SUMMARY PLAN DESCRIPTION

Level-funded health plan

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IMPORTANT INFORMATION

MEDICAL BENEFITS, CLAIMS & QUESTIONS

Customer Service	(866) 403-2785 CustomerService@AlliantPlans.com
24-Hour Nurse Advice Line	(855) 299-3087
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

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 any necessary Prior Authorization when using a PHCS or Out-of-Network Provider.

MOBILE MEMBER PORTAL

Coverage at your fingertips! Alliant has released a mobile app – available on the App Store or Google Play. Gain quick access to your plan information, claim information, EOBs, ID card, and Find a Provider for in-network services. Search Alliant Health Plans to download the Mobile Member App today!

Download on the App Store GET IT ON Google Play

IMPORTANT NOTE

When you see this symbol, 

carefully read this section to understand how to maximize your benefits.

SUMMARY NOTICE

This Summary Plan Description explains your health care benefit plan. It is written in easy-to-read language to help you understand your health care benefits.

The purpose of this document is to help you understand your coverage. A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this document carefully. If you have any questions about your benefits as presented, please call Customer Service at (866) 403-2785**.**

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional llamando a Servicio al Cliente al (866) 403-2785.

English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at (866) 403-2785*.*

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 regular business hours.

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

- Verification of benefits is NOT a guarantee of payment.
- If the verified service requires Prior Authorization, please call (800) 865-5922.

PRIOR AUTHORIZATION (also known as Pre-Certification)

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 Services under your benefit plan.

Prior Authorization approvals apply only to services that have been specified in the request for Prior Authorization or Prior Authorization list available on our website, AlliantPlans.com. 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 the payment of claims later regardless of whether such later claims have the same, similar, or related diagnoses.

IN-NETWORK

For Prior Authorization, your **PROVIDER** must call (800) 865-5922.

- Your Provider or facility is required to request a Prior Authorization for **ALL** in-patient hospital admissions that are in-network, except for maternity admissions.
    - Your **Provider** should notify us by the next business day of an emergency or maternity admission.
    - Your **Provider** can request Non-Urgent Care Prior Authorizations during regular business hours.
    - Emergency Medical Services do NOT require Prior Authorization.

Members with PHCS Network Access Only: While PHCS Providers/Facilities are considered In-Network, Prior Authorization requirements rest on **YOU**, the member. The vast majority of PHCS Providers will assist members with obtaining the Prior Authorization. For a list of services that require Prior Authorization, contact Customer Service at (866) 403-2785 for assistance.

OUT-OF-NETWORK

For Prior Authorization, **YOU** must call (800) 865-5922.

- **YOU** are required to request a Prior Authorization for ALL in-patient hospital admissions that are out-of-network or part of the PHCS network.
    - **YOU** are responsible for notifying us within one (1) business day of an emergency or maternity admission, or your claim may be denied.
    - **YOU** may request a Non-Urgent Care Prior Authorization during regular business hours.
    - Emergency Medical Services do NOT require Prior Authorization.

ELIGIBILITY

COVERAGE FOR YOU

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

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

COVERAGE FOR YOUR DEPENDENTS

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

Your employer may choose to offer coverage to:

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

Your Covered Dependents are also called Members.

YOUR ELIGIBLE DEPENDENTS MAY INCLUDE

(depending on your employer's option of coverage):

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

LATE ENROLLEES

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

OPEN ENROLLMENT

Your employer defines the Open Enrollment Period but typically begins no earlier than 31 days before the contract's renewal date. Please contact your Plan Administrator for more information.

SPECIAL ENROLLMENT PERIODS

Consumers can qualify for a Special Enrollment Period (SEP) to enroll for health insurance coverage if they meet specific 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 the primary residence.

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

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

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

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

If your employer offers coverage to Dependents, a newborn is covered for thirty-one (31) days from the moment of birth (or, in the case of adoptions, the date of assumption of legal responsibility). For coverage to continue beyond the first thirty-one (31) days, an application form to add the child as a Dependent and payment of any applicable costs must be received by us within thirty-one (31) days from the date of birth or legal assumption. The costs for coverage shall include the first thirty-one (31) days of coverage. If we do not receive the application and the additional cost within thirty-one (31) days from the date of birth or legal assumption, coverage will terminate at the end of the thirty-one (31) day period. If we receive the application and costs after the thirty-one (31) day period, but within sixty (60) days from the date of birth or legal assumption, coverage will be reinstated retroactively with no break in coverage with costs required, including the first thirty-one (31) days of coverage. The provision for newborn coverage does **NOT** apply to a child born to a covered dependent on the plan.

If you choose to enroll your newborn in a different plan, the newborn will be considered covered during the first thirty-one (31) days starting the day of birth. If there is more than one insurance policy in force, Alliant will not pay more than would be paid under the original plan (the plan where the child is added per the State of Georgia required thirty-one (31) days of coverage). 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 (866) 403-2785 to obtain a Newborn Coverage Waiver Form. The provision for newborn coverage does **NOT** apply to a child born to a Covered Dependent on the plan.

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. For a foster child to have coverage, a Member must confirm 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 payment of any applicable costs must be received by us within thirty-one (31) days from the date of legal assumption. The cost shall include the first thirty-one (31) days of coverage. If we do not receive the application and costs within thirty-one (31) days from the date of legal assumption, coverage will terminate at the end of the thirty-one (31) day period. If we receive the application and costs 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 your employer offers Dependent's coverage, then foster children for whom a Member assumes legal responsibility are not covered automatically. For a foster child to have coverage, a Member must confirm a valid foster parent relationship to Alliant. Such confirmation must be furnished at the Member's expense.

