CERTIFICATE OF COVERAGE

(Hereafter called Certificate)

SoloCare IFP (Individual, Family Plan)

Issued By: Alliant Health Plans, Inc.

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

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

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

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

Alliant Health Plans,
Mark Mixer, Chief Executive Officer

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Important Phone Numbers / Website

Customer Service

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

1-800-811-4793

If you have a question related to **pharmacy/prescription benefits**, please call:

1-866-333-2757

Pre-Certification

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

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

1-800-865-5922

Please have your Alliant ID number available when you call.

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

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

Website

For access to all services, including our Provider Directory:

AlliantPlans.com

The Health Insurance Marketplace

1-800-318-2596

(TTY: 1-855-889-4325)

Make the healthy move with the Alliant Health Plans app

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

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The Patient Protection and Affordable Care Act (PPACA)

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

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

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

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

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

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

- Eliminated Annual and Lifetime Limits;
- Installed a prohibition of rescission in accordance with regulations;
- Implemented zero-cost share preventive health service benefits;
- Extended coverage to dependents to age 26;
- Provided Summary of Benefits Coverage to each member;
- Implemented an appeals process that complies with federal and state regulations;
- Prohibited pre-existing conditions from being excluded;
- Met the standards for fair premium, limited rating factors, cost-sharing and compliant with the "metal" levels established by the Federal Government;
- Made its plan(s) available on a guarantee issue basis and implemented a prohibition of discrimination;
- Exceeded the Essential Health Benefit benchmarks set by the Federal Government; to include out-patient prescription drug coverage, habilitative and pediatric vision (and pediatric dental in some cases) coverage; as well as Mental Health Parity.
- Provided coverage for participation in Clinical Trials that are approved.
- Been certified by the National Committee for Quality Assurance (NCQA).

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

Verification of Benefits

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

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

- Verification of Benefits is NOT a guarantee of payment.
- If the verified service requires pre-certification, please call 1-800-865-5922.

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

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

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

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

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

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

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

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

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

Summary Notice

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

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

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

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. *English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID card or in your enrollment booklet.*

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

Eligibility

If you purchased coverage through the Health Insurance Marketplace, see "Reporting life & income changes to the Marketplace" at the end of this document for additional information.

Coverage for You

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

Coverage for Your Dependents

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

Your Eligible Dependents Include:

- Your Spouse; provided you are not legally separated. Domestic partners are not considered eligible dependents except when State or Federal law supersedes this contract.
- Your Dependent children through the end of the month in which they attain age 26;
    - legally adopted children from the date you assume legal responsibility,
    - children for whom you assume legal guardianship and stepchildren.
    - children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree.
    - Children who are mentally or physically handicapped and totally dependent on you for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract prior to reaching age 26. Certification of the handicap is required within 31 days of attainment of age 26. A certification form is available from Alliant and may be required periodically but not more frequently than

annually after the two year period following the child's attainment of the limiting age.

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

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

Late Enrollees

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

Open Enrollment

The open enrollment period will be defined by the federal government. This enrollment period applies whether purchasing through the Health Insurance Marketplace or directly from Alliant Health Plans.

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

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

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

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

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

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in45 CFR 147.128.

When Your Coverage Begins

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

Changing Your Coverage

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

Changing Your Coverage (Adding a Dependent)

You may add new Dependents to your Plan by contacting Customer Service.

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

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

Marriage and Stepchildren

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

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

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

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

Newborn and Adopted Children

A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility. The newborn or adopted child is not automatically added to your policy. You must take action to have them added. . In the event that you choose to enroll your newborn in a different plan; Alliant is still required to cover the newborn under your plan for the first 31-days. In the event there is more than one insurance policy in force; there is no coordination of benefits for individual/family plans (such as this one).

If you purchased through the Health Insurance Marketplace, You must notify the Health Insurance Marketplace. If you purchased outside the Health Insurance Marketplace, you must notify Alliant in-writing by submitting an enrollment application. If additional Premium is required to continue coverage beyond the 31-day period, the Member will be required to submit any additional Premium within the 31 day period or the newborn or adopted child will be treated as a Late Enrollee.

Foster Children

Foster children are children whose natural parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to Alliant. Such confirmation must be furnished at the Member's expense. Foster children for whom a Member assumes legal responsibility are not covered automatically.

If you purchased through the Health Insurance Marketplace, You must notify the Health Insurance Marketplace. If you purchased outside the Health Insurance Marketplace, you must notify Alliant in-writing by submitting an enrollment application If additional Premium is required to continue coverage beyond the 31-day period, the Member will be required to submit any additional Premium within the 31day period or the foster child will be treated as a Late Enrollee.

Changing Your Coverage or Removing a Dependent

When any of the following events occur:

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

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

If you purchased outside the Health Insurance Marketplace: notify Customer Service at 1-800-811-4793 and ask for the appropriate forms to complete.

If you purchased coverage through the Health Insurance Marketplace, see "Reporting life & income changes to the Marketplace" at the end of this document for additional information.

