) days from the date of birth, Coverage will terminate at the end of the thirty-one (31) day period. If the application and Premium are received by us after the thirty-one (31) day period, but within sixty (60) days from the date of legal assumption, Coverage will be reinstated retroactively with no break in Coverage



If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace.

In the event there is more than one insurance policy in force; there is no Coordination of Benefits for individual/family plans (such as this one).

CHANGING YOUR COVERAGE (removing a dependent)

When any of the following events occur:



- 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.

If you purchased through the Health Insurance Marketplace, you must notify the Health Insurance Marketplace.

If you purchased outside the Health Insurance Marketplace, notify Customer Service at (800) 811-4793 and ask for the appropriate forms to complete.

HOW YOUR BENEFITS WORK FOR YOU

Whether you purchased coverage through the Health Insurance Marketplace or not, there is no substantial difference in the benefits this Contract provides, with the exception of the grace period. The grace period differs based on where you purchased your policy and whether you receive an Advance Premium Tax Credit (APTC).

INTRODUCTION

All Covered Services must be Medically Necessary. A Member has Direct Access to primary and specialty care.

An In-Network Provider is a Provider who is in the managed network for this specific plan or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the allowable for this plan is the rate the Provider has agreed with Alliant to accept as reimbursement for the Covered Services.

Physicians and Hospitals participating in our Networks are compensated using a variety of payment arrangements, including but not limited to capitation, fee for service, per diem, discounted fees, and global reimbursement.

For a list of In-Network Providers and facilities, please visit AlliantPlans.com or call Customer Service at (800) 811-4793.



PREFERRED PROVIDER ORGANIZATION

Your health insurance plan is a comprehensive benefit plan called a Preferred Provider Organization. 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. Out-of-Network Care may pay differently than In-Network Care. Check your **Summary of Benefits and Coverage** for details. 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 (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 contact Alliant Customer Service at (800) 811-4793, to try to locate an In-Network Provider.

COPAYMENT OR OUT-OF-POCKET

Whether you choose In-Network or Out-of-Network Care, you may 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**.

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 your plan begins to pay benefits, other than for preventive care or in most cases where Copayment applies, you must meet any Deductible required. Deductible requirements are stated in the **Summary of Benefits and Coverage**.

CARRY FORWARD DEDUCTIBLE

When insured by this health plan, Covered Services during the last three months of a calendar year applied to that year's Deductible can carry forward and apply toward the next year's Deductible. If a change in the health plan is made during the last three months of a calendar year, the Carry Forward Deductible is restricted to the time period covered under the "newest" health plan with Alliant Health Plans. The Carry Forward Deductible provision is not available if your plan is a federally qualified High Deductible Health Plan.



COINSURANCE AND OUT-OF-POCKET MAXIMUMS

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

Out-of-Pocket Maximum are accumulated separately for In-Network and Out-of-Network Providers.

See the **Summary of Benefits and Coverage** to determine your in-network Coinsurance amount and in-network Out-of-Pocket Maximum.

ANNUAL AND LIFETIME LIMITS

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

WHAT YOUR PLAN PAYS

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

MAXIMUM ALLOWED COST (MAC)

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

You will be required to pay a portion of the MAC 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 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 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 MAC will be based on the single procedure code rather than a separate 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 MAC 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 allowed amount may vary depending upon whether the Provider is an In-Network or an Out-of-Network Provider.

For Covered Services performed by an In-Network Provider, the allowed amount 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 allowed amount as payment in full for that service, they should not send you a bill or collect for amounts above the allowed amount. However, you may receive a bill or be asked to pay all or a portion of the allowed amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service at (800) 811-4793 for help in finding an In-Network Provider or visit AlliantPlans.com.

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

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

- 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
- 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
- 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
- An amount equal to the total charges billed by the Provider, but only if such charges are less than the MAC calculated by using one of the methods described above.

The MAC for out-of-network Emergency Medical 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:

- The amount negotiated with In-Network Providers for the emergency service furnished, excluding any in-network Copayment or Coinsurance imposed;
- 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
- 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 the amount of the Provider's charge that exceeds our MAC. You are responsible for paying the difference between the 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 (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 MAC as your cost share amount (e.g., Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Maximum 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** for your cost share responsibilities and limitations, or call Customer Service to learn how your 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 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 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 Provider to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- *The Out-of-Network Provider's charge for the service is \$1,200. The 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 or \$250. 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 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 Provider for surgery. The Out-of-Network Provider's charge for the service is \$2,500. The MAC for the surgery service is \$1,500; your Coinsurance responsibility for the Out-of-Network*

Provider 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 Provider could bill you the difference between \$2,500 and \$1,500, 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 MAC and the Out-of-Network Provider's charge. Please contact Customer Service at (800) 811-4793 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 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 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 MAC of \$200. Combined with your in-network Copayment of \$25, your total out of pocket expense would be \$325.

COVERAGE AUTHORIZATION



AUTHORIZATION

Some benefits require authorization. To authorize a benefit or service, your provider should call the Medical Management Department at (800) 865-5922. Authorizations are given for services based on Medical Necessity.

Alliant also applies key medical 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 regardless of the receipt of the requested additional information. <i>(Alliant will provide oral notification of its decision within 72 hours of the initial request)</i>
Pre-Service Authorization	Within fifteen (15) calendar days. Alliant may extend the fifteen (15) day period for an additional fifteen (15) calendar days because of matters beyond Alliant's control. If this is necessary Alliant will let you know in writing within the first fifteen (15) calendar days. If the delay is because Alliant needs more information to make a decision, you will have up to forty-five (45) calendar days to provide the needed information.
Concurrent Services Authorization	Within 24 hours of request for services involving Urgent Care Services. For other requests, a decision will be made within fifteen (15) calendar days.

Urgent Care Services in this section 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 Prior Authorization can be found on our website: AlliantPlans.com or by calling Customer Service at (800) 811-4793. The Prior Authorization list is subject to change.

BENEFITS

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

ALLERGY CONDITIONS

Standard Medically Necessary testing and treatment for allergy conditions are covered. See *What is Not Covered* for non-standard tests that are considered non-covered.

AMBULANCE SERVICE

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
 - From your home, scene of an accident or medical emergency to a Hospital;
 - Between Hospitals, including when we require you to move from and out-of-network Hospital to and In-Network Hospital; or
 - Between a Hospital, Skilled Nursing Facility (ground transport only) or approved facility.

You must be taken to the nearest facility that can give care for your condition. In certain cases, we may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include Medically Necessary treatment of sickness or Injury by medical professionals during an ambulance service, even if you are not taken to a facility.

Out-of-Network Providers may bill you for charges that exceed the MAC for services that may be covered but are non-emergent.

Ground Ambulance

Services are subject to Medical Necessity review by Alliant.

All scheduled ground ambulance services for non-emergency transports, not including to acute facility to acute facility transport, must have a Prior Authorization.

Air and Water Ambulance

Air ambulance services are subject to Medical Necessity review by Alliant. Alliant retains the right to select the air ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-emergency Hospital to Hospital transports must have Prior Authorizations.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for the purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with the medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because your condition requires rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance

may also be necessary because you are located in a place that is inaccessible to a ground or water ambulance provider.

ANESTHESIA SERVICES FOR CERTAIN DENTAL PATIENTS

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 Member's surgeon.

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 and other counseling or therapy services necessary to develop, maintain, and restore the functioning of an individual with Autism Spectrum Disorder (ASD) who is six years of age or under.