OBRA 1993, AND QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

- An adopted child or a child is placed for adoption, regardless of whether the adoption has become final.

- An adopted child is under the age of 18 as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted.
- Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received a Medical Child Support Order (MCSO) determined by the employer or Plan Administrator to be a QMCSO.
- Upon receipt of an MCSO, the employer or Plan Administrator will inform the Employee, each affected child, of its receipt of the order and explain the procedures for determining if the order is a QMCSO. The employer will subsequently notify the Employee and the child(ren) of the determination.

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

MEDICAID, AND CHIP SPECIAL ENROLLMENT/SPECIAL ENROLLEES

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

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

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

WHEN YOUR COVERAGE BEGINS

If you apply when first eligible, your coverage will be effective on the date after your Group's waiting period has been met. The Effective Date of coverage is subject to any waiting period provision your employer requires (which may not exceed 90- days) as stated in the Employer Group Application, or as otherwise agreed to by the group plan sponsor, and us.

Employee eligibility date

The Employee is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the group plan sponsor, and us;
- Your Group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage) or otherwise meet the minimum eligibility requirements for working owners in accordance with the PPACA;
- The Employee is a category or classification of individuals that is covered by the plan; and
- The Employee is in an active status.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

The Group uses a look-back measurement period to determine whether an Employee is eligible for coverage. The look-back measurement method is based on IRS regulations under the PPACA. The Company establishes how long these periods will last, subject to specified IRS rules. The Group intends to follow IRS regulations (including any subsequent guidance issued by the IRS on the look-back measurement method) when administering the look-back method.

Dependent eligibility date

Each Dependent is eligible for coverage on:

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

child, or a valid court or administrative order for a spouse, which requires the Employee to provide coverage for a child or spouse as specified in such orders.

When Dependent coverage is made available, Dependents may be covered only if the Employee is also covered. A Dependent child who enrolls for other group coverage through any employment is no longer eligible for group coverage under the Master Group Contract.

CHANGING YOUR COVERAGE

There is an annual enrollment period during which time Members may elect to change their options. If your employer offers Dependent's coverage, you may add them during Open Enrollment or, if qualified, during a Special Enrollment. If you do not enroll during a regular enrollment or a special open enrollment period described below, you may enroll only during your group's annual open enrollment period, if any. Your coverage will begin on the date specified by your group following your enrollment.

LEAVES OF ABSENCE; FAMILY, AND MEDICAL LEAVE

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

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage.

CHANGING YOUR COVERAGE OR REMOVING A DEPENDENT

When any of the following events occur, notify your employer:

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

EMPLOYEE NOT ACTIVELY AT WORK DURING INITIAL ELIGIBILITY PERIOD

Initial Enrollees

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

New Hires

If an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status.

HOW YOUR BENEFITS WORK FOR YOU

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 amount 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 (866) 403-2785.

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. When you choose a Preferred Provider, you have access to In-Network Care.

By visiting AlliantPlans.com you can choose a Provider or practitioner from our network. You also may contact Alliant Customer Service at (866) 403-2785 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 (866) 403-2785, 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

The Deductible, or the portion of the bill you must pay before your medical expenses become reimbursable, is applied on a calendar year basis. Certain preventive services are covered and reimbursable prior to meeting your deductible. Deductible requirements are stated in the **Summary of Benefits and Coverage**.

CARRY FORWARD DEDUCTIBLE

Covered Services during the last three months of a calendar year applied to that year's Deductible carry forward and applied toward the next year's Deductible. If a change in the Group's health plan is made during the last three months of a calendar year, the carry forward Deductible is restricted to the time covered under the "newest" group health plan with Alliant Health Plans. The Carry Forward Deductible provision is not available if the 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 Care.
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

To assist you in understanding the MAC language as described below, please refer to the definition of In-Network Provider and Out-of-Network Provider 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 In-Network and 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 or 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 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 (866) 403-2785 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 choose to 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 at 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 is calculated as described in Title 33 of the Official Code of Georgia Annotated (OGCA) 33-20E-4; with respect to emergency services we will calculate the MAC as the greater of:

- The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance.
- The most recent verifiable amount agreed to by Alliant and the nonparticipating emergency medical provider for the provision of the same services during such time as such Provider was In-Network with Alliant.
- Such higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided.

The amount paid does not include any amount of coinsurance, copayment, or deductible you may owe. Out-of-Network Providers of emergency services may bill you for any coinsurance, copayment, or deductible you may owe according to the terms of your policy.

In the event you receive a surprise bill for nonemergency medical services from an out-of-network provider, and you did NOT actively choose the out-of-network provider prior to receiving services, we calculate the MAC as described above. Alliant reserves the right to request documentation from the out-of-network provider to confirm whether you received services through no choice of your own.

Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service at (866) 403-2785 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 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. For example, benefits may be exhausted by exceeding calendar year visit or day 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 In-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 $1500, so your total out of pocket charge would be $450 plus an additional $1,000, for a total of $1,450.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the in-network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the in-network cost share amounts to apply to a claim for Covered Services if you receive Emergency Services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the in-network cost share amounts, you may still be liable for the difference between the MAC and the Out-of-Network Provider's charge. Please contact Customer Service at (866) 403-2785 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 processes for urgent, concurrent, pre-service, and post-service review.