Eligibility

How Your Benefits Work for You

Whether you purchased coverage through the Health Insurance Marketplace or not, there is no difference in the benefits this contract provides.

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

Introduction

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

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

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

Preferred Provider Option

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

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

Out-of-Service-Area Provider Coverage

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

Copayment or Out-of-Pocket

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

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

The Calendar Year Deductible

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

Carry Over Deductible

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

Coinsurance and Out-of-Pocket Limit

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

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

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

Annual and Lifetime Limits

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

What Your Plan Pays

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

Maximum Allowed Cost (MAC) Cost (MAC)

General

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

Maximum Allowed Cost (MAC) calculated by using one of the methods described above.

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

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

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

Member Cost Share

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

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

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

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

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

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

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

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

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

Authorized Services

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

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

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

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

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Cost (MAC) of $200. Combined with

your In-Network Copayment of $25, your total out of pocket expense would be $325.

Coverage Certification

Certification

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

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

	Timeframe for Decision
Urgent Care Service	As soon as possible, but no more than 72 hours after receipt of the request for service. If more information is needed to make a decision, Alliant will notify you within 24 hours of the request for service of the needed information. Alliant will make a decision within 72 hours of receipt of the request for services decision Alliant will regardless of the receipt of the requested additional information. *(Alliant will provide oral notification of its decision within 72 hours of the initial request)*
Pre-Service Certification	Within 15 days. Alliant may extend the 15-day period for an additional 15-days because of matters beyond Alliant's control. If this is necessary Alliant will let you know in writing within the first 15 days. If the delay is because Alliant needs more information to make a decision, you will have up to 45-days to provide the needed information.
Concurrent Services Certification	Within 24 hours of request for services involving Urgent Care Services. For other requests a decision will be made within 15 days.
Post-Service Certification	Within 15 business days for electronic claims and 30 calendar days for paper claims. Alliant may extend the initial time periods for an additional 15-calendar days because of matters beyond Alliant's control. If this is necessary Alliant will let you know in writing within the first 15 business days or 30 calendar days. If the delay is because Alliant needs more information to make a decision, you will have up to 45 calendar days to provide the needed information.

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

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

Benefits

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

Allergy Conditions

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

Ambulance Service

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

Anesthesia Services for Certain Dental Patients

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

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

Assistant Surgery

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

Autism

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

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

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

Breast Cancer Patient Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in

consultation with the Member. Additional charges may apply. Mastectomy bras are covered; up to 2 per calendar year.

Breast Reconstructive Surgery

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

Cardiac Rehabilitation

Programs require prior authorization and individual case management.

Chiropractic Care

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

Clinical Trial Programs for Treatment of Children's Cancer

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

Clinical Trial Programs Required by PPACA

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

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

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

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

For Covered Services related to an approved clinical trial, cost sharing (*i.e.*, Deductible, Coinsurance and Copayments) will apply the same as if the service was not specifically related to an approved

clinical trial. In other words, you will pay the cost sharing you would pay if the services were not related to a clinical trial.

Colorectal Cancer Examinations and Laboratory Tests

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

Complications of Pregnancy

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

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

Consultation Services

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

Diabetes

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

Dialysis Treatment

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

Durable Medical Equipment

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

The equipment must meet the following criteria:

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

Emergency Room Services / Emergency Medical Services

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of

symptoms for an emergency medical condition or serious Accidental Injury which requires immediate medical care. If you require emergency care, go to the nearest Emergency Room or call 911.

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

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

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

Eye Care

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

General Anesthesia Services

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

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

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

Habilitative Services

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

Home Health Care Services

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

Some special conditions apply:

- The Physician's statement and recommended program must be Pre-Certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note:
- Covered Services available under Home Health Care do NOT reduce outpatient benefits

available under the Physical Therapy section shown in this Contract.
- A Member must be essentially confined at home.

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

Covered Services for Home Health do not include:

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

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

Hospice Care Services

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

Your Contract provides Covered Services for inpatient and outpatient Hospice care under certain conditions as stated in the **Summary of Benefits and Coverage's**. The Hospice treatment program must:
- Be recognized as an approved Hospice program by Alliant;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
    - Provides an organized system of home care;
    - Uses a Hospice team; and
    - Has around-the-clock care available.

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

Hospital Services

For In-network Care, your Physician must arrange your h o s p i t a l admission. Your Contract provides Covered Services when the following services are Medically Necessary.

Inpatient

Inpatient Hospital Services

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

Services and Supplies

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

Length of Stay

- Determined by Medical Necessity.

Outpatient

Outpatient Services

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

Medical Emergency Care

- Care or treatment for a Medical Emergency is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life-threatening Medical Emergency. See "Definitions."
- The emergency room cost-share may be required for initial services for Medical Emergencies rendered in the emergency room of a Hospital. Physician notification, if not completed prior to emergency room visit, should occur within 48 hours of seeking emergency room care.
- Use of the emergency room for conditions that are not Medical Emergencies is **not** covered.
- A Member is responsible for the required cost-share, if applicable to your plan benefits. If a copayment is applicable, it is waived if the Member is admitted to the Hospital through the emergency room.
- Covered Services for Medical Emergencies include Medically Necessary mental health emergency care provided in the emergency room. Emergency care coverage includes care related to Medical Emergencies associated with substance abuse.