If you purchased your plan outside the Health Insurance Marketplace, applied behavioral analysis is covered for the purpose of treating a person with ASD. For a plan purchased outside the Health Insurance Marketplace, there is an annual cap of \$30,000 on claims paid for applied behavior analysis as allowed 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 3 per calendar year.

BREAST RECONSTRUCTIVE CARE

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.

CHIROPRACTIC CARE

One of the Covered Services is for in-network Spinal Manipulation. There is a limit to the number of visits. See your **Summary of Benefits and Coverage** for 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 Prior Authorized as Medically Necessary costs as provided in Georgia law (OCA 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 In-Network Provider,
- Receive Prior Authorization 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.

COMPLICATIONS OF PREGNANCY

Benefits are provided for Complications of Pregnancy 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 Care section of this Contract. In and Out of Networks apply accordingly.

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

Medically Necessary 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 Prior Authorization has been obtained. If an Out-of-Network Provider is elected, then out-of-network benefits apply.

DURABLE MEDICAL EQUIPMENT

Your plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity and applicable Prior Authorization 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 Provider;
- The Provider certifies in writing the Medical Necessity for the equipment.
 - The Provider 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 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** and is the same for both In-Network and Out-of-Network Care.

EYE CARE

A Member who seeks covered 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

When Medically Necessary and ordered by the attending Physician and administered by another Physician who customarily bills for such services. The Covered Services must be connected to a 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 health care 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. These services require Prior Authorization and have visit limits. Plan limits are outlined in the **Summary of Benefits and Coverage**.

HEARING AIDS

Hearing Aid means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term Hearing Aid includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products shall not qualify as hearing aids.

If you purchased your plan outside the Health Insurance Marketplace, this Contract shall provide benefits for Hearing Aids for children 18 years of age or under in accordance with the provisions of Georgia HB 206. As required by HB 206, this Contract provides for one Hearing Aid per hearing impaired ear not to exceed \$3,000.00 per Hearing Aid every 48 months, and medically necessary services and supplies on a continuous basis, as needed, during each 48-month coverage period, not to exceed \$3,000.00 per hearing impaired ear. This Contract shall provide these benefits in accordance with the conditions, schedule of benefits, limitations, exclusions, cost-sharing arrangements and Copayment requirements as outlined in the **Summary of Benefits and Coverage**. The Hearing Aid benefit ONLY applies to plans purchased outside the Health Insurance Marketplace.

HOME HEALTH CARE SERVICES

Home Health Care provides a program for a Member's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits and Coverage**. A visit consists of 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. These services require Prior Authorization and have visit limits. Plan limits are outlined in the **Summary of Benefits and Coverage**. **Note:** Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Contract.

Some special conditions apply:

- The Physician's statement and recommended program must obtain a Prior Authorization.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
- 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 Care Nursing Aide when rendered under the direct supervision of an RN.
- Administration of prescribed drugs.
- Oxygen and its administration.



Covered Services for Home Health Care 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**. 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 obtain a Prior Authorization.

HOSPITAL SERVICES

For In-Network Care, your Physician must arrange your hospital admission.

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. Prior Authorization 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 or comfort items (such as radios, TV's, telephones, visitors' meals, etc.) are not 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 Prior Authorization.
- Refer to Emergency Room Services/Emergency Medical Services definition.

HOW TO OBTAIN CARE AFTER NORMAL BUSINESS HOURS

If you need medical attention after normal office hours because you need Urgent or Emergency Medical Services, you can find an in-network facility by contacting Customer Service at (800) 811-4793 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.

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

A Prior Authorization is required for visits. Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits and Coverage**. 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. These services have visit limits. Plan limits are outlined in the **Summary of Benefits and Coverage**.

MATERNITY CARE (PRE AND POST NATAL CARE)

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

Maternity benefits are provided for a female Subscriber 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-hour or 96-hour period or require Prior Authorization 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-hour 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.

MEDICAL BILL REVIEW (MBR) AND CLAIM AUDIT PROVISION

All health care providers must submit Clean Claims. Alliant reserves the right to request and review medical records in order to allow for the determination of benefits according to the Contract. In accordance with Alliant's policies and procedures, no

benefits will be payable by Alliant if the health care provider does not submit a Clean Claim, obtain required Prior Authorization approvals, and submit upon request complete/legible itemization and complete/legible medical records.

At Alliant's discretion, all claims are subject to audit by Alliant or by an independent bill review firm and/or claim auditor. Alliant's medical bill audit may be performed with or without records, and the review is not subject to waiver by any third-party agreement including, but not limited to, any Provider Network Agreement(s), unless specifically prohibited, or other re-pricing arrangements, or the guidelines of any health care provider (e.g., physician, hospital or other facility).

Alliant will evaluate Clean Claims to ensure that the charges are correct and proper, billed using the most accurate and appropriate Current Procedural Terminology (CPT), International Classification of Diagnosis (ICD), Healthcare Common Procedure Coding System (HCPCS) and Revenue codes, and if applicable, documented in the medical records.

All Contract/claim adjudication determinations will be made using Alliant's Policies and Procedures that are based on the coding and billing guidelines of the American Medical Association, the CMS'/Federal Government's guidelines for proper coding and billing, including, but not limited to, the CMS Provider Billing and/or Reimbursement Guidelines, the National Correct Coding Initiative ("NCCI") guidelines, the CMS Physician Fee Schedule ("PFS") Relative Value File, and other Federal/clinical acceptance or coverage guidelines published by the Food and Drug Administration ("FDA"), National Comprehensive Cancer Network ("NCCN"), and/or the Federal National Library of Medicine-National Institute of Health.

As a result of any claim audit/review, Alliant will not provide benefits for services and supplies that:

1. Are not ordered by a physician;
2. Are not documented in patient's medical record(s);
3. Do not require a physician order;
4. Are routinely ordered/provided as a general clinical requirement of the physician or facility, rather than for documented specific medical need of the patient;
5. Are routine and unbundled from the global room charge/service, unbundled from any global charge/service or a professional charge(s) that is already considered separately reimbursable;
6. Are billed as technical or professional charges using CPT/HCPCS coding that has no technical or professional component;
7. Are up-coded using either historical medical events/diagnoses that are not in active treatment, or facility or procedure acquired diagnosis(es) that are not typical to the treatment of the diagnosis(es).
8. Are not covered by any other provision of this Contract, including but not limited to, Contract limitations and exclusions, and Contract definitions of Covered Services, Maximum Allowable and Medical Necessity.

Alliant will implement and utilize all applicable rules and guidelines regardless of whether the Federal Government/CMS waives their own guideline(s) as a requirement of their own adjudication process(es).

Alliant retains maximum legal authority and discretion to determine what is covered or not covered under the Contract, based on the results of any claim audit and/or medical bill review.

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**.

Hospital Inpatient Alcohol and Drug Detoxification:

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

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

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**.

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 Prior Authorization. Please have your provider call Alliant Health Plans Medical Management at (800) 865-5922.

NUTRITIONAL COUNSELING & NUTRITIONAL COUNSELING FOR OBESITY

Nutritional counseling related to the medical management of certain disease states is limited. Please contact Customer Service at (800) 811-4793.

ORAL SURGERY

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 emergency services for the stabilization of sound natural teeth or structure, including supplies or appliances for treatment required as a result of, and directly related to, accidental bodily Injury. Replacement or repair of missing or broken teeth is not covered.
- Oral surgery precipitated or caused by TMJ.