If you have questions about how a certain service is approved, call Alliant at (866) 403-2785. 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 upon request.

	Timeframe for Decision
Urgent Care Services	As soon as possible, but no more than 72 hours after receipt of the request for service. If more information is needed to decide, Alliant will notify you within 24 hours of the request for service of the needed information. Alliant will decide within 72 hours of receipt of the request for services decision regardless of the receipt of the requested additional information. *(Alliant will provide oral notification of its decision within 72 hours of the initial request)*
Pre-Service 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 Aliant'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.
Post-Service Review	This is a medical review to determine whether a service already received is a Covered Service. A post-service review is handled in the same manner as a post-service appeal with a decision made within thirty (30) calendar days. See *"Complaints & Appeals".*

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 (866) 403-2785. The Prior Authorization list is subject to change.

All Covered Services must be Medically Necessary whether provided through In-Network Providers or Out-of-Network Providers**. Some Covered Services may require Prior Authorization, please call Customer Service at (866) 403-2785 or visit AlliantPlans.com to confirm whether a specific benefit requires Prior Authorization.**

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 a Non-Covered Service.

AMBULANCE SERVICE

Emergency ambulance services are a Covered benefit when they are considered Medically Necessary and at least one 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 an 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. During an appeal review, 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 be Medically Necessary. This may include transportation from a Hospital, Skilled Nursing Facility or Rehabilitation Facility to your residence when your condition requires skilled monitoring during transport with the services of an EMT attendant or other licensed healthcare practitioner.

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 be Medically Necessary.

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 may be Medically Necessary in exceptional circumstances. All the criteria pertaining to emergency ambulance services must be met, as well as one of the following conditions:

- Member's condition must require immediate and rapid ambulance transport to the nearest appropriate medical facility that could not have been provided by l, and ambulance.
- The point of pick-up is inaccessible by l, and vehicle.
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment.
- The patient's condition is such that the time needed to transport a patient by l, and to the nearest appropriate medical facility poses a threat to the patient's health.
- Ambulance or medical transport services are considered eligible for coverage if the patient is pronounced dead after the ambulance is called, but before pick-up, or en route to the hospital.

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, limitations as to type and scope of treatment authorized for neurological disorders, exclusions, cost sharing arrangements and Copayment requirements which exist in this Contract for neurological disorders.

This Contract provides for habilitative or rehabilitative services (including applied behavior analysis) and other counseling or therapy services necessary to develop, maintain, and restore the functioning of an individual with Autism Spectrum Disorder (ASD) who is twenty (20) years of age or under. There is an annual cap of $35,000 on claims paid for applied behavior analysis for the purpose of treating a person with ASD when applying the benefits required by Georgia law (O.C.G.A. 33-24-59.10). 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 Georgia law.

BREAST CANCER PATIENT CARE

Covered Services include Inpatient care following a mastectomy or lymph node dissection for an appropriate length 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 include care 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

Covered Services include spinal manipulation and is subject to cost sharing. A calendar year visit limit may apply as outlined in the **Summary of Benefits and Coverage.**

CLINICAL TRIAL PROGRAMS FOR TREATMENT OF CHILDREN'S CANCER

Covered Services include routine 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 (O.C.G.A. 33-24-59.1).

CLINICAL TRIAL PROGRAMS REQUIRED BY PPACA

Satisfied to the requirements below, Covered Services include routine 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; and
- 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 the medication or treatment that is the subject of the clinical trial is specifically excluded from coverage.

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

Alliant follows the recommendation of the United States Preventive Task force, grade A and B to determine the ages for preventive colorectal screenings. Covered Services include colorectal cancer screening examinations and laboratory tests specified in the 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-Network and Out-of-Network cost sharing 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 a Covered Service. 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 lesser of the purchase price of the equipment or twelve (12) months of rental charges. In addition to meeting criteria for Medical Necessity, 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. Eye care is limited to medical conditions only, not routine vision care (except for children under age 19 enrolled in Small Group Metal plans).

GENERAL ANESTHESIA SERVICES

Covered Services must be 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 also 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 have calendar year 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.

This Contract shall provide benefits for hearing aids for children 18 years of age or under in accordance with the provisions of Georgia SB 206. As required by SB 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, limitations, exclusions, cost sharing arrangements and Copayment requirements as outlined in the **Summary of Benefits and Coverage**.

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 have calendar year 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, Occupational, or Speech Therapy sections shown in this Contract.

Some special conditions apply:

- Covered Services require the Physician's certification statement and plan of care.
- 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 member is not expected to live more than six months.
- The Physician must design and recommend a Hospice Care Program; and
- Covered Services require the Physician's certification statement and plan of care.

HOSPITAL SERVICES

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

Inpatient

Inpatient Hospital Services:

- Inpatient room charges are Covered Services to 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 prevailing semiprivate room rate. If you are admitted to a Hospital that has only private rooms, Covered Services are based on the Hospital's prevailing room rate.

Services and Supplies:

- Services and supplies provided and billed by the Hospital while you receive Inpatient care, 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, VT'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.
- In an effort to manage quality and cost for our members, Alliant reserves the right to establish Preferred or In-Network Providers for certain services. To determine if a Preferred Provider exists, it is the responsibility of the member to verify the in-network status of a Provider. Members may verify network status by visiting our Find-A-Provider tool on AlliantPlans.com or calling Customer Service at (866) 403-2785.
- 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 (866) 403-2785 or visiting AlliantPlans.com. Normal office hours are 9am-5pm (EST), Monday-Friday, excluding holidays.

