POLICY

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Health Alliance NORTHWEST™

Health Alliance Northwest Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). Health Alliance Northwest Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). Health Alliance Northwest Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service.

If you believe that Health Alliance Northwest Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with: Health Alliance Medical Plans, Customer Service, 3310 Fields South Drive, Champaign, Illinois 61822, telephone: 1-800-851-3379, TTY: 711, fax: 217-902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

You can also file a civil rights compliant with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal or phone: https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, 1-800-562-6900, 1-360-586-0241 (TTD).

Compliant forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

For Language Access Services:

English:
If you, or someone you're helping, have questions about Health Alliance Northwest Health Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-851-3379.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-851-3379 (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-851-3379 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
1-800-851-3379（TTY：711）。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-851-3379 (TTY: 711) 번으로 전화해 주십시오.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-851-3379 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم711 (رقم هاتف الصم والبكم:
1 -800 -8 51 -3379

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-851-3379 (телетайп: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન1-800-851-3379 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-851-3379 (TTY: 711).

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-851-3379 (TTY: 711).

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1- 800-851-3379 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-851-3379（TTY:711）まで、お電話にてご連絡ください。

Pennsylvanian Dutch:
LET OP: Services Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-851-3379 (TTY: 711).

Ukrainian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1- 800-851-3379 (телетайп: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-851-3379 (TTY: 711).

SMALL GROUP INDEMNITY PLAN

The Health Alliance Small Group Indemnity plan is product of Health Alliance Northwest Health Plan (Health Alliance), an insurance company licensed as a Healthcare Service Contractor (HCSC). Health Alliance which is located at 411 N. Chelan Avenue Suite A, Wenatchee, Washington 98801 administers all aspects of this Health Benefit Plan. Health Alliance also maintains an administrative office located at 3310 Fields South Drive, Champaign, Illinois 61822.

The Health Alliance Small Group Indemnity plan allows you and your covered Dependents to make a choice on where you wish to receive healthcare services. Your level of coverage is determined by how you choose to receive services. You may choose to receive services from a Participating Provider and receive the highest level of benefits. A Participating Provider is a Physician or Provider that has entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance Members. These are called Participating or In-Network benefits.

You may also choose to receive services from a Non-Participating Provider. These are called Non-Participating or Out-of-Network benefits. Choosing to receive services, other than Emergency Services, from a Non-Participating Provider will result in a lower benefit level and higher Out-Of-Pocket expenses.

This policy explains your in-network benefits and your out-of-network benefits. In addition, you will be responsible for ensuring that all Prior Authorization requirements have been met.

This Policy, along with the Description of Coverage, and the Summary of Benefits and Coverage (SBC) describe the Health Benefit Plan chosen by your Employer Group. It is important for you to read this Policy as it explains your rights, benefits and responsibilities as a Health Alliance Member. As a Member, you are subject to all terms and conditions of this Policy and payment of Copayments, Coinsurance and Deductible amounts as specified on the Description of Coverage and/or the SBC.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to use the services of a Non-Participating Provider for a covered service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your Policy's fee schedule, Maximum Allowable Charge, or other method as defined by the Policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill Members for any amount up to the billed charge after the Plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Copayments, Coinsurance and Deductible amounts. You may obtain further information about the Participating status of professional Providers and information on Out-Of-Pocket expenses by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

No change in this contract will be valid unless approved by an executive officer of Health Alliance. No insurance producer has the authority to change this contract or to waive any of its provisions. Any provision, term, benefit or condition of coverage in this Policy may be amended, revised or deleted in accordance with the terms of the Group Enrollment Agreement between the Employer Group and Health Alliance, or in accordance with changes in state and/or federal law. This may be done without your consent.

Health Alliance Customer Service Representatives are available to help you understand your healthcare Plan. We encourage you to call the number on the back of your Health Alliance Identification Card to speak with one of our representatives about your benefits.

IN WITNESS WHEREOF, Health Alliance Northwest Health Plan has duly executed this Policy.

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Sinéad Rice Madigan
President and Chief Executive Officer
Health Alliance Medical Plans
Carle Health System

TABLE OF CONTENTS

MEMBERS' RIGHTS AND RESPONSIBILITIES

Rights

- A right to receive information about Health Alliance, the services Health Alliance provides, the doctors and other healthcare professionals that Health Alliance contracts with and the Member's rights and responsibilities
- A right to be treated with respect and dignity and to be given a right to privacy
- A right to participate with contracted Providers in making decisions regarding your healthcare
- A right to have a candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Health Alliance or the care provided
- A right to make recommendations regarding Health Alliance Members' rights and responsibilities Policy
- A right to have reasonable access to healthcare
- A right to receive information in a way that works for you (in languages other than English, in Braille, in large print or other alternate formats, etc.)

Responsibilities

- A responsibility to supply information (to the extent possible) that Health Alliance and its contracted Providers need in order to provide care
- A responsibility to follow plans and instructions for care that you have agreed on with your Providers
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- A responsibility to read and understand your Policy and to follow the rules of membership
- A responsibility to know the Providers in your network
- A responsibility to notify Health Alliance in a timely manner of any changes in your status as a Member or that of any of your covered Dependents

HOW THE HEALTH ALLIANCE PLAN WORKS

The Health Alliance Individual Indemnity Health Benefit Plan allows you and your covered Dependents to choose where you receive healthcare services. Healthcare services are paid according to the Indemnity Plan Description of Coverage and/or the Summary of Benefits and Coverage (SBC), up to the Maximum Allowable Charge after the individual or family Deductible has been met. The Provider may bill you for any amount up to the billed charge after the Plan has paid its portion of the bill.

Make sure that claims from Non-Participating Providers are submitted to Health Alliance within 90 days from the date of service. Claims submitted more than one year from the date of service are not covered by the Plan see the "Payment of Claims" section. You are responsible for submitting the claim or bill to Health Alliance if the Provider does not agree to send a claim on your behalf. The Provider will bill the portion you are responsible for directly to you after the Plan has determined its payment.

A Provider Directory listing Participating Providers by specialty with addresses and telephone numbers is available at HealthAlliance.org. Click on "Find a Doctor" in the site's directory. We encourage you to create a login to view your Plan-specific Providers and other Plan information at hally.com. If you do not have access to the internet or prefer to have a printed copy of the Provider Directory, a paper directory can be provided upon request. If your Primary Care Physician believes you require care from a specialist or other Provider, your Primary Care Physician will refer you to the appropriate Provider. In addition, Prior Authorization from Health Alliance is required for some types of care.

Your Relationship with Your Primary Care Physician
Upon enrollment, you must select a Primary Care Physician. We want you to have an open and honest relationship with your Primary Care Physician because this Physician will direct all your healthcare needs. The list of Participating Providers (Provider Directory) in your Provider Network is available at HealthAlliance.org/Guests/ProviderSearch or will be provided to you upon request.

In addition to their Primary Care Physician, female Members may select a Women's Principal Healthcare Provider to provide covered services within the scope of his or her license without the need for a referral from a Primary Care Physician. A Women's Principal Healthcare Provider must be selected from among the list of Participating Providers in your Provider Network.

A Primary Care Physician (allopathic or osteopathic) who specializes in pediatrics may be selected for your Dependent children on this Plan.

You may change your Primary Care Physician or Women's Principal Healthcare Provider by calling Health Alliance at the number on the back of your Health Alliance Identification Card or by writing to Health Alliance. Health Alliance requires Primary Care Physicians to provide access or direction to patients when they are unavailable or after hours. Health Alliance Members also have access to the Patient Advisory Line; this phone number is listed on the back of your Health Alliance Identification Card.

The Relationship Between Health Alliance and Participating Providers
Participating Providers are responsible for providing you with the services covered by this Policy. Health Alliance has contracted with Providers to provide you with covered services. Health Alliance does not provide medical services or make medical treatment decisions. The Participating Providers are independent contractors and not agents of Health Alliance. We have not given the Participating Providers the authority to act on behalf of Health Alliance in any manner or to make any promises or representations to you on its behalf. Participating Providers are responsible to you for the services they provide to you, including the healthcare services covered under this Policy. They are responsible for the services they provide to you and for the manner and skill with which those services are provided or rendered.

The Relationship Between Health Alliance and an Extended Network Provider
An Extended Network Provider is a Provider outside the Health Alliance network. An extended network is in place for times when members are traveling and need Covered Services as well as for employees who may live outside the Health Alliance service area. When seeing an approved Extended Network Provider you will be accessed the applicable in-network cost share and will not be balanced billed.

First Health is our extended network. The First Health logo is on your Health Alliance Identification Card. In addition, your Health Alliance Identification Card contains the First Health directory information that can be found at https://providerlocator.firsthealth.com/LocateProvider/SelectNetworkType.

If prior authorization is needed when seeing an extended network provider, that authorization will be handled between the provider and Health Alliance. The member will not be responsible for obtaining the prior authorization or need to be involved in that process. Member cost share will be the same for seeing an extended network provider as when seeing a provider in the Health Alliance network. Please see "Non-Participating Provider or Extended Network Prior Authorization Procedure" section for more details.

Specialty Care from Participating and Non-Participating Providers
If your Primary Care Physician believes specialty care is Medically Necessary, he or she may refer you to a Specialty Care Provider. Participating Physicians, Hospitals, mental health and other healthcare Providers are listed in the Provider Directory by specialty with addresses and telephone numbers. Your Primary Care Physician will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, you may apply to your Primary Care Physician for a standing referral. A standing referral will be effective for either the time period or number of visits specified by your Primary Care Physician. Health Alliance encourages our Participating Providers to have open communication about your medical care and needs. Your referring Physician will document the referral and the information regarding their referral in your medical records. If the Participating specialist requires further written information, it will be the referring Physician's responsibility to provide this to the specialist. Health Alliance does not require submission of any specialty visit referral unless it involves a procedure that requires Prior Authorization.

If the specialty services needed are not available from a Participating Provider in the Health Alliance Northwest Health Plan Network, a referral from your Primary Care Physician and Prior Authorization from Health Alliance are required for coverage of the specialty services at the Participating Provider benefit level. Female Members may obtain services from a Women's Principal Healthcare Provider without a referral from a Primary Care Physician.

Continued Care Coverage with Terminating Physicians
If your treating Physician's contract terminates with Health Alliance, you may be eligible for coverage of continued treatment by that Physician during a transitional period if you are in an ongoing course of treatment or if you are pregnant. The following conditions must be met unless otherwise approved by Health Alliance: the Physician's termination did not involve potential harm to a patient or disciplinary action by a state licensing board; the Physician remains in your Service Area; and the Physician agrees to abide by the terms and conditions of the terminating contract. You must contact the Customer Service Department at 1-866-247-3296 within 30 days of receiving the termination notice if you want coverage of continued care with a terminating Physician.

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your Physician for a period of 60 days. The 60-day period starts on the date you receive notice from Health Alliance that your Physician's contract with Health Alliance is terminating.

- **Maternity Care**
  If you are pregnant and have entered the second or third trimester of your pregnancy by the date of your Provider's termination, your Plan will cover continued care with that Provider at their previous level of

coverage through postpartum care.