How to Obtain Care After Normal Office Hours

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

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

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

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

Hospital Visits

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

Licensed Mid-Level Providers

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

Licensed Speech Therapist Services

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

Maternity Care (Pre and Post Natal Care)

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

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

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

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

Medical and Surgical Care

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

Mental Health Care and Substance Abuse Treatment

Hospital Inpatient Mental Health Care & Substance Abuse Treatment
There are also benefits for Hospital and Physician Inpatient charges. These benefits are listed for each Member is stated in the Summary of Benefits and Coverage's**.**

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

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

Professional Outpatient Mental Health Care and Substance Abuse Treatment
Benefits for outpatient charges for each Member (50-55 minute sessions or their equivalent) are stated in the **Summary of Benefits and Coverage's**.

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

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

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

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

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

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

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

Organ/Tissue/Bone Marrow Transplant

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

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

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

A covered transplant means a Medically Appropriate transplant.
Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.

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

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

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

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

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

the terms of the Contract.

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

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

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

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

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

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

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

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

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

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

Osteoporosis

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

Other Covered Services

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

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

Outpatient Services

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

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

Outpatient Surgery

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

Ovarian Cancer Surveillance Tests

- Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as:
    - (a) having a family history:
        - (i) with one or more first or second-degree relatives with ovarian cancer,
        - (ii) of clusters of women relatives with breast cancer,
        - (iii) of nonpolysis
        - colorectal cancer; or
    - (b) testing positive for BRCA1 or BRCA2 mutations.

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

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

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

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

Physician Services

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

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

Preventive Care

Preventive Care services include outpatient services and office services. Screenings and other

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

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

In-Network

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

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

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

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

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

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

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

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

Out-of-Network

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

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

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

Prosthetic Appliances

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

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

The following items are **excluded:** corrective shoes, shoe inserts; night-splint; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic injuries; bite-plates, oral splints ; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; or implants for cosmetic purposes except for reconstruction following a mastectomy.

Pulmonary Rehabilitation

Programs require prior authorization and Individual Case Management.

Reconstructive Surgery

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

Reconstructive Surgery is covered only to the extent Medically Necessary:

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

Registered Nurse First Assistant

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

nurse first assistant who is employed by a Physician or Hospital.

Second Medical Opinion

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

Skilled Nursing Facility Care

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

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

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

Covered Services include:

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

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

Benefits will not be provided when:

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

Specialist Physician (Specialty Care)

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

Telemedicine

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

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a

combination thereof does not constitute telemedicine service and is not a covered benefit.

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

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

Urgent Care Services

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

Out-Patient Prescription Drug Program

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

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

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

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

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

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

a Participating Pharmacy, you will need to submit the itemized bill to be processed.

Benefits

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

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

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

Covered Services May Include:

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

Specialty Drugs

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

You or your Physician may order your Specialty Drugs from our Network Specialty Pharmac(ies). The first time a Specialty Drug is ordered for home use you will be asked to complete a Patient Profile questionnaire. To obtain a Specialty Drug for home use, you must have a prescription for the drug which is signed by a Physician and which states the drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address. If the Specialty Drug is ordered via telephone, any Copayment or Coinsurance due can be paid by credit card or debit card. When submitting a paper prescription, a completed order form is required along with your Coinsurance or Copayment payable by check, money order, and credit or debit card.

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

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

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

Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your prescription.

Tier Assignment Process

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

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

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

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

The amount you will pay for a Prescription Drug depends on whether the drug you receive is a first-tier, second-tier, third-tier, and fourth-tier or fifth-tier drug. Refer to your **Summary of Benefit and Coverage's** to determine your Copayment, Coinsurance and Deductible (if any) amounts. Prescription Drugs will always be dispensed as ordered by your Physician. You may request, or your Physician may order, the Brand Name Drug. However, if a Generic Drug is available, you will be responsible for the difference in the allowable charge between the Generic and Brand Name Drug, in addition to your generic Copayment. The difference you will be charged between the two drug costs not including the copayment. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.

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

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

Drug Formulary

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

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

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

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

Changes can occur:

- Based on new clinical studies indicating additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient;
- When multiple Similar Drugs are available such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma
- inhalers;
- When a Brand Name Drug loses its patent and generics become available; or
- When Brand Name Drugs become available over the counter.
- Re-classification of drugs to non-formulary status when Therapeutic/Clinically Equivalent drugs are available including over the counter drugs.