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 payable for Covered Services provided by licensed mid-level providers. Such providers include, but are not limited to, Nurse Practitioners (NP), Physician Assistant (PA), Physician Assistant Anesthetists (PAA), and Athletic Trainers (LAT) when performing services within their scope of practice as defined by the state of Georgia.

LICENSED SPEECH THERAPIST SERVICES

Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits and Coverage.** Services will be covered only to treat or promote recovery of the specific functional deficits identified. These services have calendar year 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 any applicable Copayment, Deductible and Coinsurance provisions.

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

Under federal law, the Contract may not restrict the length of stay to less than the 48-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.

MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

Hospital Inpatient Mental Health Care & Substance Abuse Treatment:

There are benefits for Hospital and Physician Inpatient charges. These benefits are covered for each Member as outlined 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 covered for each member in an In-Network Hospital as outlined 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 as outlined in the **Summary of Benefits and Coverage**.

Professional Outpatient Mental Health Care and Substance Abuse Treatment:

Benefits for outpatient charges for each Member are outlined 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 Aliant's network.

NUTRITIONAL COUNSELING & NUTRITIONAL COUNSELING FOR OBESITY

Nutritional counseling related to the medical management of certain disease states is limited. Please contact Customer Service at (866) 403-2785.

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;
- 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 Aliant's criteria.

OUTPATIENT SERVICES

Outpatient services include facility, ancillary, facility-use, and professional charges when received 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 or other Provider facility providing surgery, diagnostic, x-rays, laboratory services, therapy, or rehabilitation services.

To manage quality, and cost for our members, Alliant reserves the right to establish Preferred or In-Network Providers for certain services. To determine if a Preferred Provider exists, it is the responsibility of the member to verify the in-network status of a Provider. Members may verify network status by visiting our Find-A-Provider tool on AlliantPlans.com or calling Customer Service at (866) 403-2785.

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

OUTPATIENT SURGERY

Hospital outpatient department or freestanding ambulatory facility charges are Covered Services as outlined in the **Summary of Benefits and Coverage**. In-network, and out-of-network cost sharing apply accordingly.

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 a 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.

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.

Members may choose a provider from within our network by visiting AlliantPlans.com. You also may contact Alliant Customer Service at (866) 403-2785 and a representative will help you locate an In-Network Provider or Practitioner. After selecting a provider, you may contact the provider's office to schedule an appointment.

PREVENTIVE CARE

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

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

In-Network

Preventive care services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by 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 contracted allowable 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 (866) 403-2785 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/
- 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 Contract for plan years which begin one year after the date the recommendation or guideline is issued or on such other date as required by PPACA. The plan 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 PPACA and applicable Georgia law.

Out-Of-Network

Preventive care services are not paid at 100% when utilizing Out-of-Network providers. They are paid at the MAC rate, and are subject to costs that include, but are not limited to, Deductibles, Coinsurance, or Provider balance billing amounts.

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 and 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 (except when an orthopedic shoe is joined to a brace or for the care of the diabetic foot), all shoe inserts and shoe orthotics (except for the care of the diabetic foot); night-splint; dentures; replacement 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

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 for any medical care that is a Covered Service.

SKILLED NURSING FACILITY CARE

These services have calendar year visit limits. Plan limits are outlined in the **Summary of Benefits and Coverage.** 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 wardroom 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.
- The benefit limit has been reached; see **Summary of Benefits and Coverage** or contact Customer Service at (866) 403-2785 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 (866) 403-2785.

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

Aliant's transplant network facilities are independent of our Preferred 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 are 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 cell 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:
Certain travel expenses incurred by a covered member, and support person are eligible for reimbursement. For pre-approved organ/tissue transplants, charges incurred for transportation, lodging, and food are reimbursable under this policy. Qualified, and approved reimbursable travel expenses are allowed but are limited to a combined maximum of $10,000 per covered organ/tissue transplant(s).

Travel benefits are not subject to deductibles (in or out of network) shown in the Summary of Benefits, and Coverage, nor are they applied to the Out-of-Pocket Maximum (in or out of network).
Travel expenses for the person receiving the transplant include charges for:
1. Transportation to, and from the transplant site.
   a. If a personal vehicle is used, then the mileage is reimbursed according to the IRS standard mileage rate for medical purposes effective on the date of travel.
   b. If a rental vehicle is used, then the cost of the rental car plus fuel per receipt will be reimbursed. Mileage is not applicable if renting a car.
2. Lodging while at or traveling to and from the transplant site.
   a. Lodging charges may not exceed the maximum lodging rate established by the United States General Services Administration for the county in which the covered member is receiving approved transplant-related services.

3. Food while at or traveling to, and from the transplant site.
    a. Daily per-diem rate per person, based on the United States General Services Administration per diem Meals & Incidental Expenses rate valid on the date of the transplant, for the county in which the covered member is receiving approved transplant-related services.

By way of example, but not of limitation, travel expenses will ***not*** include any charges for:

a) Transplant travel benefit costs incurred within 200 miles in one direction from the member's home.
b) Laundry bills
c) Telephone bills
d) Alcohol or tobacco products
e) Air transportation charges which exceed coach class rates
f) Car rentals charges above the economy rate
g) Any food charges above the per person per diem rate
h) Any lodging charges above the maximum lodging rate

These travel benefits are only available for covered members that are recipients of an organ/tissue transplant. No travel benefits are available for donors. Please contact Customer Service at (866) 403-2785 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.