Continued Care Coverage with Primary Care Physicians
If your Primary Care Physician's contract terminates with Health Alliance, you may be eligible for coverage of continued treatment by that Physician during a transitional period. The following conditions must be met, unless otherwise approved by Health Alliance: the Physician's termination did not involve potential harm to a patient or disciplinary action by a state licensing board; the Physician remains in your Service Area; and the Physician agrees to abide by the terms and conditions of the terminating contract. You must contact the Customer Service Department at the number on the back of your Health Alliance Identification Card within 30 days of receiving the termination notice if you want coverage of continued care with a terminating Primary Care Physician.

Continued Care Coverage for New Members
If your treating Physician is not a Participating Provider in the Health Alliance Northwest Health Plan Network, you may be eligible for coverage of continued treatment during a transitional period with that Physician if you are in an ongoing course of treatment or if you are pregnant. Your Physician must agree to accept reimbursement rates like other Participating Providers in the Health Alliance Northwest Health Plan Network, and comply with Health Alliance quality assurance requirements, and policies and procedures, unless otherwise approved by Health Alliance. You must contact the Customer Service Department within 15 days of your Effective Date of coverage if you need continued care with your Non-Participating Physician.

- **Ongoing Course of Treatment**
  If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your treating Physician for a period of 90 days from your Effective Date of coverage.

- **Maternity Care**
  If you are pregnant and have entered your second or third trimester of your pregnancy on your Effective Date of coverage, Health Alliance will cover continued care with your treating Physician through post-partum care.

Notice of Member's Right to Appeal a Surprise Bill
When you receive services from an in-network Hospital or ambulatory surgical center, certain Providers may be out-of-network. In these cases, the most those Providers may bill you is your Plan's applicable in-network cost-share. This applies to air ambulance services, Emergency Services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network Providers can't balance bill you, unless you give written consent and give up your protections.

PRIOR AUTHORIZATION

Participating Provider Prior Authorization Procedure
Health Alliance maintains a list of services that require Prior Authorization for medical necessity. Your Primary Care Physician or Participating Provider is responsible for obtaining Prior Authorization from Health Alliance on your behalf. If the Prior Authorization request is approved, you and the Primary Care Physician or Participating Provider who requested the Prior Authorization will be notified of the effective dates and the care and services you are authorized to receive. If the Prior Authorization request is denied, you, your Primary Care Physician and the Participating Provider will be notified in writing. If the Prior Authorization request is denied, the Plan will not provide coverage for the requested services.

Non-Participating or Extended Network Provider Prior Authorization Procedure
When using Non-Participating or Extended Network Providers, you are responsible for ensuring that all services listed are Prior Authorized before you receive the service. If the Prior Authorization request is approved, both you and your Provider will be notified of the effective dates and the kind of care and services you are authorized to receive. Once your Prior Authorization approval expires, it is your responsibility to notify your Provider so he/she can determine whether further care is needed, and if so, submit another Prior Authorization request to Health Alliance.

If your Prior Authorization request is denied, Health Alliance will not provide coverage for the requested services. Health Alliance maintains a list of services that require Prior Authorization for medical necessity. Prior Authorization can be initiated by calling Health Alliance at the number on the Health Alliance Identification Card.

If there is no Prior Authorization, a Retrospective Review will be performed. If Medical Necessity criteria are not met, you are responsible for the entire cost of the services received.

If your Prior Authorization request is denied, you may request an appeal of the denial; see "Appeals" and "Medical Necessity Review." If your Prior Authorization request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and you have exhausted the internal appeals process, you also have the right to request that decision be reviewed by an independent review organization; see "External Review of Appeals."

If your Prior Authorization request for urgent care is denied, you have the right to request an expedited internal appeal of the denial; see "Appeals" and "Expedited Medical Necessity Review." If your Physician or other healthcare Provider believes that the denial of coverage of healthcare services or the timeframe for completion of an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization. If your Prior Authorization request is denied due to treatment being experimental or investigational and your Physician certifies in writing that treatment would be significantly less effective if not promptly initiated, you may request an expedited external review of the denial at the same time you request an expedited internal appeal of the denial; see "External Review of Appeals" and "Expedited Medical Necessity Review."

To determine which medical procedures or durable medical supplies require Prior Authorization, log in to hally.com and click on the menu tab. In the menu, under "Find Care," select either "Medical Prior Authorization List" or "Durable Medical Supplies List". You may send a Customer Service Request from there, or contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Prior Authorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Healthcare Services that Require Prior Authorization
Health Alliance maintains a list of services that require Prior Authorization for medical necessity. Prior Authorization provides you with assurance that a Hospitalization, procedure or supply will be covered by the Plan. Coverage will not be provided for healthcare services that are not Medically Necessary. Services that require Prior Authorization will not be covered if you receive those services prior to approval of the Prior Authorization request and it is later determined the services were not Medically Necessary.

To determine which medical procedures or durable medical supplies require Prior Authorization, log in to hally.com and click on the menu tab. In the menu, under "Find Care," select either "Medical Prior Authorization List" or "Durable Medical Supplies List". You may send a Customer Service Request from there, or contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Services that do not require Prior Authorization include but are not limited to an evaluation and management visit, or any of the first six (6) treatment visits within an Episode of Care, with a Participating Provider for chiropractic,

physical therapy, occupational therapy, speech therapy, hearing therapy, massage therapy and East Asian medicine that are Medically Necessary. These services are, however, subject to quantitative treatment limits as outlined in this Policy.

When receiving treatment in a behavioral health agency that provides inpatient or residential Substance Use Disorder treatment, you will have coverage for no less than two (2) business days, excluding weekends and holidays, prior to any Prior Authorization or utilization review.

When receiving treatment in a behavioral health agency that provides withdrawal management services, you will have coverage for no less than three (3) days, prior to any Prior Authorization or utilization review.

PLEASE NOTE: You may use Non-Participating Providers and have benefits paid at the Participating Provider level only when services are not available from a Participating Provider and if you have received Prior Authorization from Health Alliance, or in a medical emergency. In other words, the Plan will pay at the Participating Provider benefit level for Non-Participating services only if you obtain Prior Authorization before receiving treatment. The only exception to this rule is for medical emergency care required to treat and stabilize a medical emergency will be covered at the same level as services received through a Participating Provider.

Notification of Emergency Services
If you are treated or are admitted as an inpatient for an Emergency Medical Condition, you must notify Health Alliance at the number listed on the back of your Health Alliance Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

COVERAGE DECISIONS

Concurrent Care Decisions
Any reduction or termination before the end of an approved period of time, length of stay or number of treatments is considered a denial of coverage. You will be notified in writing at a time sufficiently in advance of the reduction or termination in order to allow you or your authorized representative to appeal the concurrent care decision and obtain a determination on review before the coverage is reduced or terminated.

Coverage Decisions (Post-Service Claims)
Health Alliance will make a coverage decision within 30 days of receipt of a claim for payment or reimbursement of healthcare services that have already been provided. When any services are denied, you or your authorized representative will be notified in writing.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within 30 days of receipt of the claim. The determination period may be extended one time for 15 days due to circumstances beyond the control of Health Alliance. You or your authorized representative will be notified in writing of the reason for the extension.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Individuals must meet the following requirements to be eligible for enrollment in the Plan:

Policyholder
The Policyholder must be a bona fide Employee, regularly employed on a permanent basis by the Employer Group, who enrolls under his or her Employer Group's health Plan with Health Alliance. A Policyholder must live or work in the Service Area of the Employer Group's Plan and is subject to all terms and conditions of the Group Enrollment Agreement.

Dependent
A Dependent may be eligible to enroll under the Employer Group's Health Alliance Plan for coverage if he or she has one of the following relationships to the Policyholder:

- Your Legal Spouse.
- Your natural-born, legally adopted child or stepchild.
- A child for whom you or your Legal Spouse are the court-appointed legal guardian.
- A child placed in foster care, or placed for adoption with you or your Legal Spouse. Placement or placed means you assume total or partial support of the child. If the child's placement terminates, upon termination the child will no longer be eligible for benefits under the Plan.
- A Domestic Partner.

Examples of Dependents who are not eligible for coverage under the Plan include, but are not limited to grandchildren (unless you are the legal guardian), parents and other relatives.

A person is not an eligible Dependent if on active duty in the Armed Forces or National Guard of any country.

An eligible Dependent child must be under the age of 26 regardless of student status or as otherwise specified in this Policy.

An eligible Dependent may continue coverage under the Plan if, upon reaching the Limiting Age, a developmental disability or a physical disability makes the Dependent incapable of self-sustaining employment, and if they are dependent on his or her parent(s) or other care Providers for support and maintenance. Health Alliance may request documentary proof of the incapacity and dependency. Requests will be no more often than annually after the two-year period following the Dependent's attainment of the Limiting Age.

Retired Employee Enrolled in Health Alliance Medicare Plans
If a Retired Employee is covered under this Plan, or is covered under a Health Alliance administered Medicare Advantage or Medicare Supplement plan his or her Dependent Spouse and/or covered Dependent child(ren) may remain covered under this Plan if:

- The Spouse and/or Dependent child(ren) were covered under the Employer Group Plan at the time of the Employee's retirement.
- The Spouse and/or Dependent child(ren) continue to meet the eligibility requirements for Dependent coverage.
- Or as otherwise specified by your Employer Group.

Active Employees Enrolled In Medicare
In addition to this Plan, the Employer Group may offer a Medicare Advantage or Medicare Supplement plan to active Employees who are Medicare Eligible and Medicare is the primary payer if the group has 20 or less total Employees. For groups with 21 or more Employees, Medicare would be secondary to the employer plan. If offered, this plan will also be available to the Employee's Legal Spouse and Dependent children. If your Employer offers this option, you may choose to:

- enroll in this Plan
- enroll in the Employer Group's Medicare Advantage plan
- enroll in the Employer Group's Medicare Supplement plan

If enrollment in the Employer Group's Medicare Advantage or Medicare Supplement plan is elected, those eligible individuals who are not enrolled in Medicare may be enrolled in this Health Alliance Group Plan.

Contact your Employer for information concerning your eligibility for the Employer Group Medicare Advantage or Medicare Supplement plan.

Initial Enrollment
If you meet the eligibility requirements stated in the "Policyholder" or "Dependent" subsections, and you also meet the Employer Group's eligibility requirements, you may enroll by submitting a completed application to your employer within 31 days of your eligibility date.

Open Enrollment
An Employer Group may have an Open Enrollment Period where eligible Employees and his or her eligible Dependents may enroll in the Plan by submitting a completed application to their employer within 31 days of the Employer Group's renewal date.

Effective Date
The Effective Date of coverage under this Plan depends on the Employer Group's eligibility requirements. The eligibility requirements are specified in the Group Enrollment Agreement between the Employer Group and Health Alliance. This Plan will remain in effect for the term specified in the Group Enrollment Agreement, unless canceled or terminated at an earlier date by you, your Employer Group or Health Alliance.

Special Enrollment Period (SEP)
Federal law and this Policy describe special enrollment provisions, which establish a period of time in which you have the option to enroll in an Employer Group Plan or switch your plan when you or your Dependents experience a qualifying event.