Replacement or repair of teeth is not a covered service.

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.

OUTPATIENT SERVICES

See the **Summary of Benefits and Coverage** 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 Alliant. These facilities may include a non-hospital site providing diagnostic and therapy services, surgery, or rehabilitation, or other Provider facilities as determined by Alliant.

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**. Some procedures require Prior Authorization.

OVARIAN CANCER SURVEILLANCE TESTS

- Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as:
 - having a family history:
 - with one or more first or second-degree relatives with ovarian cancer,
 - of clusters of women relatives with breast cancer,
 - of nonpolyposis,
 - colorectal cancer; or
 - testing positive for BRCA1 or BRCA2 mutations.
- Surveillance tests means annual screening using:
 - CA-125 serum tumor marker testing,
 - transvaginal ultrasound, and
 - pelvic examinations.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

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 combined total maximum visits per calendar year as outlined in the **Summary of Benefits and Coverage**.

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 Provider except where indicated. However, payment is significantly reduced, or not covered, if services are received from an Out-of-Network Provider. 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 (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.

Transition from Adolescent to Adult Care

Adolescents are encouraged to transition to adult care upon reaching an age at which their pediatrician can no longer provide the best care.

Transition of Care Following Exhaustion of Benefits

Alliant Health Plans complies with CMS and NCQA (National Committee for Quality Assurance) standards for Continuity and Coordination of care through notification to members who have exhausted their medical benefits. When a member exhausts benefits available under the terms of their policy, Alliant Health Plans takes steps to educate the member regarding other available resources, whether covered by the plan or not. These resources are listed on the Alliant Health Plans website.

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 your policy with no Deductible, Copayments or Coinsurance from the

Member when provided by an In-Network Provider. That means Alliant pays 100% of the allowed amount. 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.
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 at (800) 811-4793 for additional information about these services. Information is also available at these federal government web sites:

- <https://www.healthcare.gov/coverage/preventive-care-benefits/>
- <http://www.cdc.gov/vaccines/recs/acip/>
- <http://www.ahrq.gov/clinic/uspstfix.htm>

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.

Out-Of-Network

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 Coinsurance.

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, all shoe inserts; night-splint; dentures; replacing teeth or structures directly supporting teeth, 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.

RECONSTRUCTIVE SURGERY

Prior Authorization is required. Reconstructive Surgery does not include any service otherwise excluded in this Certificate. (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 FIRST NURSE 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 an In-Network Provider with respect to any proposed surgical intervention or any medical care that is a Covered Service.

SKILLED NURSING FACILITY CARE

Benefits are provided as outlined in the **Summary of Benefits and Coverage**. All Skilled Nursing Facility admissions must be Prior Authorized. 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.
- Benefit limit reached; see **Summary of Benefits and Coverage** or contact Customer Service for benefit limitations.

SPECIALIST PHYSICIAN CARE (SPECIALTY CARE)

A Member may access Specialist Physicians; a PCP Referral is not needed. You can locate a Specialist Physician on AlliantPlans.com or by calling Customer Service at (800) 811-4793. Some services provided by a Specialist Physician may require Prior Authorization.

TELEMEDICINE

The practice of telemedicine, by a duly licensed 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 Provider and the Member. As a condition of payment, the Member must be present and participating.

The amount of payment for the professional service provided via telemedicine by the Provider at the distant site is based on the negotiated rate or current MAC for the service provided.

TRANSPLANT ORGAN/TISSUE/BONE MARROW

Alliant’s transplant network facilities are independent of our Participating Provider network. Transplants that are provided at a non-Alliant Transplant Network Facility, even if the non-Alliant Transplant Network Facility is a participating provider, are not covered.

Covered Services include certain services and supplies not otherwise excluded in this Certificate 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 Travel:

In some cases that require extensive travel to an In-Network transplant facility, you may be eligible for travel reimbursement. Please contact Customer Service at (800) 811-4793 for more information.

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.

Prior Authorization Requirement:

All transplant procedures must be Prior Authorized for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by Alliant. To Prior Authorize, call (800) 865-5922.

The Prior Authorization 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*.

URGENT CARE SERVICES

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM

This Plan uses a Pharmacy Benefits Manager (PBM) for the administration of out-patient prescription drug benefits. Magellan Rx Management is the PBM for Alliant Health Plans. For the most up-to-date information about your Prescription Benefit Program, call Magellan Rx Customer Service at (800) 424-1799.

The Magellan Rx pharmacy network includes local and retail pharmacies throughout the United States. Members may obtain prescription drug and pharmacy assistance by calling the Magellan Rx Customer Care at (800) 424-1799.

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 Drug Formulary, which is a list of Prescription Drugs that are covered by the Plan. The Drug Formulary includes brand-name and generic medications that have undergone a careful review by a committee of practicing physicians and pharmacists. This committee reviews new and existing medications for safety and efficacy, and decides which medications provide quality treatment at the best value. While the Drug Formulary is intended to provide a comprehensive coverage of your prescription medication needs, there are some products that are not covered or have limited availability. For medications that are not on the formulary or are not covered by your prescription benefit program, talk to your physician about alternative medications. If you have questions regarding the Drug Formulary or regarding your Prescription Drug Plan, call Magellan Rx Customer Service at (800) 424-1799 or visit our website at AlliantPlans.com to view the Drug Formulary. Additional information regarding Prescription Drug limitations and exclusions can be found in the Exclusions section of this Certificate.

Your benefit design as shown in the **Summary of Benefits and Coverage** 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. For prescription drugs and diabetic supplies rendered by a pharmacy, the MAC is the amount determined by us using prescription drug cost information provided by the PBM.

At the time the prescription is dispensed; present your Identification Card at the in-network pharmacy. The in-network pharmacy will complete and submit the claim for you. If you do not go to an in-network 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.

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 Prior Authorization for Medical Necessity. Prior authorization is a requirement that your physician obtain approval to prescribe a specific medication for you. We review requests for these selected drugs to help ensure appropriate and safe use of medications for your medical condition(s). If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. For a List of select medications that require prior authorization, please contact Magellan Rx Customer Service at (800) 424-1799.

Covered Services May Include:

Retail prescription medications that have been prescribed by a Provider. Retail Prescription Drugs shall, in all cases, be dispensed per 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 Prior Authorization. You may obtain the list of Specialty Drugs and contracted Specialty Pharmacies by contacting Magellan Rx Customer Care at (800) 424-1799 or online at AlliantPlans.com.

You or your Physician may order your Specialty Drugs from a number of Specialty Pharmacies. The first time a Specialty Drug is ordered for home use, a representative will contact you to gather important information to schedule your first delivery from Magellan Rx Pharmacy. 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.

Specialty Pharmacies will deliver your Specialty Drug prescriptions via common overnight carrier and are shipped directly to you or, if necessary, to a 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 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**.

Alliant Health Plans partners with Magellan Rx Management because we are all dedicated to providing quality service and personalized care. Together, we make it easy for you to quickly get your specialty medications while providing additional support to help you stay on track. We will stay in touch over the course of your therapy and will call with monthly refill reminders and address any questions you may have about your treatment. In addition, you also have access to many helpful services:

- **Insurance specialists** to help you get the most out of your benefits
- **Clinical programs** to help manage your condition
- **Educational materials about your condition or medication**, including at-home guides
- **Free delivery** to your home or another address within two days of ordering
- **Important supplies at no additional cost**, such as syringes and needles
- **Highly trained pharmacists and nurses** available toll-free to answer any questions
- **Online member portal** where you can request refills and learn more

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 call Customer Service at (800) 811-4793.