URGENT CARE SERVICES

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

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

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 Service 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 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. Where copayments exist, the copayment is expressed as a single fill or for a 31- day supply, whichever is less. Where multiple month fills (90-days for example) are made available, copayment would be required for each month (3 copayments for a 90-day fill).

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, and in accordance with applicable state and federal laws.

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 Service at (800) 424-1799 or online at AlliantPlans.com.

You or your Physician may order your Specialty Drugs from several 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 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 for this process 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 to meet requirements. For more information about these programs and how Alliant administers them, please contact Customer Service at (866) 403-2785.

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 exclude 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. 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, and 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 b and 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 PPACA. 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. You can also contact Customer Service by calling (866) 403-2785 to request a printed copy.

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;
    - When Brand Name Drugs become available over the counter; or
    - When drugs are re-classified to non-formulary status due to the availability of Therapeutic/Clinically Equivalent drugs 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 Non-Formulary Drug Exception process to request a non-formulary drug. If your Exception request is denied, you may exercise your right to appeal. For information regarding either the Exception 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.

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; and
- 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 while an Inpatient or Outpatient of a Hospital;
- 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, and which are not Prescription Drugs;
- Prescription Drugs provided by a Physician whether 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.

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 auto injections.
- **Ambulance Service –** 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 because 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.
- **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 B, and- 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 engaged in conduct, acts or omissions that may result in an indictment, arrest, or conviction for the violation of the laws if any injuries are not the result of a medical condition or an act of domestic violence or the individual is found by a court of competent jurisdiction to be found innocent of such criminal charges.

- **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.
- **Drug Screening** – Testing deemed not medically necessary, or more than the allowable limits set by the plan.

- **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 and shoe molds (except when an orthopedic shoe is joined to a brace or for the care of the diabetic foot); all shoe inserts and orthotics (except for the care of the diabetic foot); 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.
- **Employment Related Care** – Testing, training, examinations, or DME.
- **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 Aliant'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 Aliant'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.
- **Home Birth**
- **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 more than the MAC as determined by Alliant Health Plans.
- **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.
- **Mental health exams and services** –
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or intellectual disabilities and developmental delay;
  - Psychological testing for ability, aptitude, intelligence, or interest is not covered;
  - Mental Health Services that are primarily educational;
  - Religious, marital, gender, pre-marital, and sex counseling, including services and treatment related to religious counseling, marital and pre-marital/relationship, gender counseling and sex therapy;
  - Court-ordered services, or those required by court order as a condition of parole or probation;
  - Evaluation for the purpose of maintaining employment.
- **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, test, 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 (homeopath, etc.) 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. 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) or treatment relating to the consequences of, or because of bariatric services.
- **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, 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 and orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace or for the care of the diabetic foot).
- **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).
- **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.
- **Wilderness Therapy**
- **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.

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.

BALANCE BILLING

In-Network Providers are prohibited from balance billing. In-Network Providers have signed an agreement to accept a predetermined allowed amount for Covered Services rendered to a Member. A Member is not liable for fees more than the allowed amount for a Covered Service, 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.

Non-Covered Services are the sole responsibility of the Member when received from any Provider regardless of network status.

COORDINATION OF BENEFITS (COB)

Whenever the benefits under any other plan are payable without regard to benefits payable under this plan, this plan determines its order of benefits using the first of the following rules that apply. Services that are not eligible for benefits under both plans will not be subject to coordination of benefits.

Rule (1) Determining Primary Versus Secondary Coverage for the Insured
If the Subscriber of this plan is also the insured of another insurance company's individual plan, the longer plan rule applies. This means the plan, which covered the person longer, pays benefits first as the primary carrier. The plan, which covered that person for the shorter time, pays benefits as the secondary carrier. If the two individual plans are effective on the same day, We will be the secondary carrier. If both Alliant and the other insurance carrier claim to be secondary and the other carrier demonstrates its denial of primary responsibility, this plan will be primary.

Rule (2) Determining Primary Versus Secondary Coverage for Non-Dependent or Dependent
The plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

Rule (3) Dependent Children Dual Coverage and the Birthday Rule
When Dependent children are enrolled and eligible for coverage by another plan, the primary plan will be the plan of the parent whose birthday falls earlier in the calendar year. The month and day are considered, regardless of the birth year. This is termed the Birthday Rule. For example: Father's birth date is December 9th and Mother's birth date is February 4th. The mother's plan would be primary for the children because her birthday falls first in the calendar year.

Rule (4) Dependents of Divorced Parents
If the parent with custody of the covered children has not remarried, this parent's plan provides primary benefits and the parent without custody provides secondary benefits. If the parent with custody has remarried, this parent's plan still provides primary benefits, the stepparent's plan provides secondary benefits, and the parent without custody provides any balance of benefits. When there is a divorce decree, which assigns financial responsibility for health care of Dependent children, the decree will determine who must provide primary benefits for the children.

Rule (5) Longer Policy Rule
If the primary carrier cannot be determined by the above rules, the plan that has covered the Dependent longer will be the primary plan. Some insurance companies designate a father's plan as the primary plan for children. If We must coordinate coverage with a plan that follows this rule, the father's plan will be primary.

Coordination with Medicare
Unless federal law requires the plan to be the primary payor, the benefits under This plan for Member's age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit Members are entitled to under Medicare. Where Medicare is the responsible payor, all amounts for services that have been paid for by Us that should have been paid for by Medicare shall be reimbursed to Us by or on behalf of the Members.