To be eligible to enroll under these qualifying events, you must submit a written request to your employer requesting changes in your coverage within 60 days of the event. Any request to add yourself or eligible Dependents after the 60-day period will not be granted. You and/or your eligible Dependents may enroll in any benefit package under the plan. You may be required to provide supporting documentation for the change in enrollment.

You and your Dependents are eligible for a special enrollment period of 60 days when one of the following qualifying events occurs:

- You and/or your Dependents are eligible for a special enrollment period under another employer-sponsored Group health plan if you are no longer eligible for the Plan because you cease to live or work in the Service Area and there is no other benefit plan option available under the Plan. The Effective Date of coverage is impacted by the date of the qualifying event. If the date of the qualifying event is within days 1-15 of the month, the Effective Date is the first of the month following the date of the qualifying event. If the date of the qualifying event is within days 16 through the end of the month, the Effective Date is the first of the second month following the date of the qualifying event.

- If you and/or your eligible Dependents exhaust COBRA continuation or state continuation coverage or your employer's contribution or government subsidies paying for COBRA ends, you and your eligible Dependents losing coverage may enroll in the Plan. The Effective Date of coverage is impacted by the date of the qualifying event. The Effective Date of coverage for you and your eligible Dependents added through this qualifying event is the first day of the month following the qualifying event if applying before this qualifying event, or you may choose the Effective Date of the 15th of the month in which the COBRA continuation or state continuation ended. The Effective Date of coverage for you and your eligible Dependents added through this qualifying event is the first day of the second month following the qualifying event if applying after this qualifying event. You will have the option to elect coverage to begin on the first of the following month after the qualifying event or other Regular Effective Date.

- If you gain a Dependent through a court order, you may enroll yourself, your eligible Legal Spouse, the new Dependent and any other eligible Dependent children not currently enrolled in the Plan. The

Effective Date of coverage of you and your Dependent added through this qualifying event is either the date of the qualifying event, the first of the month after the qualifying event, or upon your request, a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

- If you or your eligible Dependents enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, intentional misrepresentation or inaction of an officer, Employee or agent of the Washington State Health Benefit Exchange for Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Washington State Health Benefit Exchange. In such cases, the Washington State Health Benefit Exchange may take such action as may be necessary to correct or eliminate the effects of such error, intentional misrepresentation or inaction. The Effective Date of coverage of you and your Dependent added through this qualifying event is the date of the qualifying event or, upon your request, a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

- If you have other coverage (such as a plan offered by your Legal Spouse's employer) and you lose coverage as a result of a qualifying event (such as death, legal separation, or divorce), you and your eligible Dependents may enroll in the Plan. The Effective Date is the day following the qualifying event.

- If you and/or your eligible Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours, termination of employer contributions, a termination in a class of coverage, or you receive a notice of the loss of minimum essential coverage you and your eligible Dependents may enroll in the Plan. Your prior coverage must meet minimum essential coverage standards in order for the loss of coverage to be considered a qualifying event. You have 60 days before or 60 days after a loss of coverage to select a Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the day following the qualifying event.

- If you and/or your eligible Dependents did not receive timely notice of a qualifying event, and were otherwise reasonably unaware that a qualifying event occurred, you and your eligible Dependents may enroll in a plan. You have 60 days after you are made aware or reasonably should have known of the qualifying event to select a Plan. You will have the option to elect coverage to begin on the first of the following month after the qualifying event or other Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

- In the case of a permanent move, you and/or your eligible dependents must have had qualifying coverage that met minimum essential coverage standards for one or more days in the 60 days preceding the move (or they must have lived in a foreign country or in a United States territory) in order for this to be considered as a qualifying event. You have 60 days before or 60 days after a permanent move to select a Plan. If the Plan is selected before the move, the Effective Date is the first of the month following the qualifying event. If the Plan is selected after the move, the Effective Date is the first day of the second following month after the qualifying event.

- If you and/or your Dependents become eligible or ineligible for a premium assistance subsidy under Medicaid or CHIP, you and your eligible Dependents may enroll in the Plan. The Effective Date of

coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

- If you and/or your eligible Dependent are enrolled in an eligible employer-sponsored plan that is not considered qualifying coverage, you are allowed to terminate existing coverage, and may enroll in the Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

- If you acquire, or become, a new Dependent through marriage, or a Domestic Partnership, you may enroll yourself and/or your new Spouse and eligible Dependents in the Plan. The Effective Date of coverage of you and your eligible Dependent added through this qualifying event is the date of the qualifying event.

- If you acquire a new Dependent through birth, foster care placement, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Legal Spouse, the Newborn or newly adopted child, and any other eligible Dependent children not currently enrolled in the Plan. The Effective Date of coverage of you and your Dependent added through one of these qualifying events is the date of the qualifying event or upon your request, a Regular Effective Date. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

You and your Dependents are eligible for a special enrollment period of 90 days when one of the following qualifying event occurs.

To be eligible to enroll under this qualifying events, you must submit a written request to your Employer requesting changes in your coverage within 90 days of the event. Any request to add yourself or eligible Dependents after the 90-day period will not be granted. You and/or your eligible Dependents may enroll in any benefit package under the Plan. You may be required to provide supporting documentation for the change in enrollment.

- If you are eligible for coverage but not enrolled in this Plan and you or your Dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you and your eligible Dependents may enroll in the Plan. The Effective Date of coverage for you or your Dependents added through this qualifying event is the first day of the month following receipt of the request.

There is no special enrollment opportunity allowable for an individual due to the failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage or situations allowing for a rescission of coverage.

Qualified Medical Child Support Order
If a parent who is enrolled in this Plan is required by a court or administrative order to provide healthcare coverage for his or her child, the Plan will:

(1) Upon receipt of a copy of the order and application, permit the covered parent to enroll the child who is otherwise eligible for coverage under the Plan; or
(2) Enroll the child in the Plan upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering a program for enforcing child support and establishing paternity under federal law (or another child support enforcement program), if the parent is enrolled in the Plan but fails to apply for enrollment of the child as required by the order.

The Plan may not impose on a state agency that has been assigned the rights of an enrollee in the Plan who receives Medicaid benefits, requirements that are different from requirements applicable to an assignee of any other Member in the Plan.

Your employer will notify you whether the Dependent is eligible for coverage within 31 days of receipt of the order. If the Employer Group offers more than one Plan option, the Dependent will be enrolled in the same Plan in which the Policyholder is enrolled. The Dependent's eligibility for enrollment will be under the same terms and conditions as other Dependents of the Plan. Your employer does not need approval from you to add a Dependent to the Plan. Children covered under a Qualified Medical Child Support Order and who reside in a Health Alliance Service Area that is different from the Health Alliance Service Area of the Policyholder will receive the same covered benefits as the Policyholder when using contracted Providers in the Dependent's Health Alliance Service Area and following the Plan's requirements.

The Dependent may designate another person, such as a custodial parent or legal guardian, to receive the Policy, Description of Coverage, the SBC, and reimbursement for claims and other Plan materials.

If your employer decides that the order is not a Qualified Medical Child Support Order, each Dependent specified in the order as entitled to enroll in the Plan may submit a written appeal to the employer. The employer is required to respond in writing within 31 days of receiving the appeal.

The Plan may not disenroll, or otherwise eliminate the coverage of the Dependent child unless the Plan is provided satisfactory written evidence of either of the following:

- The court or administrative order is no longer in effect.
- The child is or will be enrolled in a comparable healthcare plan obtained by the parent under such order and that enrollment is currently in effect or will take effect no later than the date coverage under the Plan is terminated.

Coverage under a court or administrative order is subject to the provisions of the Termination section of this Policy.

Enrollment of a Dependent in response to a Qualified Medical Child Support Order must be made according to the specifications of the order, without regard for normal enrollment dates.

Newborns, Adopted Children, Children Placed for Adoption or Children Placed in Foster Care
If you are the birth mother paying premiums for individual coverage (Employee only), your Newborn child is covered initially from birth, for a minimum of three weeks or the length of time the child's birth mother is admitted for delivery, whichever is longer. Health Alliance must be notified of the birth to apply this initial coverage. For the Newborn to be continually covered past the initial coverage timeframe, you must submit an application to your employer to add the child within 60 days of birth. If you are paying premiums for Family Coverage, your Newborn child is covered for the first 60 days of birth. If payment of an additional premium is required, coverage after 60 days is contingent upon the submission of a completed application to your employer and payment of the additional premium within 60 days following the birth. Coverage for the Newborn will include illness, Injury, congenital defects, birth abnormalities and premature birth. A Newborn of a Dependent child is not covered.

If you adopt a child, serve as a child's legal guardian or a child is placed for adoption with you or placed in foster care with you, coverage may be subject to the submission of written documentation accompanied by a completed application within 60 days from the date of the order or agreement. Examples of accepted written documentation would be an interim court order or a final order of adoption, guardianship or placement for adoption or placement in foster care, signed by a judge.

Premiums for coverage of a Newborn, adopted child, child placed for adoption or placed in foster care will be payable from the date of eligibility and must be paid within 60 days from the date your request for coverage is received.

OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS

Copayments, Coinsurance and Deductible
All Copayment, Coinsurance and Deductible amounts are specified on the Description of Coverage and/or the SBC. Any Coinsurance from Participating Providers is based on the amount the Participating Provider has agreed with Health Alliance to accept as full payment for the service, which is referred to as the discounted or allowed amount. Coinsurance for Non-Participating Providers is based on the Maximum Allowable Charge (MAC) for the service, not the billed charge. You are required to pay any charges in excess of the Maximum Allowable Charge (MAC) amount.

Out-of-Pocket Maximums
The Out-of-Pocket Maximum amounts for an individual and family are specified on the Description of Coverage and/or the SBC. These are the maximum amounts you are required to pay in Copayments, Coinsurance and Deductibles for Basic Healthcare Services during the Plan Year.

Any Copayment, Coinsurance or Deductible amounts for Basic Healthcare Services exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Plan Year. If you believe you have paid any Copayment, Coinsurance or Deductible amounts after you have reached your Out-of-Pocket Maximum, you may request a review of your claims. Requests for claim review must be submitted to Health Alliance prior to the end of the Plan Year or as soon as reasonably possible. Health Alliance is not responsible for refund of overpayments, as payment is made to the Provider. Requests for refunds of payment should be made to your Provider.

Any Copayment, Coinsurance or Deductible amounts for non-Basic Healthcare Services that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage and/or the SBC. Payments for non-covered items or services and amounts over the Usual, Customary and Reasonable do not apply to your Out-of-Pocket Maximum.

Plan Year Maximum Benefit
The Plan Year Maximum Benefit is the total benefit amount for an individual for specific non-Essential Health Benefits and is specified on the Description of Coverage and/or the SBC. This is the maximum amount the Plan will pay for the specified medical services during the Plan Year.

Lifetime Maximum Benefit
The Lifetime Maximum Benefit is the total benefit amount for an individual on specific non-Essential Health Benefits and is specified on the Description of Coverage and/or the SBC. This is the maximum amount the Plan will pay for the specified medical services in a Lifetime. You must reimburse the Plan for any amounts exceeding the Lifetime Maximum that the Plan pays on your behalf.