The determination of tiers is made by Alliant 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 oral, injectable, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

Drug Tiers

The amount you will pay for a Prescription Drug depends on the tier of the drug you receive. Refer to your **Summary of Benefit and Coverage** 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 does not include the Copayment, if applicable. The difference you will be charged between the two drug costs does not include the Copayment, if applicable. This difference is referred to as a DAW (Dispense as Written) Penalty.

Example of DAW Penalty: Your physician orders a 30-day supply of the Brand Name Drug Coumadin, which has a cost of \$75. The Generic Drug Warfarin is available for \$5 for a 30-day supply this is a \$70 difference. Your Brand Name Drug Copayment is \$10 and if you elect to use the Coumadin in place of the Warfarin, your cost will be \$80. (The dollars listed are for example only and are not representative of the actual cost of these drugs.)

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 more or less tiers than the five listed above.



DRUG FORMULARY

A Member shall be entitled, upon request, to a copy of the Drug Formulary, which is also available on our website: AlliantPlans.com. Contact Customer Service by calling (800) 811-4793 to request a printed copy.

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 Magellan Rx Customer Service at (800) 424-1799. 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.

SPECIALTY 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, 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 U.S. Food and Drug Administration (FDA).

All off-label drugs must be pre-approved by Alliant Health Plans.

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 Brand Drug as outlined in the **Summary of Benefits and Coverage**, PLUS the difference in the cost of the two drugs.



OUTPATIENT PRESCRIPTION DRUG BENEFITS DO NOT INCLUDE THE FOLLOWING:

- 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;
- Injectables (except with Prior Authorization as required);
- 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;
- 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 the Off-Label Drugs section 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 General 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

This section describes the services and supplies available to Covered Persons up to but not including the age of 19. 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 prescribed Lenses and Frames; see limitations below. 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. Coverage is not provided for contact lenses.

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

- For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
- For Lenses which are not prescribed.
- For the replacement of Lenses or Frames except as specified in the **Summary of Benefits and Coverage**.
- For safety glass, safety goggles and sports glasses.
- Services that Alliant determines are special or unusual; such as orthoptics, vision training and low vision aids.
- For tints other than Number One or Two.
- For tints with photosensitive or antireflective properties.
- For progressive Lenses.
- For spectacle lens treatments or "add-ons", except for tints Number One or Two.
- 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).
- For Non-Covered Services or services specifically excluded in the text of this Certificate.

PEDIATRIC ORAL (DENTAL) BENEFITS

Pediatric dental benefits are available for covered members, up to but not including, the age of 19. This pediatric coverage includes services for evaluations, preventive treatments and dental radiology. This benefit is subject to the member's Deductible and Coinsurance. Listed below are the Covered Services and any applicable limitations.

Clinical Oral Evaluation	
Combined limit of 2 evaluations per year	
Periodic oral evaluation.	Limited to 2 per year; with a minimum of 6 months apart. Benefit is only allowed for a covered person showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when comprehensive oral evaluation is performed.
Limited oral evaluation – problem focused	Limited to 2 per year; with a minimum of 6 months apart.
Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	Limited to 2 per year; with a minimum of 6 months apart.
Comprehensive oral evaluation	Limited to 2 per year; with a minimum of 6 months apart.
Comprehensive periodontal evaluation.	Limited to 2 per year; with a minimum of 6 months apart. Benefit is only allowed for a covered person showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when comprehensive oral evaluation is performed.
Palliative treatment of dental pain	Emergency basis

Dental Radiology	
Intraoral – complete series (including bitewings)	Limited to 1 every 5 years. A complete series is a least 14 films, including bitewings.
Intraoral – periapical first film	Limited to 2 sets per year*
Intraoral – periapical, each additional film	Limited to 2 sets per year*
Intraoral – occlusal film	Limited to x-rays necessary to diagnose a specific treatment.
Bitewings – single film	Limited to 2 sets per year*
Bitewings – two films	Limited to 2 sets per year*
Bitewings – four films	Limited to 2 sets per year*
Vertical bitewings – 7-8 films	Limited to 2 sets per year*
Panoramic film	Limited to 1 every 5 years.
Cephalometric x-ray	Limited to x-rays necessary to diagnose a specific treatment.
Oral/Facial Photographic Images	Limited to x-rays necessary to diagnose a specific treatment.

Preventive Treatment	
Prophylaxis – adult (to age 19), including all scaling and polishing procedures.	Limited to 2 per year; with a minimum of 6 months apart.
Prophylaxis – child, including all scaling and polishing procedures.	Limited to 2 per year; with a minimum of 6 months apart.
Topical application of fluoride varnish	Limited to 2 per year; with a minimum of 6 months apart.
Topical application of fluoride – excluding varnish	Limited to 2 per year; with a minimum of 6 months apart.

Sealant - per tooth - unrestored permanent molars	Limited to 1 per tooth every 3 years.
Space maintainer – fixed – unilateral	Installation of initial space maintainers for retaining space when a primary tooth is prematurely lost. Benefit does not include separate adjustment expenses.
Space maintainer – fixed – bilateral	Installation of initial space maintainers for retaining space when a primary tooth is prematurely lost. Benefit does not include separate adjustment expenses.
Space maintainer - removable	
Space maintainer - removable	
Re-cementation of space maintainer	

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 acupressure 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.
- **Ambulance** – Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to: A Physician's office or clinic; a morgue or funeral home. Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.
- **Animal Assisted Therapy**
- **Aquatic Therapy**
- **Aromatherapy**
- **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.
- **Before Coverage Begins/After Coverage Ends** – Services rendered or supplies provided before coverage begins, i.e., before a Member'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 Member's Effective Date, continue after the Member's Effective Date.
- **Behavioral Disorders** – Behavioral modification, behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental retardation, anoxic birth injuries, birth defects, cerebral injury, non-acute head injuries, or cerebral palsy.
- **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 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 Member's house or place of business, and adjustments made to vehicles. Computer equipment to aid in speech or hearing loss.
- **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.

- **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.
- **Custodial Care** – Custodial Care, convalescent care or rest cures. 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.
- **Daily Room Charges** – Daily room charges while paying for 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 Certificate. Coverage for pediatric dental may be available based on eligibility circumstances; see Pediatric Oral (Dental) Benefits. Replacement or repair to missing and/or broken teeth.
- **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; all shoe inserts; orthopedic or corrective shoes; shoe molds; and support stockings.
 - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
 - Sterile water;
 - TENS units;
 - Sequential stimulators;
 - Conductive garments;
 - 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 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 do not meet the listed criteria.
 - Duplicate medical equipment.
- **Educational Services** – Services or supplies for teaching, vocational, or self-training purposes.
- **Employer-Run Care** – Care given by a medical department or clinic run by your employer.
- **Enteral Feeding** (unless it is documented as a sole source of nutrition)