CARE RECEIVED OUTSIDE THE U.S.

Emergency care and/or treatment received outside the United States is a covered benefit. Non-emergency care received outside the United States is not a covered benefit. Any care received must be a Covered Service as outlined in this Contract. Members should pay the provider of service at the time treatment is received and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with a claim. All services are subject to appropriateness of care. Members will be reimbursed directly. Payment is based on the MAC. Assignment of benefits to foreign Providers or facilities is not permitted.

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 (866) 403- 2785.

- 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 or your claim may be denied.
- 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.

FINANCIAL INCENTIVES

Medical Management decision making is based only on Medical Necessity criteria, a member's benefit plan, individual needs and circumstances, and the local delivery system. We do not reward or compensate Physicians, Providers, or other individuals for issuing denials of coverage. No financial incentives are given to staff to encourage decisions that result in underutilization.

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.

GOVERNMENTAL HEALTH CARE PROGRAMS

If you are enrolled in a group with fewer than twenty (20) employees, your benefits will be reduced if you are enrolled for coverage under any federal, state (except Medicaid) or local government health care program.

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

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 Aliant'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 Aliant's discretion, all claims are subject to audit by Alliant or by an independent bill review firm and/or claim auditor. Aliant'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 Aliant'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 considered a Non-Covered service by any other provision of this Contract, including but not limited to, Contract limitations and exclusions, and Contract definitions of Covered Services, Maximum Allowable Charge 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.

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.

The benefits under this Certificate for Members age 65 and older, or Members otherwise eligible for Medicare, except those Members with chronic kidney disease or End Stage Renal Disease (ESRD), do not duplicate any benefit for which Members are entitled under Medicare, except when federal law requires us to be the primary payor. Where Medicare is the primary payer, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to us, 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).

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.

POPULATION HEALTH MANAGEMENT

We offer a variety of services to you through our Population Health Management program, which includes Case Management.

Case management is available to all plan members who need assistance with coordinating health care services and/or accessing resources. Registered nurses, pharmacists and social workers, referred to as Care Managers, assist members with needs spanning behavioral services and the medical community. If you are facing a serious illness or medical condition, then Case Management may be right for you.

Case Management Services

General Case Management and disease specific case management programs are available. The goals of these services are:

1. To increase member care through coordination of services between the primary care provider, specialist and other health team members;
2. To provide ongoing education and prevention resources to our members; and
3. To improve the member care experience.

Examples of diagnoses and/or conditions that we frequently assist with include:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Cerebral Vascular Accident (CVA)/Stroke
- Diabetes
- Heart Disease
- Medication Management
- Substance Misuse

Complex Case Management is another program available to our members. If you have complex health needs, we can help you manage your plan of care. Examples of when you may need to enroll in case management are below, but keep in mind these are not all the reasons:

- You are going through a transplant.
- You have had multiple hospitalizations.
- You have been told you are pregnant and are at high risk.
- You have a severe and persistent mental illness.

Contacting Case Management

If you have any questions about our Population Health Management program or would like to make a case management referral for yourself or a loved one, please call Aliant's Member Care Line at: (800) 865-5922. All Population Health Management programs are provided by Alliant at no cost.

Additional Population Health Management program information is available for review at AlliantPlans.com.

PREVENTATIVE CARE AND WELLNESS PROGRAM

If you are eligible for coverage under the Plan, you may participate in a Preventive Care and Wellness Program that is intended to improve your health and prevent disease. The Preventive Care and Wellness Program offers opportunities for you to earn points through "Expeditions" focused upon education, physical activities, nutrition, preventive screening exams and community involvement. Only individuals age 18 or older are eligible to participate in the Preventive Care and Wellness Program.

In the event that you elect to participate in the Preventive Care and Wellness Program, you may earn points that may be redeemed for limited financial benefits. Specifically, in exchange for participating in Expeditions and achieving the goals established by the program, you can earn points that accumulate towards monetary consideration that may be utilized for specific purposes related to preventive care and wellness initiatives, including but not limited to good nutrition purchases or other lifestyle benefits. The monetary incentive to participate in the Preventive Care and Wellness Program is not a rebate or discount from your health plan premiums. You and your employer are responsible for any taxes related to the redemption of rewards under the Preventative Care and Wellness Program. Your participation in the Preventive Care and Wellness Program is voluntary and is not a requirement for eligibility for health plan benefits.

If you are not able to participate in an activity to earn points under this Preventive Care and Wellness Program due to a disability or medical condition, you might qualify for an opportunity to earn the same incentive by different means. Call Client Services at (866) 403-2785 to find an accommodation for the activity (or a different activity that offers the same incentive). The Preventive Care and Wellness Program does not endorse any vendor, product or service associated with this program. If you are interested in participating in the Preventive Care and Wellness Program, visit https://www.live4it.com/Alliant.

NOTICE REGARDING PREVENTATIVE CARE AND WELLNESS PROGRAM

The Preventative Care and Wellness Program is a voluntary wellness program available to all employees who participate in the Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the Preventative Care and Wellness Program, you may have the opportunity to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease) to earn points towards incentives under the Preventative Care and Wellness Program. You may also have the opportunity to complete a biometric screening, which may include a blood test for certain health conditions, to earn points towards incentives under the Preventative Care and Wellness Program. If offered, you are not required to complete any HRA or biometric screening to participate in the Preventative Care and Wellness Program. However, employees who complete the HRA or biometric screening, if applicable, may earn points towards incentives under the Preventative Care and Wellness Program. The information from your HRA and/or biometric screening (if applicable), should you choose to complete one, will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Monetary incentives may be available under the Preventative Care and Wellness Program for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your human resources representative or calling Client Services at (866) 403-2785.