PREMIUMS

Payment of Premiums
You, or anyone paying on your behalf, must remit the specified premium to Health Alliance by the date due. You are entitled to benefits under this Policy only if Health Alliance receives the full amount of the premium within the required time period.

Premium Rate Revision
Premium rates are subject to change annually upon the Plan Year renewal date. Notice of a change in the annual premium rate will be provided to you not less than 31 days prior to the Effective Date of the change. Rates may also be subject to change during a Plan Year due to a change in age, number of eligible Dependents or geographic

location. Any rate revision based on changes during the Plan Year will be effective the first of the next month after the change.

Health Alliance reserves the right to change the premium rate if state or federal laws require a change in benefits or other terms of coverage. Written notice will be provided to you not less than 31 days prior to the premium rate change.

Please contact Health Alliance at the number on the back of your Health Alliance Identification Card with any questions about your bill or to confirm any rate changes.

Premium Due Date
The first monthly premium must be paid on or before the Effective Date of this Policy and the succeeding premiums must be paid on or before the due date, subject to the grace period and Special Enrollment Period provisions.

Grace Period
If you or anyone paying on your behalf fails to pay the premium within 31 days after it becomes due, this Policy is automatically canceled and you will not be entitled to further benefits. During the grace period, if you receive any services, you will remain liable for the payment of the premium for the time coverage was in effect, as well as for any Copayment, Coinsurance or Deductible owed because of services received during the grace period.

Unpaid Premiums
Any premium due and unpaid may be deducted from the payment of a claim under this Policy.

Reinstatement
In the event the premium is not paid within the time granted, including any grace period, and coverage is terminated, reinstatement of coverage under this Policy is subject to the Enrollment Periods described in this Policy.

Composite vs. Per-member Premiums
Your Employer Group has the option to elect per-member or composite premiums. If your Employer Group elects composite premiums, this means that the average premium amount would be calculated at the start of the Plan Year. The amount of the premium would not be allowed to vary for Members throughout the Plan Year, for the Plan elected, even if the composition of the Employer Group were to change. Health Alliance would recalculate the average Member premium for the Employer Group only upon renewal.

WHAT IS COVERED

The following healthcare services covered under this Policy are subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum benefits specified on the Description of Coverage and/or the Summary of Benefits and Coverage (SBC).

Expenses for healthcare services, including Basic Healthcare Services, are covered only if the services are Medically Necessary for the treatment, maintenance or improvement of your health. Some healthcare services are subject to Prior Authorization by Health Alliance and a determination that criteria have been met. Health Alliance maintains a list of services that require Prior Authorization for medical necessity. Prior Authorization can be initiated by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Medical policies have been developed as a guide for determining Medical Necessity. These medical policies provide the criteria to be met before coverage is provided for some healthcare services covered under this Policy. To view these policies, go to HealthAlliance.org/Medical-Policies, or you can request a paper copy of a medical policy by contacting Health Alliance at the number listed on the back of your Health Alliance Identification Card.

If you are unsure whether a diagnostic test or treatment will be covered, call Health Alliance at the number listed on the back of your Health Alliance Identification Card to verify coverage and Prior Authorization requirements prior to receiving services.

Abortion
Services, drugs, or supplies related to abortions are covered. Please refer to the Abortion Services section on the Description of Coverage for cost share information.

Acupuncture
Acupuncture and Eastern medicine treatment is covered when determined to be Medically Necessary. Acupuncture visit limitations are subject to the limitations listed on the Description of Coverage and/or the SBC. Acupuncture visits for Chemical Dependency are not subject to the limitations listed on the Description of Coverage. These visits will continue to be covered when Medical Necessary without benefit limitation. Please refer to the section labeled Other Covered Services on the Description of Coverage for cost share information as well as Contract Year Maximum Benefits for visit limitations.

Additional Opinion
A consultation with a board certified surgeon is covered after you receive a recommendation for surgery. If a second opinion does not confirm the primary surgeon's opinion, a third opinion is covered. Please refer to the sections labeled Primary Care Physician Office Visits and Specialty Care Physician Office Visits on the Description of Coverage for cost share information.

Allergy Testing and Treatment
Allergy Testing and Treatment is covered when determined to be Medically Necessary. Please refer to the sections labeled Allergy Treatment and Testing on the Description of Coverage for cost share information.

Ambulance

- **Air Transportation** – Emergency transportation by air ambulance is covered for an Emergency Medical Condition when Medically Necessary. Air ambulance services are not covered when you could be safely transported by ground ambulance, by means other than by ambulance, or for stable patients for distances up to twelve (12) hours.
- **Ground Transportation –** Emergency transportation by ground ambulance is covered for an Emergency Medical Condition when Medically Necessary.

Please refer to the section labeled Emergency Ambulance Transportation on the Description of Coverage for cost share information.

Amino Acid-Based Elemental Formulas
Amino acid-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders, Phenylketonuria (PKU) disease and short bowel syndrome are covered when prescribed by a Physician as Medically Necessary. Please refer to the sections labeled Durable Medical Equipment as well as Home Health on the Description of Coverage for cost share information.

Biomarker Testing
Biomarker testing is covered when conducted in an efficient manner to provide the most accurate range of results. Biomarker testing must be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test is Medically Necessary, including, but not limited to:

- Labeled indications for an FDA-approved test or indicated tests for an FDA-approved drug,
- Federal centers for Medicare and Medicaid Services National Coverage Determinations,
- Nationally recognized clinical practice guidelines,

- Consensus Statements,
- Professional society recommendations,
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database of Health Services Technology Assessment Research; and 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.

Blood
Blood and blood products are covered when determined to be Medically Necessary by your Participating Physician. Costs related to the administration and procurement of blood and blood components are also covered, including the processing and storage of blood you donate for yourself. Please refer to the section labeled Other Covered Services on the Description of Coverage for cost share information.

CAR T Therapy
Medically Necessary Chimeric Antigen Receptor (CAR) T-Cell Immunotherapy is covered for Members at facilities in your Provider Network.

Cardiac Rehabilitation Services
Cardiac Rehabilitation is covered. Please refer to the sections labeled Inpatient Hospitalization Facility Fees, Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information.

Outpatient Cardiac Rehabilitation services are covered at the other covered services benefit as listed on your Description of Coverage and/or the SBC.

Chemotherapy and Radiation
Chemotherapy and radiation are covered when determined to be Medically Necessary. Please refer to the sections labeled Other Covered Services on the Description of Coverage for cost share information.

Chiropractic Services
Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness, are generally furnished for the diagnosis and/or treatment of a neuromusculoskeletal condition associated with an injury or illness, and that are determined by Health Alliance Medical Plans to be Medically Necessary. An initial office visit will be covered to establish a plan of care. Any additional charges billed by a Chiropractor (D.C.), including but not limited to office visits, will be subject to the appropriate Deductible, Copayment and/or Coinsurance as listed on your Description of Coverage.

Chiropractic Services are subject to coverage limitations specified on the Description of Coverage and/or the SBC. Spinal manipulations may be provided by a Doctor of Osteopathy (D.O.), a Chiropractor (D.C.) or other Provider that can provide this service within the scope of their state license. Any service or treatment not outlined in this section is not covered under the Chiropractic Services benefit.

Clinical Trials
During an Approved Clinical Trial, Health Alliance covers routine patient care costs for standard of care items and services typically provided absent a clinical trial. Costs for investigational item(s) in the clinical trial such as an investigational drug, procedure, device, and/or service, is not covered as the item(s) are being investigated and are not standard of care at the time of the trial. Costs paid for, or items and services provided free of charge, by the Approved Clinical Trial Providers or research sponsors are also not covered. Each covered service is subject to the applicable Copayment, Coinsurance, and/or Deductible amounts specified on the Description of Coverage and/or the SBC.

For coverage of a phase I, phase II, phase III or phase IV clinical trial, the trial must be:

- Prior Authorized by Health Alliance
- Approved by one of the following agencies: the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs or the United States Department of Energy; and/or
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Contraceptive Drugs, Devices and Services
FDA-approved prescription Contraceptive devices, injections, procedures and services, including Natural Family Planning, are covered.

FDA-approved devices and the medical fitting insertion and/or removal of devices for Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to IUDs, diaphragms, cervical caps or Implanon®. Additional charges billed will apply to the appropriate Durable Medical Equipment Copayment, Coinsurance or Deductible as specified on the Description of Coverage and/or the SBC.

FDA-approved injectables and the injection intended for Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to DepoProvera®. Additional charges billed will apply to the appropriate Primary Care Physician Office Visits, Specialty Care Physician Office Visits and Durable Medical Equipment Copayment, Coinsurance or Deductible as specified on the Description of Coverage and/or the SBC.

FDA-approved sterilization procedures, intended for Contraceptive purposes are covered under the wellness benefit. Additional charges billed will apply to the appropriate Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services, Laboratory and X-rays Copayment, Coinsurance or Deductible as specified on the Description of Coverage and/or the SBC; see "Sterilization Procedures" under "What is Covered."

Prescription Contraceptive services as specified in this section that are prescribed or recommended to treat medical conditions with a medical diagnosis and are not used for Contraceptive purposes or for unintended pregnancy for females are not considered wellness and are subject to the medical Primary Care Physician Office Visits, Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services Deductible, Copayment or Coinsurance as specified on the Description of Coverage and/or the SBC.

FDA-approved prescription Contraceptives, including but not limited to, Contraceptive pills, patches, and rings, are covered under the wellness benefit for Contraceptive purposes, including when received in the Provider's office; see the Pharmacy section under "What is Covered/What is Not Covered—Pharmacy Benefits."

Dental Services
Charges incurred and anesthetics provided in conjunction with Dental work that is provided in a Hospital or ambulatory surgical treatment center are covered when determined to be Medically Necessary for the following:

- Children age seven and under;
- Individuals with a medical condition that requires hospitalization or general anesthesia for Dental care; and
- Individuals who are disabled;

See “Oral Surgery” in this section for other covered services.

This Policy provides essential coverage for dental services for Members under the age of 19. This section describes what services are covered as well as the limitations. Each covered service is subject to the Deductibles, Copayments or Coinsurance amounts specified on the Description of Coverage.

Preventive Pediatric Dental Services
The following services or treatments are considered preventive services and are only covered for Members under the age of 19.

- **Dental sealants** are covered and are limited to one sealant per tooth in a three-year period.
- **Diagnostic services—**X-rays are covered and includes the following: complete or full-mouth X-rays limited to one set every 36 months. Bitewing films limited to two set per Benefit Year. Cephalometric films limited one set every two years. Panoramic X-rays limited to once every three years. Occlusal intraoral X-rays limited to once every two years. Periapical X-rays not included in a complete series for diagnosis in conjunction with definitive treatment.
- **Diagnostic Services**—Evaluations and examinations are covered. Initial or periodic oral examinations and evaluations are covered. Oral examinations and evaluations are limited to two per Benefit Year, beginning before one year of age, plus limited oral evaluations when necessary to evaluate for a specific dental problem or oral health complaint, dental emergency or referral for other treatments. Caries susceptibility testing is also covered. Limited visual oral assessments or screening, limited to two per member per calendar year, not performed in conjunction with other clinical oral evaluations services are covered.
- **Prophylaxis and fluoride treatments** are covered. Prophylaxis/cleanings are limited to two times per Benefit Year beginning at age six months. Fluoride treatments are limited to two times per Benefit Year.
- **Space maintainers** are covered. Fixed or removable space maintainers are covered. The re-cementation and removal of a fixed maintainer is also covered.