- **Excess** – Charges not payable under the Contract due to application of any Contract maximum or limit or because the charges are in excess of the Maximum Amount/Maximum Allowable Charge, or are for services not deemed to be Reasonable or Medically Necessary, based upon Alliant’s determination as set forth by and within the terms and provisions of this document;
- **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 Member is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a 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.
- **Food, Medical Food or Food Products**
- **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.
- **Free Services** – Services and supplies for which you have no legal obligation to pay, or for which no charge has been made.
- **Freezing and storage of blood, sperm, gametes, embryos, or other tissues.**
- **Gene therapy and parentage testing.**
- **Genetic testing for infant gender identity.**
- **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 Member 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
- **Health Club Memberships and Fitness Services** – Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment or facilities used for physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.
- **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 or long term care facilities.
- **Hormone Pellets** – All implantable hormone pellets.
- **Hypnotherapy**
- **Immunizations for work or travel.**
- **Industrial Rehabilitation Therapy**
- **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.
- **Infant Formula**
- **Infertility** – Services related to or performed in conjunction with artificial insemination, in-vitro fertilization (IVF), ZIFT, GIFT ICSI and other related services, reverse sterilization or a combination thereof. Donor egg retrieval.
- **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 Member 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 Member 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.
- **Massage Therapy**
- **Maximum Allowed Cost (MAC)** – Expenses in excess of the MAC as determined by Alliant.
- **Medical Alert Devices**
- **Medical Reports** – Specific medical reports, including those not directly related to treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- **Methadone** – Methadone is excluded for coverage when used 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** – Any item, service, supply or care not specifically listed as a Covered Service in this Certificate.
- **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.
- **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. Inpatient services 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. 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, actinic 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, entertainment, homemaker services, travel expenses, and take-home supplies.
- **Prescription Drugs** – for exclusions *see not Covered Services* in the Out-Patient Prescription Drug Program section of this document.
- **Private Room** – Private room, except as specified as Covered Services.
- **Private Duty Nursing**
- **Providers who are closely related** – 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.
- **Recreational Therapy**

- **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.
- **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** – All 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.
- **Surrogate Mother Services** – Services or supplies for a person not covered under the plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Telehealth**
- **Thermograms**
- **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 is limited;
 - 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 any service 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.
- **Vestibular Rehabilitation Therapy**
- **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. Coverage for pediatric vision may be available based on eligibility circumstances; see Pediatric Vision Benefits.
- **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 Member but which has been waived or paid by a third party. If a Provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, benefits are determined by calculating 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.
- **Work Hardening Therapy**
- **Workers' Compensation** – Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.



COORDINATION OF BENEFITS (COB)

Individual/Family Plans, such as this one, do NOT coordinate benefits with any other health coverage that you, your spouse, or dependents may have.

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. 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.
- 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 Certificate of Coverage 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

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 Office Visits 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 Prior Authorization including, but not limited to, Prior Authorization, 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 In-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 In-Network Providers to disclose such information upon Member request.
- Receive, upon request and payment of a reasonable cost, a summary of how Physicians, Hospitals and other Providers are compensated using a variety of methodologies, including but not limited to 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 In-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.



MEMBER RESPONSIBILITIES

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 Maximums 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 Providers 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 Provider(s).

FINANCIAL INCENTIVES

Medical 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. We do not specifically reward Providers or other individuals for issuing denials of coverage. Financial incentives for 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 claims when services are rendered by an In-Network Provider.

A Member shall make payment to a Physician or Provider rendering services under this Contract only to comply with those Copayments, Deductible, and out-of-pocket requirements outlined in the **Summary of Benefits and Coverage**. We are authorized by you to make payments directly to the Provider of Covered Services.

Each person enrolled through the Plan receives an Identification Card. When admitted to an Alliant In-Network Hospital, present your Identification Card. Upon discharge, you may be billed only for those charges not covered by your Plan. The Hospital will bill us directly for Covered Services.

Out-of-Network Providers

When Covered Services are rendered out-of-network, services are performed by Out-of-Network Providers. Out-of-Network Providers are not required to file a claim on your behalf; you may have to pay the bill at the time of service and submit an itemized bill or claim to us for reimbursement.

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 predetermined allowed amount for Covered Services rendered to a Member. A Member is not liable for fees in excess of the allowed amount, except what is due under the Contract, e.g., Copayments, Deductibles or Coinsurance.

Out-of-Network Providers are not under an agreement with Alliant and may bill you for fees in excess of the MAC.

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 that 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 at an Out-of-Network Hospital, the claim for Hospital services is usually handled in the same manner as with an In-Network Hospital and the Hospital files the claim. 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.

If you need to submit a claim for services by an Out-of-Network Provider or reimbursement for services you had to pay, you must submit a claim form. You can obtain a blank claim form by visiting AlliantPlans.com or calling Customer Service at (800) 811-4793.

- You have one-hundred and eighty (180) 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 fifteen (15) working days of receipt for electronic claims and thirty (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 fifteen (15) working days for electronic claims and thirty (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.

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.

NONDISCRIMINATION

Notice of Non-Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans:

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

If you need these services, contact Sabrina LeBeau.

If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sabrina LeBeau, Compliance Officer, 1503 N. Tibbs Rd. Dalton, GA 30720, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sabrina LeBeau is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

TTY/TDD

If you speak another language, language assistance services are available, free of charge. For TTY/TDD access call (800) 811-4793.

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793]。

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, શેલ કરો (800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

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यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भाषण से बात करने के लिए, (800) 811-4793 पर कॉ करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans akenfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

هي انودنم لتغلب فيروصول ات امولع مل او ةدع مل مل اىلع لىلج ايف قجل الفى دلف ، Alliant Health Plans ، قلىض أ ددع مل لىلجى دل و ألقى دل ن كن إ قلىلكت (800) 811-4793 ب لىلج ا ملىلج م ع ملىلج لىلج . قلىلكت

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

از دوخ ن لبز دبت اع الط ا وکک دک نیر اد ار نی اقح نیش لب نیش اد ، نیکیکی کک و اد اب اش دکوسک لی ، اش رگ ا نیی اش لى اس اش . نیی اش نیش لی ر د ن گى ار روط د ب (800) 811-4793

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

TTY/TDD

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 811-4793 (TTY/TDD: (800) 811-4793).

ATENCION: Si habla español, servicios de asistencia de traducción, gratis, están disponibles para usted. Llame al 1-(800)811-4793 (TTY/TDD:1-(800) 811-4793)

QUESTIONS ABOUT COVERAGE OR CLAIMS

If you have questions about your coverage or claims, contact your Plan Administrator or Alliant Customer Service at (800) 811-4793. Be sure to always give your Member ID number.

When asking about a claim, provide 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).

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 Coinsurance requirements specified in your **Summary of Benefits and Coverage**. This Certificate of Coverage supersedes any previously distributed Certificate of Coverage.

Benefit payment for Covered Services or supplies will be made directly to whoever submits the claim. If the Provider submits the claim, we will make payment to the Provider. If you submit the claim, payment will be made directly to you and you are responsible for making payment to the Provider.

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 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.

FRAUD OR MISREPRESENTATION

Fraudulent statements and/or intentional misrepresentation on application forms, claims, Identification Cards or other identification to obtain services or a higher level of benefits are prohibited. This includes, but is not limited to, the fabrication and/or alteration of a claim, Identification Card or other identification. Misrepresentation involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for rescinding coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Unauthorized use of your Identification Card, by you or an unauthorized person, or if you fraudulently use the Identification Card of another covered person, including but not limited to the use of card before coverage is in effect or after coverage has ended. Under these circumstances, the person who receives the services provided by misuse of the Identification Card will be responsible for payment of those services. Fraudulent misuse could also result in termination of the coverage.

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 U.S.

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 MAC. You may not assign benefits to foreign Providers or facilities.

MEDICARE

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

Except when federal law requires Alliant to be the primary payer, the benefits under this Certificate 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 payer, 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 Medicare Parts B and D, Alliant will calculate benefits upon receipt of the Member's Explanation of Medicare Benefits (EOMB) or for Part D payment data obtained from an authorized Prescription Benefit Manager (PBM).