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

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

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

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

Special Pharmacy Programs

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

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

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

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

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

The following are not Covered Services under this Contract:

- Prescription drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule;
- Prescription Drugs received through an Internet pharmacy provider or mail order provider except for our designated mail order provider;
- Newly approved FDA drugs that have not been approved for at least 180-days.
- Non-legend vitamins;
- Over-the-counter items;
- Cosmetic drugs;
- Appetite suppressants;
- Weight loss products;
- Diet supplements;
- Syringes (for use other than insulin) except when in coordination with an approved injectable;
- Non-contraceptive injectables (except with pre-certification);
- The administration or injection of any Prescription Drug or any drugs or medicines;
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued;
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order;
- Prescription Drugs for which there is no charge;
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use;
- Prescription Drugs for use as an Inpatient or outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients;
- Charges for delivery of any Prescription Drugs;
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs (except insulin);
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs;
- Prescription Drugs which are not Medically Necessary or which we determine are not consistent with the diagnosis (See Off-Label Drugs for exceptions);

- Prescription Drugs which we determine are not provided in accordance with accepted professional medical standards in the United States;
- Any services or supplies, which are not specifically listed as covered under this Prescription Drug program;
- Prescription Drugs which are Experimental or Investigational in nature as explained in the "Limitations and Exclusions" section;
- Prescription medicine for nail fungus except for immunocompromised or diabetic patients;
- Non-formulary drugs except as described in this Prescription Drug Program section.

Pediatric Vision Benefits

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

The following Routine Vision Care Services are covered:

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

- a case history
- general patient observation
- clinical and diagnostic testing and evaluation
- inspection of conjunctivae and sclera
- examination of orbits
- test visual acuity
- gross visual field testing
- ocular motility
- binocular testing
- examination of irises, cornea(s), lenses, and anterior chambers
- examination of pupils
- measurement of intraocular pressure (tonometry)
- ophthalmoscopic examinations
- determination of refract status
- color vision testing
- stereopsis testing
- case presentation including summary findings and recommendations including prescribing Lenses

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

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

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

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

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

Pediatric Oral (Dental)

Pediatric oral (dental) benefits are available for members under age 19. This pediatric coverage is for a number of routine dental care procedures. For each evaluation you pay a $25 copayment when using in-network providers and Alliant Health Plans takes care of the rest. In order to receive benefits, you must use a Preferred dentist, except if dental care is required due to an accidental injury. Below is a complete list of the covered procedures and fee schedule amounts. Any service not listed is not covered.

Clinical Oral Evaluations

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

Dental Radiology

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

Preventive

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

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

General Limitations and Exclusions

What Is Not Covered

Your coverage does not provide benefits for:

- **Abortion** and care for abortion are not covered.
- **Acupuncture** - Acupuncture and acupuncture therapy.
- **Allergy Services** - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- **Beautification Procedures** - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by Alliant, is not covered.
  - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries
  - when performed within two years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
  - The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum.
  - This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this Certificate Booklet.
- **Before Coverage Begins** - Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
- **Behavioral Disorders** - Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to, hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
- **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.
- **Care, Supplies, or Equipment** - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators,

elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.

- **Complications** - Complications of non-covered procedures are not covered.
- **Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- **Court-Ordered Services** - Court-ordered services, or those required by court order as a condition of parole or probation.
- **Covered Services** - Any item, service, supply or care not specifically listed as a Covered Service in this Certificate Booklet.
- **Crime** - Injuries received while committing a crime as long as any injuries are not the result of a medical condition or an act of domestic violence.
- **Daily Room Charges** - Daily room charges while the Contract is paying for an Intensive Care, cardiac care, or other special care unit.
- **Dental Care** - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this booklet. Coverage for pediatric dental may be available based on eligibility circumstances.
- **Disposable Supplies** - Supplies, equipment or personal convenience items including, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags, unless Medically Necessary.
- **Drugs** - Any drug or other item which does not require a prescription.
- **Durable Medical Equipment** - The following items related to Durable Medical Equipment are specifically *excluded*:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports and orthopedic or corrective shoes; shoe inserts; orthopedic or correct shoes; shoe molds; and support stockings.
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - TENS units;
    - Sequential stimulators;
    - Conductive garmets;
    - Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment; light-box therapy for SADS;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which Alliant feels do not meet the listed criteria.
    - Duplicate medical equipment.
- **Employer-Run Care** - Care given by a medical department or clinic run by your employer.
- **Experimental or Investigational** - Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in Alliant's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

- **Failure to Keep a Scheduled Visit** - Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
- **Foot Care** - Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
- **Foreign Travel** – Benefits do not include non-emergent care when traveling outside the United States. Benefits do include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. We cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange.
- **Free Services** - Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
- **Government Programs** - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- **Hair** - Hair transplants, hairpieces or wigs wig maintenance, or prescriptions or medications related to hair growth
- **Hearing Services** - Hearing aids, hearing devices and related or routine examinations and services.
- **Homes** - Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- **Hypnotherapy**
- **Ineligible Hospital** - Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
- **Ineligible Provider** - Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
- **Infertility** - Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.
- **Injury or Illness** - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness.
- **Inpatient Mental Health** - Inpatient Hospital care for mental health conditions when the stay is:
    - determined to be court-ordered, custodial, or solely for the purpose of environmental control;
    - rendered in a home, halfway house, school, or domiciliary institution;
    - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations.
- **Inpatient Rehabilitation** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Participant has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
- **Maximum Allowed Cost (MAC) –** Expenses in excess of the Maximum Allowed Cost (MAC) as determined by Alliant.