Minor Restorative Pediatric Dental Services
The following services or treatments are considered minor restorative services and are only covered for Members under the age of 19.

- **Restorative services (fillings)** are covered as follows: Multiple restorations on one surface will be considered one restoration. This includes: amalgam restorations (primary or permanent) and synthetic restorations using either silicate cement, acrylic, plastic or composite resin; crowns using acrylic, plastic or stainless steel; pins and pin retention exclusive of restorative material; and/or re-cementation with inlay, onlay, crown or bridge.
- **Endodontic services** are covered as follows: Pulp capping (excluding final restoration), pulpotomies—therapeutic and partial (excluding final restoration) and pulpal therapy and pulpal regeneration.
- **Periodontic services** are covered as follows: Periodontal scaling and root planning—four or more teeth per quadrant is limited to once per quadrant every 24 months, one to three teeth per quadrant is limited to once per site every 24 months. Also covered is the localized delivery of antimicrobial agents and periodontal maintenance following active periodontal therapy (limited to twice per Benefit Year). Also covered is gingivectomy or gingivoplasty (limited to once in a 36-month period), osseous surgery (limited to once in a 36-month period), pedicle, free and subepithelial tissue graft procedures, full-mouth debridement.
- **Oral Surgery** is covered as follows: Extractions, which include extraction of one or more teeth; surgical removal of erupted or impacted teeth, involving tissue flap and bone removal of teeth. Also covered are alveoloplasty procedures, incision and drainage of abscess, and removal of exostosis.

Major Pediatric Dental Services
The following services or treatments are considered major services and are only covered for Members under the age of 19.

- **Restorative services** are covered as follows: Cast restorations and crowns are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with a routine filling material. Restorations can include any of the following: inlays; onlays, in addition to inlay allowance; crowns and posts made of acrylic with metal, porcelain, porcelain with metal full-cast metal (other than stainless steel), 3/4 cast metal (other than stainless steel); cast post and core, in addition to crown (not a thimble coping); steel post and composite or amalgam core, in addition to a crown; cast dowel pin (one-piece cast with crown attachment, including pontics); and simple stress breakers, per unit. Stainless steel crowns for primary antierior teeth once every three years, if age thirteen and older are covered.
- **Root Canal Therapy** is covered as follows: Root canals (excluding final restoration services) are covered. Retreatment of previous root canal therapy, apexification/recalcification visits, apicoectomy/periradicular surgery, root amputation and Hemisection (not included in any root therapy) is covered.
- **Periodontic services** are covered as follows: Gingivectomy or gingivoplasty (limited to once in a 36-month period), osseous surgery (limited to once in a 36-month period), pedicle, free and subepithelial tissue graft procedures, full-mouth debridement.
- **Dentures** are covered as follows: Dentures including all adjustments done by the dentist furnishing the denture in the first six months after installation. The following is a list covered under this Plan: full dentures, upper and lower; partial dentures—includes base, all clasps, rests and teeth; repairs of dentures. Rebasing and relining of dentures is not covered within the first six months of placement and is limited to once in a 36-month period. Tissue conditioning is also covered.
- **Implants** are covered as follows: If determined to be a Medical Necessity. If Prior Authorization is approved, coverage includes the implant/abutment procedure.
- **Crowns and Pontics** are covered as follows: Crowns and pontics are covered on posterior teeth only.

Orthodontic Pediatric Dental Services
The following services or treatments are considered orthodontic services and are only covered for Members under the age of 19.

- Orthodontic treatment is only covered when determined to be Medically Necessary. Approved orthodontia already in progress will cease to be covered once the Member turns 19.

For other services done in a Provider's office, see Other Covered Services as well as Specialty Care Physician Office Visits on the Description of Coverage for cost share information. For services done in a facility, see "Outpatient Surgery/Procedures Facility Fee" as well as "Outpatient Surgery/Procedures Physician/Surgeon Services" on the Description of Coverage for cost share information.

Diabetic Equipment and Supplies
Blood glucose monitors, cartridges for the legally blind, insulin infusion devices, lancets and lancing devices are covered subject to the durable medical equipment Deductible, Coinsurance or Copayment amount specified on the Description of Coverage and/or the SBC. The diabetic equipment listed in this subsection must be obtained from a qualified Provider, and determined to be Medically Necessary. Diabetic equipment not listed in this subsection is covered when Medically Necessary. Please refer to the section labeled Durable Medical Equipment on the Description of Coverage for cost share information.

Diabetic Self-Management Training and Education
Outpatient self-management training and education, including but not limited to nutritional training for the treatment of all types of diabetes and gestational diabetes mellitus, are covered when Medically Necessary and provided by a qualified Provider. Nutritional counseling related to diabetic conditions are not subject to the limitations listed in the

"What is Covered, Nutritional Counseling" section of this Policy. Please refer to the section labeled Other Covered Services on the Description of Coverage for cost share information.

Diagnostic Testing
Diagnostic testing, including but not limited to X-ray examinations, genetic tests, laboratory tests and pathology services, are covered when ordered by Physician and Medically Necessary. Please refer to the section labeled MRI and CT Scans as well as Laboratory and X-rays on the Description of Coverage for cost share information

Dialysis Treatment
Medically Necessary dialysis treatment is covered for in-home and outpatient clinic settings. Dialysis services are also covered while provided during an inpatient stay. Each covered service is subject to the Other Covered Services Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

Dressings and Supplies
Dressings, splints, casts and related supplies are covered when Medically Necessary and when administered by a Participating Provider or by a nurse or other healthcare professional under the direction of a Physician. Please refer to the section labeled Durable Medical Equipment as well as Other Covered Services on the Description of Coverage for cost share information.

Durable Medical Equipment, Orthopedic Appliances and Devices
Corrective and orthopedic appliances (such as leg braces and knee sleeves) and durable medical equipment (such as wheelchairs, surgical beds, insulin pumps and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. Coverage of Durable Medical Equipment includes sales tax. Items and supplies provided under this subsection must be prescribed by a Provider.

Based on Medical Necessity the equipment is made available through rental or purchase agreements. A maximum benefit limit may apply. Costs associated with the repair of covered equipment are covered if Health Alliance determines the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered. The rental or purchase of a breast pump is covered during pregnancy and through the postpartum period under the Plan's wellness benefits; see "Wellness Care" under "What is Covered."

To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount under this benefit. Coverage can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Please refer to the section labeled Durable Medical Equipment on the Description of Coverage for cost share information.

Emergency Services
Emergency Services received inside or outside your Service Area for an Emergency Medical Condition are covered. In an emergency, seek immediate care or call 911 if it is available in your area. Emergency Medical Condition means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition placing the health of the Member (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. Unexpected hospitalization due to complications of pregnancy is covered.

Care required to treat and stabilize an Emergency Medical Condition when received from a Non-Participating Provider will be covered at no greater expense to you than if the services had been provided by a Participating

Provider. Emergency Services are subject to the Participating (In-Network) Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

The Emergency Services Deductible, Copayment or Coinsurance is waived if you are admitted to the Hospital when your Plan requires an inpatient Hospital Deductible, Copayment or Coinsurance. Elective care or care required as a result of circumstances that could reasonably have been foreseen prior to leaving your Service Area is not covered.

Health Alliance will cover Post-Stabilization Medical Services, after an emergency medical treatment, if the services are Medically Necessary. With respect to a pregnancy and/or the health of the unborn child, coverage includes, but is not limited to, behavioral health emergency services, mental health treatment or substance use disorder treatment.

Erectile Dysfunction
Treatment is covered for Members with documented erectile dysfunction without a correctable cause.

Medications will be excluded from coverage unless they meet one of the following requirements:

- Medication is required by a state regulation
- Medication is used to treat a medical condition not related to lifestyle enhancement or performance

Each service and prescription drugs are subject to the applicable Primary Care Physician Office Visits, Specialty Care Physician Office Visits Deductible, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC.

Gender Affirmation Treatment
Gender affirmation treatment, such as but not limited to, breast removal, phalloplasty (or surgical alteration of female genitalia to male), and vaginoplasty (or surgical alteration of male genitalia to female) is covered when determined to be Medically Necessary.

Genetic Testing
Genetic testing and molecular diagnostic testing are covered when determined to be Medically Necessary. Testing that is determined to be experimental or investigational is not covered; see "Experimental Treatments/Procedures/Drugs/Devices/Transplants" under "What is Not Covered." Please refer to the section labeled Laboratory and X-rays on the Description of Coverage for cost share information.

Hearing Evaluations
Hearing evaluations performed by licensed Providers are covered. Cochlear Implants are covered when determined to be Medically Necessary. Please refer to the section labeled Primary Care Physician Office Visits, Specialty Care Physician Office Visits, as well as Other Covered Services on the Description of Coverage for cost share information.

Home Health Services
Intermittent skilled nursing and skilled therapeutic home services are covered when you are homebound, when given under the direction of and approved by a Physician and when it has been determined by the Physician, with consent of the Member, to be the most medically appropriate care.

Private Duty Nursing Services are covered under home health services when determined Medically Necessary and provided by a licensed or registered nurse who is not an immediate family member. Private Duty Nursing is not meant to provide for long-term supportive care. All Copayment, Coinsurance and Deductible amounts and limitations for Home Health are specified on the Description of Coverage and/or the SBC.

Home Infusion Services
Home infusion services, including medication and supplies, are covered when Medically Necessary and given under the direction of and approved by a Physician. Please refer to the section labeled Home Health on the Description of Coverage for cost share information. Home Infusion Services are not subject to Home Health plan year maximum limitations.

Hospice Care
Hospice care program charges, including but not limited to durable medical equipment, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day healthcare, and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments, are covered when ordered by your Primary Care Physician or treating specialist and when it has been determined, with consent of the Member, to be the most medically appropriate care. For purposes of this subsection, hospice care program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Member and the Member's family, which includes respite care, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. Hospice refers to a program that meets the following requirements:

- It must be licensed by the laws of the jurisdiction where it is located and must be operated as a Hospice as defined by those laws.
- It must provide a program of treatment for an individual who has been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a Physician, is expected to live less than six months as a result of that illness.
- It must be administered by a Hospital, home health agency or other licensed facility.

Hospice care is subject to the "Other Services" Deductibles, Copayment or Coinsurance as listed in the Other Covered Services section on the Description of Coverage.

Hospital Care
Hospital services are covered for an unlimited number of days when hospitalization is ordered by and provided by a Physician. Coverage is limited to a semi-private (two-bed) accommodation, unless a medical or behavioral health condition warrants otherwise.

Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Provider to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient; and for a post-discharge Provider office visit or in-home nurse visit within 48 hours after discharge is also covered.

If you are hospitalized prior to your Effective Date, coverage begins on your Effective Date. Expenses incurred prior to your Effective Date are not covered under this Plan. Inpatient services require notification to Health Alliance within 24 hours of admission, except in emergency situations.