WHEN YOUR COVERAGE TERMINATES

When will my Alliant Membership end?

Alliant Health Plans will renew or continue your coverage if you wish to remain enrolled. The Affordable Care Act preserves existing requirements under HIPAA that require insurers to renew coverage on a guaranteed basis with some exceptions, such as the nonpayment of premiums and fraud, among others, that are explained below.

TERMINATION OF BENEFITS & COVERAGE

The termination date of your coverage is the first day you are not covered with Alliant (for example, if your termination date is July 1, 2014, your last minute of coverage was at 11:59 p.m. on June 30, 2014). If your coverage terminates for any reason, you must pay all amounts payable and owed related to your coverage with Alliant, including Premiums, for the period prior to your termination date.

Except in the case of fraud or deception in the use of services or facilities, Alliant will return to you within 30 days the amount of Premiums paid to Alliant which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Alliant.

Your membership with Alliant will terminate if you:

- No Longer Meet Eligibility Requirements:
 - You no longer meet the age or other eligibility requirements for coverage under this plan as required by Alliant or the Marketplace.
 - You no longer live in Alliant's Service Area for this product. The Marketplace and/or Alliant will send you notice of any eligibility determination. Alliant will send you notice when it learns you have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to you unless you request an earlier termination effective date.
 - For Dependents, upon reaching age 26, your coverage will terminate at the end of the calendar year in which you turn 26.
- Request Disenrollment: You decide to end Your membership and disenroll from Alliant by notifying Alliant if you purchased directly from us or the Marketplace if you purchased from the Health Insurance Marketplace. Your membership will end at 11:59 p.m. on the 14th day following the date of your request or a later date if requested by you. Alliant may, at its discretion, accommodate a request to end your membership in fewer than 14 days, but will not accommodate any requests to end membership earlier than the date of your request.
- Change Health Plans: You decide to change from Alliant to another health plan either during an annual open enrollment period or other special enrollment period for which you have been determined eligible in accordance with the special enrollment procedures or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the Effective Date of coverage through your new health plan.
- Fraud or Misrepresentation: You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of your coverage with Alliant. We reserve the right to rescind your coverage after we provide you a 30-calendar day advance written notice that coverage will be rescinded. You have the right to appeal the rescission. The termination date will be the date of the fraud or intentional misrepresentation or a material fact or the original date of your enrollment, whichever is later.
See Fraud or Misrepresentation in the General Information section of this Certificate for additional information.
- Accept Reimbursement for Premium: You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider, any health care provider sponsored organization, any pharmaceutical company, or any sales agent or broker for any portion of the Premium for coverage under this Certificate. This prohibition does not apply to the following third parties:
 - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
 - Indian tribes, tribal organizations or urban Indian organizations.
 - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.



After Your first 24 months of coverage, Alliant may not terminate Your coverage due to any omissions, misrepresentations or inaccuracies in Your application form (whether willful or not).

If Alliant terminates your membership for cause, you will not be allowed to enroll with us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

- **Discontinuation:** If Alliant ceases to provide or arrange for the provision of health benefits for new or existing health care service plan Contracts, in which case Alliant will provide you with written notice at least 180 days prior to discontinuation of those Contracts.
- **Withdrawal of Plan:** Alliant withdraws this product from the market, in which case Alliant will provide you with written notice at least 90 days before the termination date.
- **Nonpayment of Premiums:** If you do not pay required Premiums by the due date, Alliant may terminate your coverage as further described below.

Your coverage under certain Benefits and Coverage will terminate if your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision or Dental Services covered under this Agreement and, as a result, such Member's coverage under those specific Benefits and Coverage will terminate on his or her 19th birthday, without affecting the remainder of this Certificate.

PREMIUM PAYMENTS & TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums. Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the first day of that month. This is the "Due Date." Alliant will send You a bill in advance of the Due Date for the upcoming coverage month. If Alliant does not receive the full Premium payment due on or before the Due Date, Alliant will send a notice of non-receipt of Premium payment and cancellation of coverage (the "Late Notice") to the Subscriber's address of record. This Late Notice will include, among other information, the following:
 - A statement that Alliant has not received full Premium payment and that we will terminate this Agreement for nonpayment if we do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
 - The amount of Premiums due.
 - The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if we do not receive the required Premiums.
- If You have received a Late Notice that Your coverage is being cancelled or not renewed due to failure to pay your Premium, Alliant will give you a "grace period"; during the grace period, you can avoid cancellation or nonrenewal by paying the Premium you owe to Alliant. If you do not pay the Premium by the end of the grace period, this Agreement will be cancelled. You will still be responsible for any unpaid Premiums you owe Alliant for the grace period.
 - If you purchased your SoloCare policy on the Marketplace (Federal Facilitated Exchange) and you receive an Advanced Premium Tax Credit (APTC), you have a three-month grace period. Alliant holds payment for Covered Services after the first month of the grace period until we receive the delinquent Premiums. If Premiums are not received in full by the end of the three-month grace period, the Subscriber is responsible for payment of the Covered Services received during the second and third months of the grace period.
 - If you purchased your SoloCare policy on the Marketplace (Federal Facilitated Exchange) but do NOT receive an Advanced Premium Tax Credit (APTC), you have a 31-day grace period. If Premiums are not paid in full during that 31-day grace period, coverage is terminated as of the last day of your grace period.
 - If you purchased your SoloCare policy off the Marketplace (Federal Facilitated Exchange) you have a 31-day grace period. If Premiums are not paid in full during that 31-day grace period, coverage is terminated as of the last day of your grace period.

REINSTATEMENT AFTER TERMINATION FOR NON-PAYMENT OF PREMIUMS

- When you have been terminated for nonpayment of Premiums, you may not enroll in Alliant within a 12-month period unless all amounts have been owed are paid to Alliant.
- If Alliant terminates this Agreement for nonpayment of Premiums, we may permit reinstatement of this Agreement once during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice, described below. Alliant will not reinstate this Agreement if you do not obtain reinstatement of your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than



once in a 12-month period. In either case, you will be ineligible to re-enroll for a period of 12 months from the effective date of termination unless all amounts owed in arrears are paid to Alliant.

Termination Notice: Upon termination of this Agreement, if initiated by Alliant, Alliant will mail a Termination Notice to the Subscriber’s address of record specifying the date and time when the membership ended.

If you purchased your coverage through the Health Insurance Marketplace, see “REPORTING LIFE & INCOME CHANGES TO THE MARKETPLACE” at the end of this document for additional information.

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.

Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis, where 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.

Applicant

The individual who 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

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.

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.

Certificate

A short, written statement which defines our legal obligation to the Members.

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.

Clean Claim

Providers are required to submit clean claims. A clean claim is defined by the Georgia Department of Community Health as a claim received for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Alliant.

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. This is different than Copayment.

Combined Limit

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

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, and 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/developmental 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

The Certificate, the Alliant Formulary, any amendments or riders, and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate or any amendment or rider, the amendment or rider shall control.

Contract Year

A period of one calendar year commencing on January 1 at 12:01am and ending December 31 at 12:00pm midnight.

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. The Member is usually responsible for payment of the Copayment at the time health care is rendered.

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

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Certificate and has enrolled and complied with the Premium requirements.