Protections from Disclosure of Medical Information

The Plan is required by law to maintain the privacy and security of your personally identifiable health information. Aggregate information collected from the Preventative Care and Wellness Program may be used to design a program based on identified health risks in the workplace, and personal information may be shared with your employer as necessary to administer the Preventative Care

and Wellness Program, including as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Preventative Care and Wellness Program. Medical information that personally identifies you that is provided in connection with the Preventative Care and Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Preventative Care and Wellness Program. Anyone who receives your information for purposes of providing you services as part of the Preventative Care and Wellness Program will abide by the same confidentiality requirements. In addition, all medical information obtained through the Preventative Care and Wellness Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Preventative Care and Wellness Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Preventative Care and Wellness Program, you will be notified.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Preventative Care and Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your human resources department.

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 or the Group 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.

QUALITY IMPROVEMENT PROGRAM

You may call Customer Service at (866) 403-2785 to request information on Aliant's Quality Improvement (QI) program, or you may view program information at AlliantPlans.com. The annual QI program executive summary includes information on quality improvement program processes, goals and outcomes, as they relate to member care and services.

QUESTIONS ABOUT COVERAGE OR CLAIMS

If you have questions about your coverage or claims, contact your Plan Administrator or Alliant Customer Service at (866) 403-2785. 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).

RIGHT OF RECOVERY

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.

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.

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce this plan's rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

RIGHT OF SUBROGATION

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

RIGHT OF REIMBURSEMENT

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid plan benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

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 Alliant of your new address.

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.

NON-DISCRIMINATION

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis or race, color, national origin, age, disability, or sex. Alliant Heath 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 Customer Service at (866) 403-2785.

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, PO BOX 1128, Dalton, GA 30722, Phone: (706) 237-8802 or (888) 533-6507 ext. 125, Facsimile: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, facsimile, or email. If you need assistance filing a grievance, Sabrina LeBeau is available to assist 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, Washing, D.C. 20201, (*00) 368-1019 or (800 537-7697 (TTD). Complaint form are available at https://www.HHS.Gov/OCR/Office/File/Indes.html

WHEN YOUR COVERAGE TERMINATES

A. TERMINATION OF COVERAGE (GROUP)

We may cancel the entire Group contract in the event of any of the following:

1. The Group fails to make payments in accordance with the terms of its Contract.
2. The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or obtaining coverage.
3. The Group has fallen below the minimum employer contribution or Group participation rules. We will submit a written notice to the Group and provide 60 days to comply.
4. We terminate, cancel or non-renew all coverage under a particular policy form, provided that:
    - We provide at least 90 days' notice of the termination of the policy form to all Members;
    - We offer the Group all other group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
    - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

B. TERMINATION OF COVERAGE (INDIVIDUAL)

Your coverage ceases as a result of the first to occur of the following:

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the leave of absence rules herein);
- For Spouses, the date of divorce or other termination of marriage;
- For children or other Dependents, the date a child or individual ceases to be a Dependent;
- For Incapacitated Dependents over the age of 26, the date such individual ceases to meet the definition of an Incapacitated Dependent;
- For the employee and his or her dependents, the date of the employee's death;
- You fail to pay your group any contribution amount due within 30 days after the day due;
- The date on which the Group Contract ceases.

In all cases, termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and your dependents in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

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

Alliant will give you 30 days written notice that your coverage will be rescinded prior to processing a rescission and voiding your coverage. Please note that coverage rescission is retroactive, causing the individual to have had no coverage.

C. CONTINUATION OF COVERAGE UNDER FEDERAL LAW – COBRA

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

<u>Qualifying Events for Continuation Coverage Under Federal Law (COBRA)</u>

COBRA continuation coverage is available when your Group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a

"qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and Group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

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

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

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

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

Second Qualifying Event

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

Notification Requirements

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

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

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. This provision will only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of coverage costs for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.

Continuation of Coverage (Federal Law – USERRA)

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

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

Also, when the Member returns to work, if the Member meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Member did not elect COBRA continuation.

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

Trade Adjustment Act Eligible Individual

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

D. WHEN COBRA COVERAGE ENDS

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

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fail to pay a required coverage costs on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA;
- The Group terminates its group welfare benefit plans with Alliant Health Plans.

E. EXTENSION OF BENEFITS IN CASE OF TOTAL DISABILITY

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

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

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

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

EXTENDED BENEFITS

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

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

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

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

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

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

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 (866) 403-2785. 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 provided to you, which will, hopefully resolve the issue to your satisfaction.

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 (866) 403-2785. 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 Aliant'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 coverage costs or contributions toward cost of coverage.

The denial of payment for services or charges (in whole or in part) pursuant to Aliant'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 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 (866) 403-2785. You may submit appeals to the following addresses, dependent upon the type of appeal:

Medical & Administrative Claims Appeals:	Alliant Health Plans PO BOX 1247 Dalton, GA 30722
MedPharm Appeals:	Magellan Rx Management Appeals Department PO BOX 1459 Maryland Heights, MO 63043
Pharmacy Appeals:	Magellan Rx Management Appeals Department PO BOX 1599 Maryland Heights, MO 63043

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 initial appeal (Level I) within 180 days from the date of the notice of Adverse Benefit Determination. If your initial appeal is denied, you may file a second appeal (Level II) within 60 days from the date your initial (Level I) appeal was denied.
SPANISH (Española): Para obtener asistencia en Español, llame al (866) 403-2785.