Please refer to the section labeled Inpatient Hospitalization Facility Fees, Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information. Home Infusion Services are not subject to Home Health plan year maximum limitations.

Infertility Diagnostic Services
Infertility services are covered only to diagnose this condition, including a consultation and diagnostic evaluation. Infertility diagnostic services are covered when the Member meets all Health Alliance criteria for coverage. Based on the individual service received, each covered service is subject to the applicable Deductibles, Copayments or Coinsurance amounts specified on the Description of Coverage and/or the SBC. Any infertility services required to treat or promote conception are not covered as is described in the "What is Not Covered" section of this Policy. The following Infertility diagnostic services are covered:

- Infertility evaluation by a Participating Physician or Mid-Level Provider.
- Office visits related to the initial evaluation or follow-up appointments during the diagnostic evaluation.
- Lab and X-ray, Huhner test (postcoital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, semen analysis, acrosome reaction test, urological evaluation, testicular biopsy.

Mandibular and Maxillary Osteotomy
A mandibular or maxillary osteotomy is covered. Please refer to the sections labeled Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services, Inpatient Hospitalization Facility Fees as well as Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information.

Maternity Care
Services rendered by the attending obstetrician or family practitioner or other licensed Provider, such as a nurse Practitioner or midwife, during the course of a pregnancy are covered for all eligible policyholders and dependents subject to the Routine Prenatal Care Deductible, Copayment or Coinsurance specified on the Description of Coverage and/or the SBC. Medical care, consultation or services rendered by a specialty care Provider, or a Provider other than the attending Provider during the course of the pregnancy are not considered routine prenatal care and are subject to additional applicable specialty care office visit Copayments, Coinsurance or Deductible as specified on the Description of Coverage and/or the SBC.

Maternity Care Services include, but are not limited to, the following services:

- In-utero treatment for the fetus
- Nursery services and supplies for Newborns, including newly adopted children
- Prenatal and postnatal care and services, including screenings
- Fetal loss/fetal demise
- Complications of pregnancy such as, but not limited to:
    - Fetal distress
    - Gestational diabetes
    - Pregnancy associated uncontrolled hypertension

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the Newborn. Your Primary Care Physician, Women's Principal Healthcare Provider or attending Provider may determine after consultation with you that a shorter or longer length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of the attending Physician, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge is also covered.

Home births, including any Medically Necessary supplies, are covered only when there is a low-risk pregnancy as determined by your attending Provider.

Coverage for the properly enrolled Newborn is provided subject to the Newborn Copayment, Coinsurance and Plan Year Medical Deductible amount specified on the Description of Coverage and/or the SBC. See the "Newborns, Adopted Children or Children placed for Adoption" section for more information on eligibility requirements.

Lactation counseling and/or support and the rental or purchase of a breast pump is covered during pregnancy and through the postpartum period under the Plan's wellness benefit.

Medical Social Services
Medical social services, including Hospital discharge planning and assistance in accessing community service agencies and other related services, are covered when you are coping with a medical condition. Please refer to the sections labeled Inpatient Hospitalization Facility Fees as well as Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information.

Mental Health Care
Mental Health Care is defined as Medically Necessary services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Examples of covered Mental Health Care services include but are not limited to inpatient, residential, and Outpatient mental health and substance use disorder treatment, including diagnosis, prescription medication, partial hospital programs or inpatient services. Mental Health Care services for Medically Necessary treatment and/or crisis intervention are covered as specified on the Description of Coverage and/or the SBC. Inpatient hospitalization and residential care are subject to inpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC. Inpatient Mental Health Care services require notification to Health Alliance within 24 hours of admission, except in emergency situations.

Outpatient mental health care visits, including group Outpatient visits, are subject to any Outpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC. Outpatient mental health care services in a home health setting are subject to any home health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC; see "Home Health" in the "What is Covered" section of this Policy.

Care in a day Hospital program or intensive Outpatient program are subject to the Deductibles, Copayments or Coinsurance as specified in the Other Covered Services section of the Description of Coverage.

The services may be provided by a Physician, a registered clinical psychologist or by an ancillary mental health professional under the supervision of a Physician or registered clinical psychologist.

When receiving treatment in a behavioral health agency that provides inpatient or residential Substance Use Disorder treatment, you will have coverage for no less than two (2) business days, excluding weekends and holidays, prior to any Prior Authorization or utilization review.

When receiving treatment in a behavioral health agency that provides withdrawal management services, you will have coverage for no less than three (3) days, prior to any Prior Authorization or utilization review.

When receiving treatment from a behavioral health agency providing withdrawal management services from a Non-Participating Provider services will be covered at no greater expense to you than if the services had been provided by a Participating Provider. You would not be balance billed for these services.

Services not covered include care provided by a non-licensed mental health professional, non-Medically Necessary services and services with a diagnosis of marriage or social counseling unrelated to mental health conditions.

Neurodevelopment Therapies
Neurodevelopmental therapies are covered under the Outpatient Rehabilitation Services benefit and are subject to the limitations listed on the Description of Coverage. This includes coverage for speech, physical and occupational therapies provided for neurodevelopmental therapy. Neurodevelopmental Therapies with a DSM diagnosis will not apply to the contract year limitation.

Nutritional Counseling
Nutritional counseling is covered with a Provider for up to three visits per lifetime. For diabetics, this limit does not apply; see "Diabetic Self-Management Training and Education" in the "What is Covered" section of this Policy. Please refer to the section labeled Other Covered Services on the Description of Coverage for cost share information.

Office Visits
Office visit charges are covered when performed by your Primary Care Physician, treating specialist or a Healthcare Professional. For purposes of this subsection, office visit benefits include, but are not limited to:

- In person visits at your provider's office
- Virtual check-ins (by phone or video chat) with your provider for 5-10 minutes if:
    - You're not a new patient and
    - The check-in isn't related to an office visit in the past 7 days and
    - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
- Evaluation of video and/or images you send to your provider, and interpretation and follow up by your provider within 24 hours if:
    - You're not a new patient and
    - The evaluation isn't related to an office visit in the past 7 days and
    - The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your provider has with other providers by phone, internet, or electronic health record if you're not a new patient

All Copayment, Coinsurance and Deductible amounts for office visits are specified on the Description of Coverage and/or the SBC.

Oral Surgery
Oral surgical procedures are covered in connection with the following limited conditions:

- Traumatic Injury to sound natural teeth for Medically Necessary non-restorative services within 30 days of Injury.
- Traumatic Injury to the jawbones or surrounding tissue within 30 days of the Injury.
- Correction of a non-dental pathological condition such as cysts and tumors.
- Medical Dental work needed in order to treat cancer itself.

Please refer to the sections labeled Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services and Specialty Care Physician Office Visits on the Description of Coverage for cost share information.

Organ Donor
If a Member is the recipient of a living human organ donation, coverage at a Health Alliance approved facility is provided for the donor beginning with the evaluation and ending one year after surgical removal of the organ even if the donor is not a Member. Coverage includes complications related to the surgical removal of the donated organ. Donor charges are applied to the recipient's benefits.

If the recipient of the living human organ donation is not a Member and you (the Member) are the living organ donor and you have no coverage from any other source, then benefits will be provided to you under this Policy. This would also include any complications related to the surgical removal of the donated organ.

If both the recipient of the living human organ donation and the living organ donor are Members with Health Alliance policies, the recipient's policy would cover the living organ donor's expenses, beginning with the

evaluation and ending one year after surgical removal of the organ. This coverage also includes any complications related to the surgical removal of the donated organ.

Please refer to the section labeled Inpatient Hospitalization Facility Fees, Inpatient Physician/Surgeon Fees on the Description of Coverage for the cost share information.

Organ Transplants
Organ transplants are covered, with Participating Providers only, for non-experimental organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, when Medically Necessary and is not excluded from coverage under any other sections of this Policy. This also includes artificial organ transplants when Medically Necessary. Transplants must be performed at a Health Alliance approved facility. Coverage for benefits under this subsection begins with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and ends one year after transplant. Office visit and Hospital care Copayments or Coinsurance apply as specified on the Description of Coverage and/or the SBC.

Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.

The Plan covers transportation, lodging and meals for the transplant recipient and a companion for travel to and from the Health Alliance designated transplant center. If the patient is a minor, transportation, reasonable necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

Orthotics
Specially molded and custom-made orthotics are covered when prescribed by a Physician. The durable medical equipment and orthopedic appliance Copayment or Coinsurance amount specified on the Description of Coverage and/or the SBC applies. Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure are covered.

Other Covered Services
Other covered services may include but are not limited to, facility fees, surgical fees, anesthesia charges and other Medically Necessary services as required. These services are subject to the Other Covered Services Deductible, Copayments and Coinsurance as defined on the Description of Coverage and/or the SBC.

Outpatient Prescription Drugs
Outpatient Prescription Drugs are covered as defined in the Pharmacy section of this Policy. Please refer to the section labeled Prescription Drugs on the Description of Coverage for cost share information.

Pain Therapy
Medically Necessary pain therapy that is medically based and includes reasonably defined goals, including but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals is covered. Medically Necessary pain medications are covered as defined in the Pharmacy section of this Policy. Please refer to the sections labeled Other Covered Services, and Prescription Drugs on the Description of Coverage for cost share information.

Pediatric Vision Therapy
Office-based vision therapy is covered for treatment of Convergence Insufficiency in children under the age of 18 years when determined to be Medically Necessary as specified on Description of Coverage and/or the SBC.

Physician Services
Diagnostic and treatment services and wellness care, for illness or Injury provided by a Physician or under the supervision of a Physician, including the recommended periodic healthcare examinations and well-child care are

covered, as specified on the Description of Coverage and/or the SBC. Physician Services include Medically Necessary treatment, Virtual Visits, or services received from a primary care physician, including pediatricians, and specialists.

Physician services are covered if you are hospitalized and they are subject to the provisions of the "Prior Authorization" section and "Hospital Care" subsection of this Policy.

Please refer to the sections labeled Primary Care Physician Office Visits, Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Physician/Surgeon Services and Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information.

Podiatry Services
Services are covered when determined to be Medically Necessary. This includes but is not limited to services related to diabetes. Please refer to the section labeled Specialty Care Physician Office Visits on the Description of Coverage for cost share information.

Prostheses
Prosthetic devices (such as artificial limbs) are covered when Medically Necessary due to an illness or Injury and prescribed by a Physician. Devices must be prescribed by a Physician.

To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount. Coverage can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Please refer to the section labeled Durable Medical Equipment on the Description of Coverage for cost share information.

Pulmonary Rehabilitation
Pulmonary Rehabilitation is covered. Pulmonary Rehabilitation services are covered at the other covered services benefit as listed on your Description of Coverage and/or the SBC.

Reconstructive Surgery
Services are covered to correct a functional defect resulting from an acquired and/or congenital disease or Injury when Medically Necessary. Services are also covered when performed to correct a condition resulting from accidental Injury or incident due to surgery. Correction of a congenital defect or birth abnormality of an enrolled Newborn is covered.