Covered Services

Those charges for Medically Necessary health care services, treatment and supplies intended to improve a condition or Member's health 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. Covered Services are determined based upon all other Contract provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Service is the least costly option that is no less effective than any other option. The Covered Services are also subject to the Maximum Allowable Cost (MAC), as defined herein and all Contract exclusions will be taken into consideration to determine the Covered Service.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a ninety (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.

Deductible

The portion of the bill you must pay before your medical expenses become reimbursable. It 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.

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 access to primary and specialty care Physicians without the need for an Alliant approved referral.

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

The date on which benefits begin for each member.

Elective Surgical Procedure

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

Emergency Medical Services

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
- Serious dysfunction of any bodily organ or part

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.

Experimental and/or Investigational

Experimental and/or Investigational shall mean any drug, biological product, medical treatment/procedure and/or medical device/equipment (herein collectively known as healthcare services or services) that are not commonly and widely used or accepted by the vast majority of practitioners in the United States, and/or services that lack credible evidence to support positive short-term and/or long-term outcomes from the services rendered; further, the healthcare services are not reimbursable under the CMS guidelines established for Medicare coverage and/or are healthcare services which meet any of the following criteria:

1. Are in any phase of clinical trials;
2. Are not of proven benefit for the specific diagnosis or treatment of the covered patient's particular condition;
3. Do not constitute acceptable medical practice under the standards of the covered patient's case and by the standards of a reasonable segment of the medical community or governmental oversight agencies at the time services were rendered, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration ("FDA"), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine- National Institute of Health;
4. Are rendered on a research basis as determined by governmental oversight agencies, including, but not limited to, the FDA and the AMA's Council on Medical Specialty Societies.
5. Are generally recognized that additional study on its safety and efficacy for the specific diagnosis or treatment of the covered patient's particular condition is recommended, taking into consideration the medical community or governmental oversight agencies at the

time services were rendered, including, but not limited to, the AMA, FDA, NCCN and/or the Federal National Library of Medicine-National Institute of Health;

A drug, biological product, medical treatment, medical procedure, medical device/equipment or any other healthcare service is considered Experimental and/or Investigational if:

1. It cannot be lawfully marketed without the approval of the FDA and the approval for marketing had not been given at the time the aforementioned healthcare services were rendered or furnished to the covered patient;
2. Reliable evidence shows that any of the aforementioned healthcare services is:
 - a. the subject of ongoing Phase I, II or III clinical trials; or
 - b. under study to determine its safety, efficacy, maximum tolerated dose, toxicity and/or its efficacy as compared with the standard means of treatment or diagnosis; or
 - c. considered among experts to need further studies or clinical trials to determine its safety, efficacy, maximum tolerated dose, toxicity and/or its efficacy as compared with the standard means of treatment or diagnosis.
3. In the case of a drug, biological product or device/equipment, it is not being used to treat the particular diagnosis or condition that it has been approved for by the FDA; in other words, it is considered off-label use.
4. It does not meet the Technology Assessment Criteria as defined by Alliant.

Reliable evidence shall include:

1. Published reports and articles in authoritative and scientific literature from the medical community and/or governmental oversight agencies, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration (FDA), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine-National Institute of Health;
2. The written protocol(s) used by the treating provider/facility or the protocol(s) of another comparable provider/facility that is significantly studying the drug, biological product, medical treatment, medical procedure, medical device/equipment or other healthcare service in question;
3. The written informed consent used by the treating provider/facility or by another comparable provider/facility that is significantly studying the drug, biological product, medical treatment,

medical procedure, medical device/equipment or other healthcare service in question.

Alliant shall have full authority and discretion to interpret, administer and apply the terms of this section, as well as to determine what is Experimental and Investigational, to the greatest extent permitted by law.

Frame

Standard eyeglasses excluding the Lenses.

Generic Drugs

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

Hearing Aid

Hearing Aid means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term Hearing Aid includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products shall not qualify as hearing aids.

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 name, covered Dependents, your ID numbers, the type of coverage you have the claim submission address, and phone numbers for Customer Service, Prior Authorizations and Pharmacy Help Line.

Incapacitated Dependent

A Dependent in which the subscriber or the subscriber's spouse is the court-appointed legal guardian; and the dependent is mentally or physically incapable of earning a living as determined by the Georgia Department of Human Resources, and the dependent is chiefly dependent upon the Subscriber for support and maintenance, provided that the onset of such incapacity occurred before the dependent was 26.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Prior Authorization 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.

Injury

Bodily harm from a non-occupational accident.

In-Network Care

Covered Services provided to Members by their Physician through In-Network Hospital and In-Network Providers.

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.

In-Network Provider

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies, who is in the managed network for this specific plan or other closely managed specialty network, or who has a participation contract with us.

Inpatient

A Member who is admitted into a Hospital and receives lodging and food, as well as treatment.

Late Enrollees

Late Enrollees means Applicant 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 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 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 or Maximum Allowable Charge (MAC)

Maximum Allowed Cost and/or Maximum Allowable Charge shall mean the maximum amount payable for a Covered Service under the Contract, and meeting Medical Necessity and Prior Authorization requirements. MAC will be the amount equal to the greatest of the following:

- The amount negotiated with in-network providers for the service furnished;
- The amount for the service calculated using the same method the plan generally uses to determine payments for out-of-network services; or
- The amount that would be paid under Medicare for the same service.

The MAC will not include any identifiable billing mistakes including, but not limited to, up-coding, unbundled services/charges, duplicate charges, and charges for services not performed.

Medical Child Support Order (MCSO)

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 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 health plan.

Medical Facility

Any Hospital, ambulatory care facility, Chemical Dependency Treatment Facility, Skilled Nursing facility, Home Health Care Agency or mental health facility, as defined in this Certificate. 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 Certificate, 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.

Non-Covered Services

Any item, service, supply or care not specifically listed as a Covered Service under this 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 to provide primary nursing and basic medical services.

Out-of-Network Care

Care received 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 an In-Network Provider contract with Alliant.

Out-of-Pocket Maximum

(May apply to in-network or out-of-network—Refer to **Summary of Benefits and Coverage**) The maximum amount of a Member's Copayments 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 MAC. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the MAC for Covered Services.

Outpatient

A Member who receives medical treatment without being admitted to a hospital.

Outpatient Prescription 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) Prior Authorization 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.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

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 to provide basic medical services under the supervision of a licensed Physician.

Physician Assistant Anesthetist (PAA)

An individual duly licensed to provide anesthesia services under the supervision of a licensed Physician specializing in anesthesia.

Policies and Procedures

Alliant's quality assurance, quality improvement, accreditation, risk management, Utilization Management, Payment Policies, claims processing, claims adjudication and administrative Policies and Procedures. These provisions may change from time to time. Policies are not authorizations, certifications, explanation of benefits, or contracts for payment. Benefits and eligibility are determined by Alliant before medical guidelines and payment guidelines are applied. Benefits are determined by Alliant that is in effect at the time Covered Services are rendered. Policies are created and derived from medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing Alliant reserve the right to review and revise their medical Policies periodically. Payment Policies are the guidelines utilized for calculating payment of claims under this Contract. Such guidelines include Alliant's standard claim coding and bundling methodology and claims processing Policies and Procedures.

PPACA

Patient Protection and Affordable Care Act.

PPO Network

A Preferred Provider Organization (PPO) is a limited panel of Providers as designated by Alliant known.

PPO Network Provider

A Preferred Provider Organization (PPO) is 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 required to pay for 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 family practice, general practice, pediatrics, non-specialized obstetricians and gynecologists, or internal medicine Physician who has entered into an agreement to coordinate the care of Members.