- **Medical Reports** - Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- **Medicare** - Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
- **Methadone** - Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Contract has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
- **Miscellaneous Care** - Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
- **Non-covered Services -** Services that are not Covered Services under the Contract.
- **Non-Physician Care** - Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.
- **Not Medically Required** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
- **Obesity** – Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).
- **Orthoptics** - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- **Outpatient Therapy or Rehabilitation** - Services for outpatient therapy or rehabilitation other than those specifically listed in this Certificate Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, ctinic changes and/or which are performed as a treatment for acne, services and supplies.
- **Personal Comfort Items** - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **Private Room** - Private room, except as specified as Covered Services.
- **Private Duty Nursing**
- **Provider** (Close Relative) - Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or

sister, by blood, marriage or adoption.

- **Routine Physical Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.
- **Safe Surrounding** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- **Sclerotherapy** - Sclerotherapy performed for cosmetic purposes and that is not medically necessary.
- **Self-Help** - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- **Sexual Modification/Dysfunction Treatments** - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
- **Shoes** - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
- **Skilled Nursing Facility** - Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
- **Telehealth** - Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.
- **Thermograms** - Thermograms and thermography.
- **Transplants** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
  - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
  - Transportation, travel or lodging expenses for non-donor family members;
  - Donation related services or supplies associated with organ acquisition and procurement;
  - Chemotherapy with autologous, allogenic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
  - Any transplant not specifically listed as covered.
- **Transportation** - Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered.
- **Treatment (Outside U.S.)** - Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
- **Vision** - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. This exclusion does not apply to vision for pediatric members under the age of 19.
- **Vision (Surgical Correction)** - Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- **Waived Fees** - Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, Alliant will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
- **War** - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- **Workers' Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Alliant does not pay for care of any condition or injury recognized or allowed as a compensable

loss through any Workers' Compensation, occupational disease or similar law. The State Board of Workers' Compensation in Georgia requires that workers' compensation benefits are required if your employer has at least three or more employees. As many as five officers may waive coverage on themselves. If waived, Alliant may request a copy of the WC-10 as proof of waiver. If a member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

Coordination of Benefits

Individual/Family plans, such as this one, do not coordinate benefits.

Right of Recovery

- If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this plan, we shall have a right of recovery. Our right of recovery shall be limited to the amount of any benefits paid for covered medical expenses under this plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery shall include compromise settlements. You or your attorney must inform Alliant of any legal action or settlement discussion, ten days prior to settlement or trial. We will then notify you of the amount we seek, and the amount of your legal expenses we will pay.
- Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 12 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

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

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

General Information

Member Rights and Responsibilities

Your rights as an Alliant Member

As a Member, you have the right to:

- Recommend changes to the Member's Rights and Responsibilities policy**.**
- Receive information about the Plan, its services, its Providers, and about your Rights and

Responsibilities as a Member.

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

Your responsibilities as an Alliant Member

As a Member, you have the responsibility to:

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

- Follow the plans and instructions for care that you have agreed on with your Physician(s).

Financial Incentives

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

Proof of Loss, Payment of Claims

In-network Providers

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

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

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

Out-of-Network Providers

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

For health care expenses other than those billed by an In-Network Hospital or licensed health care Provider, your Provider should submit an itemized bill to Alliant. The claim should include your name, Member and Group ID numbers exactly as they appear on your Identification Card. Make certain the bills are itemized to include dates, places and nature of services and/or supplies. Be sure to keep a photocopy of all forms and bills for your records.

Balance Billing

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

Filing and Payment of Claims

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

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

If you need to submit a claim to Alliant Health Plans for services by an out-of-network provider or

reimbursement for services you had to pay, you must submit a claim form to Alliant Health Plans. You can obtain a blank claim form by calling Customer Service at 1-800-811-4793.

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

Processing Your Claim

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

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

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

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

Physical Examinations

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

Non-Discrimination

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

Unauthorized Use of Identification Card

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

the coverage.

Questions About Coverage or Claims

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

Write

Alliant Health Plans
Customer Service Department
PO Box 3708
Corpus Christi, TX 78463

When asking about a claim, give the following information:

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

We Want You to be Satisfied

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

Complaints about Alliant Health Plans Service

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

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

Summary of Grievances

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

Complaints about Provider Service

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

Terms of Your Coverage

We provide the benefits described in this booklet only for eligible Members. The health care

services are subject to the limitations, exclusions, Copayments, Deductibles and percentage payable requirements specified in this booklet. Any Group Alliant Contract or Certificate which you received previously will be replaced by this Contract.

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

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

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

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

General Information

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

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

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

Acts Beyond Reasonable Control (Force Majeure)

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

Care Received Outside the United States

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

Medicare

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

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

Governmental Health Care Programs

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

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

When Your Coverage Terminates

When Will My Alliant Membership End?