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 Aliant'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 ALLIANT TO RESPOND TO APPEAL	
REQUEST TYPES	**TIMEFRAME FOR DECISION**
EXPEDITED APPEALS	WITHIN 72 HOURS OR 3 CALENDAR DAYS
PRE-SERVICE APPEALS (LEVEL I & II)	WITHIN 15 DAYS
POST-SERVICE APPEALS (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 Alliant. 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 submit a request for external review online at www.externalappeal.com, by calling (888) 866-6205 to ask for an external review request form, or by sending the request via email to ferp@maximus.com . To request an external review by fax or mail:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite
705
Pittsford, NY 14534
Fax: (888)866-6190

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 request an expedited external review by fax or mail:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite
705
Pittsford, NY 14534
Fax: (888)866-6190

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

ERISA Rights

If you are enrolled in a private employer plan, then you may also have the right to bring a civil action under Section 502 (a) of ERISA following the full internal review of your complaint by Alliant. All civil actions under Section 502(a) of ERISA following the full internal review of your compliant must, in any case, be brought within 12 months following final adjudication under the claims procedures set forth herein.

General Rules and Information

General rules regarding Aliant'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.

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

Application for Enrollment

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

Autism

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

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 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 in conjunction with the Group Health Care Contract, the Group Health Care Contract Application, the Alliant Formulary, any amendments or riders, your Identification Card and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate or the Group Health Care Contract and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate and the Group Health Care Contract, the Group Health Care Contract shall control.

Contract Year

A period of one calendar year commencing on the Effective Date (or renewal date) at 12:01am and ending on the last day of the one-year period at 11:59pm eastern time.

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 coverage payment requirements set forth in the Group Health Care Contract.

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 O.C.G.A. 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, if 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 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

Employee

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

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; 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.
4. 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 health care 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 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.

Group

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

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 and SimpleCare Group 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 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 does not otherwise meet the requirements to contract with Alliant. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility

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

Initial Enrollees

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

Injury

Bodily harm from a non-occupational accident.

In-Network Care

Covered Services provided to Members by their Physician through 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 Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Contract: (b) the person enrolls during a special enrollment period; or
(c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Contract, but only if 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. 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 Group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group health plan.

Medical Facility

Any Hospital, ambulatory care facility, Chemical Dependency 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 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.

New Hire

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

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 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

The maximum amount of a Member's Copayments and Coinsurance payments (including any required Deductible) during a given calendar year. Out-of-Pocket Maximums are accumulated separately for In-Network and Out-of-Network Care as defined in the **Summary of Benefits and Coverage**. Such amount does not include cost of coverage or charges for Non-Covered Services or fees more than the MAC. When the Out-of-Pocket Maximum is reached, the plan pays 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.

Plan Administrator

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

Policies and Procedures

Aliant'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 Aliant'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.

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.

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.

Qualified Medical Child Support Order (QMCSO)

A QMCSO creates or recognizes a right of a child who is recognized under the order as having the right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Reasonable and/or Reasonableness

Shall mean in Aliant'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 follow 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 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 to employer groups.

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 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

Telehealth means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

Telemedicine

Telemedicine is a form of telehealth which is the delivery of clinical health care services by means of real time two- way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self- management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site. 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 most 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.

STATEMENT OF ERISA RIGHTS

GENERAL INFORMATION ABOUT ERISA

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

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

Please note, Alliant Health Plans is not your Plan Administrator.

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

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

CLAIMS DISCLOSURE NOTICE

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

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 as outlined in the **Summary of Benefits and Coverage**.

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

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 Health One Alliance LLC, its subsidiaries or affiliates (collectively referred to herein as "Health One Alliance, LLC") for safeguarding individually identifiable protected health insurance. The terms of this Notice apply to members and dependents for their individual and group health insurance.

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 if it remains in effect. We reserve the right to change the terms of this Notice if 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, Health One Alliance, LLC, P.O. BOX 1128, Dalton, GA 30722.

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, Health One Alliance, LLC, P.O. BOX 1128, Dalton, GA 30722. A form to revoke an authorization can be obtained from the Health Information Privacy 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 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, cost of coverage 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 cost of coverage 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, 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, Health One Alliance, LLC, P.O. BOX 1128, Dalton, GA 30722. 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, Health One Alliance, LLC, P.O. BOX 1128, Dalton, GA 30722. 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, Health One Alliance, LLC, P.O. BOX 1128, Dalton, GA 30722. 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, Health One Alliance, LLC, P.O. BOXBOX 1128, Dalton, GA 30722. 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 within the six years immediately preceding your request. To request an accounting, you must send a written request to: Privacy Officer, Health One Alliance, LLC, P.O. BOXBOX 1128, Dalton, GA 30722. 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.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to the Privacy Officer, Health One Alliance, LLC, P.O. BOXBOX 1128, Dalton, GA 30722 or at HIPAA@AlliantPlans.com 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 Health One Alliance, LLC at (866) 403-2785. If you would like a copy of this Notice of Privacy Practices, please request a copy at HIPAA@AlliantPlans.com

Level-funded Plan

Stop-loss coverage insured by:

Alliant Health Plans, Inc.
A Provider Sponsored Health Care Corporation (PSHCC)

PO BOX 2088
Dalton, GA 30722
AlliantPlans.com

2023