Prior Authorization

A process used by Alliant to determine if a procedure or treatment is a medically necessary, covered service eligible under the plan for payment consideration. Prior Authorization approval is subject to all plan limits and exclusions.

Provider

Any Physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a Hospital, clinical laboratory, Ambulatory Surgery Center, 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.

Reasonable and/or Reasonableness

Shall mean in Alliant's discretion, services or supplies, which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that a service(s) is reasonable will be made by Alliant, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. Alliant retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to Alliant. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment, when they result from Provider error(s) and/or facility-acquired

conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines. Alliant reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by Alliant, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by Alliant under the Contract."

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 may 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

Specific geographic areas (such as counties) where coverage is offered.

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 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 Prior 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 Telemedicine, 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

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

Treatment of an Urgent Care medical problem is not life threatening and does not require a trip to 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**.



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.

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 Customer Service at (800) 811-4793. 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 below.
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 Customer Service at (800) 811-4793. 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
c/o Magellan Health
Appeals Department
PO Box 9780
Salt Lake City, UT 84109

Pharmacy Appeals (Level I & II): Magellan Rx Management
Appeals Department
2520 Industrial Row Drive.
Troy, MI 48084

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 30 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.

Other Resources to Help You

You or your authorized representative may submit a complaint by notifying the Georgia Department of Insurance Consumer Services Division by phone at (800) 656-2298. You or your authorized representative may also submit a complaint 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
Complaints and Appeals
PO BOX 1247
Dalton, GA 30722
(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**.



IMPORTANT: The following information only applies if you purchased your plan on The Health Insurance Marketplace.



REPORTING LIFE & INCOME CHANGES TO THE MARKETPLACE

Once you have Marketplace coverage, you must report certain life changes. This information may change the coverage or savings you're eligible for.

Important: Do not report these changes by mail. See below for instructions on how to report changes.

Life changes to report:

You must report a change if you:

- Get married or divorced
- Have a child, adopt a child, or place a child for adoption
- Have a change in income
- Get health coverage through a job or a program like Medicare or Medicaid
- Change your place of residence
- Have a change in disability status
- Gain or lose a Dependent
- Become pregnant
- Experience other changes that may affect your income and household size
- **Other changes to report:** change in tax filing status; change of citizenship or immigration status; incarceration or release from incarceration; change in status as an American Indian/Alaska Native or tribal status; correction to name, date of birth, or Social Security number.

When and how to report changes:

- You should report these changes to the Marketplace as soon as possible.
- If these changes qualify you for a special enrollment period to change plans, in most cases you have 60 days from the life event to enroll in new coverage. If the changes qualify you for more or less savings, it's important to make adjustments as soon as possible.

Important: Do not report these changes by mail.

You can report these changes 2 ways:

- **Online.** [Log in to your account](#). Select your application, then select "Report a life change" from the menu on the left.
- **By phone.** Contact the Marketplace Call Center at (800) 318-2596 (TTY: (855) 889-4325)

After you report a change to the Marketplace, you'll get a new eligibility notice that will explain:

- Whether you qualify for a special enrollment period that allows you to change plans
- Whether you're eligible for lower costs based on your new income, household size, or other changed information. You may become eligible for the first time, for a different amount of savings, or for coverage through Medicaid or the Children's Health Insurance Program (CHIP). You also could become ineligible for savings--if your income has gone up, for example.

If you're eligible for a special enrollment period:

You'll be able to shop for a different plan in the Marketplace. You usually have up to 60 days from the date of the qualifying event to enroll in a new plan.

If you have a special enrollment period, you can change plans 2 ways:

- **Online.** Log in to your account and select your application. Then select "Eligibility and Appeals" from the menu on the left. Next, scroll down and click the green "Continue to enrollment" button. You can then shop for plans and change your selection.
- **By phone.** Contact the Marketplace Call Center at (800) 318-2596 (TTY: (855) 889-4325).

If you're not eligible for a special enrollment period but the tax credit you qualify for has changed, you can't change plans. But you can choose to adjust the amount of the tax credit to apply to your monthly premiums.

Changing your profile information:

You should report changes that don't affect your coverage or savings as well.

- To change your home address, email address, or phone number, [update the information on your Marketplace Profile page](#).
- **Be sure to report address, email, and phone changes to Alliant Health Plans.** Otherwise we may not know about your new contact information. Contact Customer Service at (800) 811-4793.

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Alliant Health Plans, Inc. for safeguarding individually identifiable protected health information. The terms of this Notice apply to members and dependents for their individual and group health insurance. This Notice is effective March 23, 2013.

We are required by law to maintain the privacy of our members' and dependents' protected health information, provide notice of our legal duties and privacy practices with respect to protected health information and notify affected individuals of a breach of their unsecured identifiable protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. You have the right to request a paper copy of the Notice by sending your request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720.

Uses and Disclosures of Your Protected Health Information Authorization. Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing our use or disclosure, including most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures for sale of protected health information. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to revoke an authorization can be obtained from the Health Information Protection Officer.

Disclosures for Treatment. We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment. We use and disclose your protected health information as necessary for payment purposes. For instance, we may use your protected health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also disclose information to another insurer in order to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We may contact your health care providers concerning prescription drug or treatment alternatives.

Genetic Information Non-discrimination Act. We are prohibited from using your genetic information for underwriting purposes. Genetic information for purposes of the underwriting means, with respect to any individual, information about (i) such individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual (i.e., family medical history). It also includes the collection of genetic information for clinical research purposes, but excludes information about the sex or age of any individual.

Information Received Pre-enrollment. We may request and receive from you and your health care providers' protected health information prior to your enrollment under the group health insurance policy. We will use this information to determine whether you are eligible to enroll under the policy and to determine the premium rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associates. Certain aspects and components of our services are performed by third party persons or organizations pursuant to agreement or contract with us. It may be necessary for us to disclose your protected health information to these third-party persons or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your protected health information as required by law.

Family, Friends and Personal Representatives. With your written authorization, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information to such persons without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (*for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect*);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (*for example, inspections, licensure actions or civil, administrative or criminal proceedings or actions*);
- For judicial or administrative proceedings (*for example, pursuant to a court order, subpoena or discovery request*);
- For law enforcement purposes (*for example, reporting wounds or injuries or for identifying suspects, witnesses or missing people*);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces, for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation insurance purposes.

We will adhere to all applicable state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation. Except for the types of uses and disclosures of protected health information described in this Notice, we may make other uses and disclosures of protected health information only with your written authorization.

Your Rights Regarding the Restriction on Use and Disclosure of Your Protected Health Information. You have the right to request certain restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care of the paying of your health care. To request a restriction, you must send a written request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction, except for a restriction to disclose your protected health information to a health plan if the purpose is to carry out payment or health care operations which is not otherwise required by law and the protected health information pertains solely to a health care item or service for which a person, other than the health plan, has paid the health care provider in full. If we agree to your request for a restriction, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information. You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests for such alternative means. To request a confidential communication, you must send a written request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information. You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with a few exceptions. To request access, you must send a written request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee will be charged to you for copying and postage.

Amendment of Your Protected Health Information. You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures of your protected health information made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee will be charged to you for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to the Privacy Officer, Alliant Health Plans, 1503 N. Tibbs Rd, Dalton, GA 30720 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Customer Service Department at Alliant Health Plans at (800) 811-4793.