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

Termination of Benefits and Coverage

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

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

Your membership with Alliant will terminate if You:

- **No Longer Meet Eligibility Requirements:**
  - You no longer meet the age or other eligibility requirements for coverage under this plan

as required by Alliant or the Marketplace.

- You no longer live or work in Alliant's Service Area for this product. The Marketplace and/or Alliant will send You notice of any eligibility determination. Alliant will send You notice when it learns You have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

- **Request Disenrollment:** You decide to end Your membership and disenroll from Alliant by notifying Alliant if you purchased directly from us or the Marketplace if you purchased from the Health Insurance Marketplace. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Alliant may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.

- **Change Health Plans**: You decide to change from Alliant to another health plan either during an annual open enrollment period or other special enrollment period for which you have been determined eligible in accordance with the special enrollment procedures or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Alliant, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed. Some examples include:
  - Misrepresenting eligibility information.
  - Presenting an invalid prescription or physician order.
  - Misusing an Alliant Member ID Card (or letting someone else use it).

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

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

- **Discontinuation:** If Alliant ceases to provide or arrange for the provision of health benefits for new or existing health care service plan contracts, in which case Alliant will provide You with written notice at least 180 days prior to discontinuation of those contracts.

- **Withdrawal of Plan:** Alliant withdraws this product from the market, in which case Alliant will provide You with written notice at least 90 days before the termination date.

- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Alliant may terminate Your coverage as further described below.

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

Premium payments and termination for non-payment

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

- Your Premium payment for the upcoming coverage month is due no later than the first day of that month. This is the "**Due Date.**" Alliant will send You a bill in advance of the Due Date for the upcoming coverage month. If Alliant does not receive the full Premium payment due on or before the Due Date, Alliant will send a notice of non-receipt of Premium payment and cancellation of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:

    - A statement that Alliant has not received full Premium payment and that we will terminate this Agreement for nonpayment if we do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
    - The amount of Premiums due.
    - The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if we do not receive the required Premiums.

- If You have received a Late Notice that Your coverage is being cancelled or not renewed due to failure to pay Your Premium, Alliant will give You a 30-day "grace period"; *(except for Subscribers who receive an advance payment of the premium tax credit. Subscribers who are receiving an advance payment of the premium tax credit will be given a three month "grace period.")* During the grace period, You can avoid cancellation or nonrenewal by paying the Premium You owe to Alliant. If You do not pay the Premium by the end of the grace period, this Agreement will be cancelled. You will still be responsible for any unpaid Premiums You owe Alliant for the grace period.

- Alliant will pay for Covered Services received during the 30-day grace period (during the first month for those receiving an advance payment of the premium tax credit. For Subscribers entitled to the three month grace period (those receiving an advance premium tax credit), Alliant will hold back payment for Covered Services after the first month of the grace period until we receive the delinquent Premiums. If Premiums are not received by the end of the three month grace period, the Subscriber will be responsible for payment of the Covered Services received during the second and third months.

Reinstatement after Termination for Nonpayment of Premiums

- When You have been terminated for nonpayment of Premiums, You may not enroll in Alliant even after paying all amounts owed unless we approve the enrollment.

- If Alliant terminates this Agreement for nonpayment of Premiums, we may permit reinstatement of this Agreement once during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice, described below. Alliant will not reinstate this Agreement if You do not obtain reinstatement of Your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than once in a 12-month period. In either case, You will be ineligible to re-enroll for a period of 12 months from the effective date of termination.

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

If you purchased coverage through the Health Insurance Marketplace, see "Reporting life & income changes to the Marketplace" at the end of this document for additional information.

Definitions

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

After-Hours Office Visit
Care rendered as a result of a condition that has an onset after the Physician's business hours.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contract Year

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

Coordination of Benefits

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

Copayment

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

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

Cosmetic Surgery

Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

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

Covered Services

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

Creditable Coverage

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

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; (c) is a level

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

Deductible

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

Dependent

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

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

Detoxification

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

Developmental Delay

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

Direct Access

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

Drug Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals by us that may include but not be limited to (1) a listing of preferred and non-preferred prescription medications that are covered and/or prioritized in order of preference by us, and are dispensed to Members

through pharmacies that are Network Providers, and (2) Pre-Certification rules. This list is subject to periodic review and modification by us, at our sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Drug Formulary.

Durable Medical Equipment

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

Effective Date

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

Elective Surgical Procedure

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

Emergency Medical Services

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

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

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

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

Enrollment Date

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

Essential Health Benefits

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

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

Exchange

See "Health Insurance Marketplace".

Experimental or Investigational

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

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

Frame

Standard eyeglasses excluding the Lenses.

Freestanding Ambulatory Facility

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

Generic Drugs

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

Health Insurance Marketplace

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

Home Health Care

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

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

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

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

Hospital
An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

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

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

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

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

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

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

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

Injury
Bodily harm from a non-occupational accident.