Coverage is provided for reconstructive surgery or a prosthetic device following a mastectomy when Prior Authorized by Health Alliance for the length of time determined by the attending Physician. Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed
- Reconstructive surgery of the other breast to produce a symmetrical appearance
- Prosthesis and treatment for all physical complications at all stages of mastectomy including lymphedema
- Removal or replacement of an implant is covered if the original reconstruction qualified for coverage and there is a documented medical problem.
- Post-discharge office visits or in-home nurse visits within 48 hours of discharge

Please refer to the sections labeled Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services, Inpatient Hospitalization Facility Fees and Inpatient Physician/Surgeon Fees on the Description of Coverage for cost share information.

Registered Nurse or Advanced Registered Nurse Practitioner (ARNP) Services
Benefits under this contract will not be denied for any healthcare service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW.

Please refer to the section labeled Primary Care Physician Office Visits on the Description of Coverage for cost share information.

Rehabilitation and Skilled Care—Inpatient
Inpatient services for rehabilitation and Skilled Care with initial and ongoing documentation of Medical Necessity are covered subject to any inpatient rehabilitation and Skilled Care coverage limitations specified on the Description of Coverage and/or the SBC.

Rehabilitative Therapy Services—Outpatient
Speech, physical, occupational and massage therapies as well as hot/cold pack therapies, for medical conditions received in the Outpatient or home setting when you are homebound, which are directed at improving your physical functioning are covered subject to any Outpatient rehabilitation coverage limitations specified on the Description of Coverage and/or the SBC per Primary Medical Diagnosis per Benefit Year. Speech, physical, occupation and message therapies for the same Primary Medical Diagnosis are combined toward your coverage limitations as specified on the Description of Coverage and/or the SBC. Therapies are counted by type and date of service. Habilitation services are also covered under the Rehabilitation services benefit.

Sexual Assault or Abuse Victims
Hospital and medical services in connection with sexual abuse or assaults are covered. The Copayment, Coinsurance and Deductible amount will be waived.

Specialty Medical Drugs
Specialty Medical Drugs are defined as any prescription drugs, regardless of dosage form, which require at least one of the following in order to provide optimal patient outcomes, and are identified as a Specialty Medical Drug on the Health Alliance Drug Formulary:

- Specialized procurement handling, distribution or is administered in a specialized fashion;
- Complex benefit review to determine coverage;
- Complex medical management; or
- FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.

Examples of Specialty Medical Drugs include, but are not limited to biological specialty drugs, growth hormones and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription Drug Formulary at HealthAlliance.org/Pharmacy.

Cancer specialty drugs, whether oral, intravenous or injected medications, are covered at the same financial requirement regardless of the location they are administered.

Specialty Medical Drugs are covered under this Policy subject to a prior written order by your Physician and Prior Authorization by Health Alliance. Specialty Medical Prescription Drugs are those Specialty Medical Drugs received in the Physician's office and/or are administered by a healthcare professional in an office or other healthcare setting. Coverage for Specialty Medical Drugs is subject to the Deductibles, Copayments or Coinsurance specified on the Description of Coverage and/or the SBC.

To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Medical Drugs and the medical conditions for which they are approved for coverage. Coverage can be verified by calling Health Alliance at the phone number listed on the back of your Health Alliance Identification Card or at HealthAlliance.org.

Sterilization Procedures
Elective sterilization procedures, such as tubal ligation, and vasectomies are covered. Sterilization procedures are covered under the wellness benefit listed on the Description of Coverage and/or the SBC.

Surgical procedures performed to reverse voluntary sterilization are not covered.

Substance Use Detoxification
Acute inpatient Substance Use Detoxification is covered if it is determined by your Physician that Outpatient management is not medically appropriate. Treatment is considered medical and does not apply to the Substance Use Treatment benefit until the patient is discharged from the Hospital or transferred to a Substance Use unit. Inpatient admissions require notification to Health Alliance within 24 hours of admission, or as soon as reasonably possible after care begins, except in emergencies.

Please refer to the section labeled Mental Health/Substance Use Treatment Inpatient Services on the Description of Coverage for cost share information.

Substance Use Disorder Treatment
Substance Use Disorder rehabilitation services or treatment is covered for Medically Necessary treatment, subject to any coverage limitations specified on the Description of Coverage and/or the SBC.

Inpatient benefits, including Medically Necessary Inpatient hospitalizations and residential care, are subject to the Substance Use Deductibles, Copayments and/or Coinsurance as specified on the Description of Coverage and/or the SBC. Inpatient services require notification to Health Alliance within 24 hours, or as soon as reasonably possible after care begins, except in emergencies.

Outpatient benefits include individual counseling sessions or group Outpatient visits. Substance Use Disorder services in a home health setting are subject to any home health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage and/or the SBC; see the "What is Covered, Home Health" section of this Policy.

Care in a day Hospital program or intensive Outpatient treatment program are subject to Deductibles, Copayments or Coinsurance as specified in the Other Covered Services section of the Description of Coverage.

Inpatient and Outpatient Substance Use Disorder treatment coverage does not include family retreats, unless such treatment is Medically Necessary.
When receiving treatment in a behavioral health agency that provides inpatient or residential Substance Use Disorder treatment, you will have coverage for no less than two (2) business days, excluding weekends and holidays, prior to any Prior Authorization or utilization review.

When receiving treatment in a behavioral health agency that provides withdrawal management services, you will have coverage for no less than three (3) days, prior to any Prior Authorization or utilization review.

When receiving treatment from a behavioral health agency providing withdrawal management services from a Non-Participating Provider services will be covered at no greater expense to you than if the services had been provided by a Participating Provider. You would not be balance billed for these services.

The medical, non-psychiatric treatment of Substance Use Disorder, such as detoxification, is covered and is subject to the Physician/Office Visit and Hospital Care Copayments or Coinsurance specified on the Description of Coverage and/or the SBC.

Surgical Procedures
Medically Necessary inpatient or outpatient surgeries and procedures are covered as defined in this Policy. Covered services may include assistant surgeons, surgical assistant, surgical fees, facility fees, anesthesia charges and other Medically Necessary services as required. Elective surgeries and procedures may require Prior Authorization. Surgeries and procedures are subject to the Deductible, Copayments and Coinsurance as defined on the Description of Coverage and/or the SBC.

Surveillance Tests for Ovarian Cancer
Surveillance tests for ovarian cancer for female Members who are at risk for ovarian cancer are covered.

At risk for ovarian cancer means having a family history:

- with one or more first-degree relatives with ovarian cancer
- of clusters of female relatives with breast cancer
- of non-polyposis colorectal cancer, OR
- testing positive for *BRCA1* or *BRCA2* mutations.

"Surveillance tests for ovarian cancer" means annual screening using (i) CA-125 serum tumor marker testing, (ii) transvaginal ultrasound, (iii) pelvic examination.

Please refer to the section labeled Laboratory and X-rays on the Description of Coverage for cost share information.

Telemedicine Services
Medically Necessary Telemedicine services are covered. This includes medical exams and consultations and behavioral health, including Substance Use Disorder evaluations and treatment.

Covered telemedicine service locations are hospitals, rural health clinics, federally qualified health centers, Physician or other Provider offices, community mental health centers, skilled nursing facilities, renal dialysis centers (expect independent renal dialysis centers), Member's residence, or any location determined by the Member receiving the service.

Benefits for Telemedicine services are available to the same extent as benefits provided for other services.

Please refer to the section labeled Primary Care Physician Office Visits, Specialty Care Physician Office Visits, as well as Mental Health/Substance Use Treatment Outpatient Office Visits on the Description of Coverage for cost share information.

Temporomandibular Joint Syndrome (TMJ)
Temporomandibular joint services and treatment are covered. Please refer to the section labeled Specialty Care Physician Office Visits, Outpatient Surgery/Procedures Facility Fee, Outpatient Surgery/Procedures Physician/Surgeon Services as well as Laboratory and X-rays on the Description of Coverage for cost share information. Subject to the limitations listed on the Description of Coverage and/or the SBC.

Tobacco Cessation Program
Tobacco cessation is covered, including Health Alliance's Quit For Life® program. Tobacco cessation pharmacological therapy, as defined by the Health Alliance formulary, is covered subject to the Pharmacy Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and/or the SBC.

Urgent Care
Services obtained at an Urgent Care Center are covered. These services are intended for immediate Outpatient treatment of an unforeseen illness, Injury or condition to prevent serious deterioration. Urgent Care Centers also may be referred to as convenient care, prompt care or express care centers, and treat patients on a walk-in basis without a scheduled appointment. Urgent care is subject to the Deductible, Copayment or Coinsurance as listed on the Description of Coverage and/or the SBC and any Plan guidelines as defined in this Policy. Other services that may be provided during this visit, such as diagnostic testing or durable medical equipment, are subject to the Deductibles, Copayment or Coinsurance for those services as listed on the Description of Coverage and/or the SBC.

Vision Care
Vision screenings and examinations for prescribing glasses or for determining the refractive state of the eyes are covered once every 12 months, unless otherwise specified on the Description of Coverage and/or the SBC.

One pair of eyeglasses or one contact lens per affected eye is covered following cataract surgery. The maximum allowable benefit for frames and lenses is the standard allowable established by the Centers for Medicare and Medicaid Services (CMS).

One pair of eyeglasses, which includes lenses and frames, is covered once every 12 months for all Members under the age of 19, subject to the limitations listed on the Description of Coverage and/or the SBC.

Contacts for Members under the age of 19 are covered once every 12 months for a one-year supply as follows:

- Standard lenses
- Monthly lenses
- Bi-weekly lenses
- Daily lenses

Frames and lenses for Members under the age of 19 are covered once every 12 months as follows:

- One pair of standard frames as defined by the Centers for Medicare and Medicaid Services (CMS).
- One standard lens per eye as defined by the Centers for Medicare and Medicaid Services (CMS).

Additional charges for upgraded or deluxe frames or additional treatments on lenses that are not Medically Necessary (including but not limited to anti-glare coating) are not covered.

Members under the age of 19 are covered for low vision services. Low vision coverage is coverage for professional services for severe visual problems not correctable with regular lenses, including:

- Supplemental Testing that includes evaluation, diagnosis and prescription of vision aids where indicated
- Supplemental Vision Aids

Please refer to the section labeled Pediatric Vision Exam and Pediatric Vision Materials on the Description of Coverage for cost share information.

Low vision services are subject to the Deductibles, Copayments and/or Coinsurance and limitations specified on the Description of Coverage and/or the SBC.

Health Alliance maintains a list of covered and non-covered items and services. Coverage can be verified by calling Health Alliance at the number on the back of your Health Alliance Identification Card.

Please refer to the section labeled Vision Exam on the Description of Coverage for cost share information as well as Contract Year Maximum Benefits for Adult Vision Exam limitations.

Wellness Care
Well-child care, annual physicals and annual well women visits are covered as wellness visits, when performed by a Participating Provider. If you elect to see a Non-Participating Provider for these services you will be subject to Non-Participating office visit Copayments or Coinsurance and/or Deductible on the Description of Coverage and/or the SBC. Wellness screenings are covered as wellness for asymptomatic Members. Additional visits are subject to the office visit Copayments or Coinsurance and/or Deductible on the Description of Coverage and/or the SBC.