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

In-Network Hospital
A Hospital which is a party to a written agreement with, and in a form approved by, Alliant to provide services to its Members.
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In-Network Provider
A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies in the Service Area that has a Network Provider Contract with us to provide Covered Services to Members.

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

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

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

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

Long Term Acute Care
Long Term Acute Care requires a Hospital Environment which provides the patient with daily Physician visits, a critical care and medical/surgical experienced nursing staff, a complete respiratory department (24 hours a day, 7 days a week), an in-house rehab department, case management, social services, an in-house pharmacy, radiology, an operating room, an ICU, and a complete health care system designed to meet the needs of highly acute patients. This acute care environment promotes timely and effective responses to maximize the recovery potential of the

patient, and prevents the need for discharge when complications arise. Such care differs from skilled nursing facility/subacute facility care because that care is limited in the range and frequency of services provided and does not offer a complete health care delivery system.

Maternity Care

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

Maximum Allowed Cost (MAC)

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

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

MCSO-Medical Child Support Order

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

- Provides for child support payment related to health benefits with respect to the child of a Group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group health plan.

Medical Facility

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

Medical Necessity or Medically Necessary

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

We consider a health care service Medically Necessary if it is:

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

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

Member

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

Contract.

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

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

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

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

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

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

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

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

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

Periodic Health Assessment

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

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

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

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

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

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

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

PPACA
Patient Protection and Affordable Care Act

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

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

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

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

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

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

Professional Ambulance Service

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

Provider

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

Psychiatric Services within a General Hospital Facility

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

QMCSO – Qualified Medical Child Support Order

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

Qualified Health Plan

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

Referral

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

Respite Care

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

Retail Health Clinic

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

Semiprivate Room

A Hospital room which contains two or more beds.

Service Area

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

Similar Drugs

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

Skilled Convalescent Care

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

Skilled Nursing Facility

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

Specialty Drugs

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

Specialty Pharmacy

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

Spinal Manipulation

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

Subscriber

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

Substance Abuse

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

Substance Abuse Rehabilitation

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

Substance Abuse Residential Treatment Center

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

Substance Abuse Services within a General Hospital Facility

A general Hospital facility that provides services, on an inpatient, 24-hour basis, for medical detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or

other drugs.

Technology Assessment Criteria

Five criteria all procedures must meet in order to be Covered Services under this Contract.

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Telehealth Services

A health care service, other than a telemedicine service, delivered by a licensed or certified health professional, acting within the scope of the healthcare professional's license or certification, who does not perform a Telemedicine Medical Service, which requires the use of advanced telecommunications technology, other than by telephone or facsimile including:

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

Telemedicine Medical Service

A health care medical service initiated by a Physician or provided by a health care professional, diagnosis, treatment or consultation by a Physician, or the transfer of medical data that requires the use of advance communications technology, other than by telephone or facsimile including:

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

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

Therapeutic / Clinically Equivalent

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

Urgent Care

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

Urgent Care Center

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

Appeals

Definitions

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

"Adverse Benefit Determination": means

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

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

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

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

"Post-Service Claim": means an Adverse Benefit Determination has been rendered for a service that has already been provided. "Pre-Service Claim": means an Adverse Benefit Determination was rendered and the requested service has not been provided. "Urgent Care Services Claim": means an Adverse Benefit Determination was rendered and the requested service has not been provided, where the application of non-urgent care appeal time frames 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:

Alliant Health Plans, Inc.

Attention: Complaints and Appeals Coordinator
1503 N. Tibbs
Dalton, GA 30720

Toll-free: 1-800-811-4793
Facsimile: 1-866-470-1829
AlliantPlans.com

If you are Hearing impaired you may also contact Alliant via the National Relay Service at 711.

You (or your Authorized Representatives) must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination.

SPANISH (Español): Para obtener asistencia en Español, llame al 800-811-4793.

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

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

TIMEFRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIMEFRAME FOR DECISION**
URGENT CARE SERVICE	WITHIN 72 HOURS.
PRE-SERVICE AUTHORIZATION	WITHIN 30 DAYS. .
CONCURRENT SERVICE (A REQUEST TO EXTEND OR A DECISION TO REDUCE A PREVIOUSLY APPROVED COURSE OF TREATMENT)	WITHIN 72-HOURS FOR URGENT CARE SERVICES AND 30-DAYS FOR OTHER SERVICES
POST-SERVICE AUTHORIZATION	WITHIN 60 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

After you have exhausted the internal appeal rights provided by Alliant, you have the right to request an external/independent review of this adverse action. You (or your Authorized Representative) may file a written request for an external review. Your notice of Adverse Benefit Determination and Final Adverse Benefit Determination describes the process to follow if you wish to pursue an external appeal.

You must submit your request for external review within 123 calendar days of the date you receive the notice of Adverse Benefit Determination or Final Adverse Benefit Determination.

You can request an external appeal in writing by sending it electronically to DisputedClaim@opm.gov; or by faxing it to 202-606-0036, or by sending it by mail to:

Office of Personnel Management (OPM)
P.O. Box 791
Washington, DC 20044

You may also file an external appeal or complaint with the Georgia Insurance Commissioner's Office. They will review your appeal or complaint and coordinate an independent external review.

Mailing address:
Georgia Insurance Commissioner's Office
Consumer Services Division
2 Martin Luther King, Jr., Drive
Suite 716, West Tower
Atlanta, GA 30334
Fax: (404) 657-8542

If you have any questions or concerns during the external appeal process, you (or your Authorized Representative) can call the toll-free number 877-549-8152. You (or your representative) can submit additional written comments to the external reviewer at the mailing address above. If any additional information is submitted, it will be shared with Alliant in order to give us an opportunity to reconsider the denial.

Request for expedited external appeal – you (or your representative) may make a written or oral request for an expedited external appeal with the external reviewer when you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an appeal of an Urgent Care Service would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for a review of an Urgent Care Service; or

- A Final Adverse Benefit determination, if you have a Medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

- An Adverse Benefit Determination that relates to Experimental or Investigational treatment, if the treating physician certified that the recommended or requested health care service, supply, or treatment would be significantly less effective if not promptly initiated.

In expedited external appeal situations, requests for expedited review can be initiated by calling the OPM toll free number 877-549-8152.

Additionally, at Your request, Alliant can send You copies of the actual benefit provision, and will provide a copy at no charge, of the actual benefit, clinical guidelines or clinical criteria used to make the determination upon receipt of Your request. A request can be made by calling the Alliant Complaints and Appeals Coordinator.

General Rules and Information

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

- You must cooperate fully with Alliant in our effort to promptly review and resolve a complaint or appeal. In the event you do not fully cooperate with Alliant, You will be deemed to have waived your right to have the Complaint or Appeal processed within the time frames set forth above.

- Alliant will offer to meet with you by telephone. Appropriate arrangement will be made to allow telephone conferencing to be held at our administrative offices. Alliant will make these telephone arrangements with no additional charge to you.

- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.

- Alliant will provide you with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Alliant to send any new medical information to review directly so you have an opportunity to review the claim file.

Telephone Numbers and Addresses

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

Georgia Department of Insurance
Consumer Services Division
2 Martin Luther King, Jr. Drive
Suite 716, West Tower
Atlanta, Georgia 30334
Toll-free: 1-656-2298
Fax: 404-657-8542

Alliant Health Plans, Inc.
Attention: Complaints and Appeals Coordinator
1503 N. Tibbs Road
Dalton, GA 30720

Toll-free: 1-800-811-4793
Facsimile: 1-866-470-1829
AlliantPlans.com

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

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

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

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

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

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

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

Reporting life & income changes to the Marketplace

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

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

Life changes to report:

You must report a change if you:

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

When and how to report changes

You should report these changes to the Marketplace as soon as possible.

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

Important: Do not report these changes by mail.

You can report these changes 2 ways:

- **Online.** Log in to your account. Select your application, then select "Report a life change" from the menu on the left.
- **By phone.** Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325)

After you report a change

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

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

If you're eligible for a special enrollment period

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

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

- **Online.** Log in to your account and select your application. Then select "Eligibility and Appeals" from the menu on the left. Next, scroll down and click the green "Continue to enrollment" button. You can then shop for plans and change your selection.
- **By phone.** Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

If you're not eligible for a special enrollment period but the tax credit you qualify for has changed

You can't change plans. But you can choose to adjust the amount of the tax credit to apply to your monthly premiums.

Changing your profile information

You report changes that don't affect your coverage or savings differently.

- To change your home address, email address, or phone number, update the information on your Marketplace Profile page.
- **Be sure to report address, email, and phone changes to Alliant Health Plans too.** Otherwise we may not know about your new contact information. Contact Customer Service at 1-800-811-4793.

Language Assistance

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

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

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

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

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

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

እርስዎ፣ ወይም እርስዎ የሚረዱት ሰው ስለAlliant Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ (800) 811-4793 ይደውሉ።

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

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

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

إذا كان لديك أو لدى شخص تقدم له المساعدة أسئلة بخصوص Alliant Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات اللازمة بلغتك دون أي تكلفة. للتحدث مع مترجم فوري، اتصل بالرقم (800) 811-4793.

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

اگر آپ ، یا وہ شخص جس کی آپ مدد کر رہے ہیں ، کو Alliant Health Plans، کے بارے میں سوالات درکار ہیں تو آپ کو حق حاصل ہے کہ آپ اپنی زبان میں بغیر کسی لاگت کے مدد اور معلومات حاصل کریں۔ ترجمان سے بات کرنے کے لیے (800) 811-4793. پر کال کریں

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

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

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).

Non Discrimination

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

Alliant Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視 任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Alliant Health Plans يلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base naraça, cor, nacionalidade, idade, deficiência ou sexo.

Alliant Health Plans و کند می تبعیت مربوطه فدرال مدنی حقوق قوانین از هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، ملیتی، اصلیت یا ناتوانی سن، جنسیت شود نمی قایل افراد.

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別 に基づく差別をいたしません。