Immunizations
Medically Necessary immunizations are covered including, but not limited to:

- Human papillomavirus vaccine for Members ages 9–26;
- Shingles vaccine for Members 50 years old and older;
- Hepatitis A and B;
- Influenza vaccine;
- MMR (measles, mumps and rubella);
- Meningococcal;
- Pneumococcal;
- Tetanus, Diphtheria, Pertussis;
- Varicella; and
- All routine immunizations that are included as part of adult and children vaccination schedules as determined by published preventive care guidelines.

Immunizations that can be safely administered without the supervision of healthcare professionals will be administered at the most appropriate level of care. Unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups are not covered.

Clinical Breast Exams
A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer is covered.

Mammograms
A screening mammogram is covered annually under the wellness benefit for women ages 35-74 and diagnostic mammography is covered when medically necessary without cost-share to the member. Screening mammograms are covered annually for women under age 35 who are considered high-risk.

Pap Smear
One cervical smear or Pap smear test every three years is covered for females ages 21–65. Additional Pap smear tests are subject to the appropriate Copayment, Coinsurance and/or Deductible listed on the Description of Coverage and/or the SBC.

Prostate Exam
Annual digital rectal exams are covered. Additional Prostate tests are subject to the appropriate Deductible and/or Copayment or Coinsurance listed on the Description of Coverage and/or SBC.

Colorectal Cancer Screening

- A screening for colorectal cancer for asymptomatic, average risk Members ages 45–75, by means of an at home DNA stool test every three years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.

- A screening for colorectal cancer for asymptomatic Members under age 45 who are considered high risk, by means of an at home DNA stool test every three years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.
- A screening for colorectal cancer for asymptomatic Members under age 45 who are considered high risk by means of a fecal occult blood test, including immunoassay, FIT, one to three simultaneous determinations is covered annually under the wellness benefit as specified on the Description of Coverage and/or the SBC.
- A screening for colorectal cancer for asymptomatic Members ages 45–75, by means of colonoscopy every 10 years or sigmoidoscopy one every five years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.
- A screening for colorectal cancer for asymptomatic Members under age 45 who are considered high risk by means of a colonoscopy every 10 years or sigmoidoscopy every five years is covered under the wellness benefit as specified on the Description of Coverage and/or the SBC.
- Colonoscopies and sigmoidoscopies done other than what is listed under wellness are subject to the office visit and/or Outpatient Surgery/procedure (when there is an associated facility fee) Deductibles, Copayments and Coinsurance as specified on the Description of Coverage and/or the SBC.
- Bowel Prep Kits used prior to a colonoscopy for Members ages 45 and older, or under age 45 who are considered high risk are covered as wellness once per year.

Osteoporosis Screening
Bone mass measurement screening for osteoporosis is covered as wellness. Additional osteoporosis screenings are subject to the office visit and/or diagnostic testing Copayments, Coinsurance and Deductible as specified on the Description of Coverage and/or the SBC.

Cholesterol/Lipid Screening
Cholesterol or lipid screenings are covered under the wellness benefit once every five years for Members age 20 and older. Cholesterol testing done-other than the wellness screenings listed here—or additional charges will be subject to the appropriate Copayments, Coinsurance or Deductibles on the Description of Coverage and/or the SBC.

Sexually Transmitted Infection Counseling and Screening
Intensive behavioral counseling for all sexually active Members who are at an increased risk for sexually transmitted infections is covered annually under wellness.

In addition to counseling, the below screenings are covered for Members under wellness:

Human Immunodeficiency virus (HIV) Screening
Screenings for the human immunodeficiency virus (HIV) are covered annually under wellness.
Syphilis Screening
Screenings for syphilis are covered annually under wellness.

Hepatitis C virus (HCV) Screening
Screenings for the hepatitis C virus (HCV) are covered annually under wellness.

Chlamydia and Gonorrhea Screening
Screenings for chlamydia and gonorrhea are covered annually under wellness for women up to and including age 24, and in older women at an increased risk for infection.

High-Risk HPV (human papillomavirus) Screening
Screening for human papillomavirus (HPV) by DNA testing for women ages 30 and older, once every five years, is covered under the wellness benefit.

Additional charges or testing will be subject to the appropriate Copayments, Coinsurance and/or Deductible on the Description of Coverage and/or the SBC.

Domestic Violence Counseling and Screening
Annual screening and counseling for interpersonal, intimate partner and domestic violence is covered for women under the wellness benefit. Additional charges or visits will be subject to the appropriate Deductible and/or Copayments, Coinsurance on the Description of Coverage and/or the SBC.

Ultrasound for Abdominal Aortic Aneurysm
A one-time ultrasound screening for men ages 65–75 who have ever smoked is covered.

Alcohol and Drug Misuse Counseling and Screening
Counseling and screening for alcohol and drug misuse are covered, up to four visits annually.

Fall Prevention
Primary care counseling for exercise or physical therapy to prevent falls in community-dwelling adults ages 65 years or older who are at increased risk for falls is covered.

Blood Pressure Screenings
High blood pressure screenings to obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment, for adults ages 18 and older are covered.

Behavioral Counseling for Skin Cancer Prevention
Counseling for individuals, age 6 months to 24 years old with fair skin, regarding minimizing their exposure to ultraviolet radiation to reduce risk for and prevent incidence of skin cancer is covered.

Depression Screening
Depression screening for Members as part of a clinical exam to ensure accurate diagnosis and treatment follow-up is covered.

Diabetes Screenings
Annual diabetes screenings for Members is covered.

Healthy Diet and Physical Activity Counseling
Annual healthy diet and physical activity counseling for adults with cardiovascular risk factors is covered.

Obesity Screening and Counseling
Obesity screening for adults and children ages 6 and older is covered. Obesity counseling is covered for adults and children ages 6 and older. Services include, but are not limited to, group and individual sessions of high intensity, behavioral management activities and weight loss goals.

Tobacco Use Screening
An annual tobacco use screening as part of a clinical exam is covered. Intervention methods, up to eight visits annually, are covered. See the "Tobacco Cessation" section of this Policy regarding the tobacco cessation program that is covered.

Lung Cancer Screening
Annual screening with low-dose computed tomography (LDCT) for Members ages 50–80 who have a 20 pack/year smoking history and currently smoke or Members who have quit within the past 15 years is covered. Screening would be discontinued once a Member has not smoked for 15 years or the Member develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Additional charges or visits will be subject to the appropriate Deductibles, Copayments, or Coinsurance on the Description of Coverage and/or the SBC. Prior Authorization is required.

BRCA Counseling and Evaluation
BRCA counseling and evaluation for women whose personal or family history of breast, ovarian tubal or peritoneal cancer is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes is covered. BRCA counseling and evaluations for reasons other than what is listed here or additional charges, will be subject to the appropriate Copayments, Coinsurance or Deductibles on the Description of Coverage and/or the SBC. Prior Authorization is required for BRCA testing.

Breast Cancer Chemoprevention Counseling
Breast cancer chemoprevention counseling is covered for women at an increased risk for breast cancer and at low risk for adverse medication effects of risk reducing chemoprevention.

Hepatitis B Virus (HBV) Screening
Screening for hepatitis B virus (HBV) infection is covered for Members at high risk for infection.

Tuberculosis Infections Screening
Screening for latent tuberculosis infection (LTBI) is covered for adults who are at increased risk.

Contraception Services
For a description of the contraceptive services, supplies, devices and drugs covered under the wellness benefit, see "Contraceptive Drugs, Devices and Services" under "What is Covered" section and "Outpatient Pharmacy Contraceptives" under "What is Covered /What is Not Covered—Pharmacy Benefits.".

Preventive Drugs
The following are covered at Participating pharmacies under the wellness benefit:

- Folic acid supplements for women who may become pregnant.
- Iron supplements for children ages 6 months to 12 months who are at risk for anemia.
- Gonorrhea preventive eye medication for Newborns.
- Aspirin for women as a preventive medication after 12 weeks of gestation in Members who are at high risk for preeclampsia.
- Statin preventive medication for adults 40-75 years old with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater.
- Tobacco Cessation products as defined by the Health Alliance formulary.
- Select vaccinations administered at pharmacies.
- Bowel Prep Kits, as defined by the Health Alliance formulary used prior to a colonoscopy for Members ages 45 and older once per year.
- Tamoxifen and raloxifene used for breast cancer risk reduction.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection.
    - For Members taking PrEP medication or being considered for this therapy, the following services are covered as preventive:
        - Venipuncture for blood draws for these tests.
        - HIV testing prior to the start of PrEP therapy, and then once every three months.
        - Hepatitis B and C testing prior to starting PrEP therapy, and then periodically, including after PrEP is concluded.
        - Creatinine testing.
        - Pregnancy testing before beginning PrEP therapy and during PrEP therapy.
        - Sexually Transmitted Infection Screening at baseline, and periodically thereafter while on PrEP therapy.
        - Adherence counseling to ensure adherence to the prescribed medication, and to maximize PrEP's effectiveness.

See “Preventive Drugs” under “What is Covered/What is Not Covered-Pharmacy Benefits.”

Wellness services for children, in addition to any wellness services already listed, include:

- Autism screening for children at 18 and 24 months.
- Behavioral assessments as part of preventive exams.
- Dyslipidemia screening for children at higher risk of lipid disorders.
- Fluoride chemoprevention supplements for children 6 months to 5 years without fluoride in their water source.
- Coverage for prescription oral fluoride supplement products, generic single ingredient only, for children ages 0–6 months old.
- Varnish application for children ages 0–6 years old.
- Hearing screening for Newborns and children.
- Height, weight and Body Mass Index as part of preventive exams for children.
- Hematocrit or Hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for Newborns.
- Lead screening for children ages 0–6 years old who are at risk for exposure.
- Oral health risk assessment for young children.
- Phenylketonuria (PKU) screening for this genetic disorder in Newborns 0–28 days old.
- Tuberculin testing for children at higher risk of tuberculosis.
- Congenital Hypothyroidism screening for infants 0–90 days old.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Vision screening for children.

Wellness services for pregnant women, in addition to any wellness service already listed, include:

- Anemia screenings
- Urinary tract or other infection screenings
- Annual gestational diabetes screening once per pregnancy
- Hepatitis B screening
- Rh Incompatibility screening, which also includes follow-up testing for women at high risk
- Breastfeeding counseling, breast pumps and breastfeeding supplies. See the “Maternity Care” section in this Policy
- Preeclampsia screening
- Sexually transmitted infections screening

Wellness care coverage includes any preventive services recommended by the United States Preventive Services Task Force (USPSTF) that have in effect a rating of A or B; preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, and immunizations for routine use recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control (CDC), adopted by the Director of the CDC, and listed on the Immunization Schedules of the CDC.

Wellness Brochure
To access the most up-to-date version of our wellness brochure, *Be Healthy*, log in to hally.com. This brochure includes a detailed listing of services and procedures, and their associated procedure codes, that are covered under wellness Care.

WHAT IS COVERED/WHAT IS NOT COVERED—PHARMACY BENEFITS

Your Prescription Drug Rights
You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact Health Alliance at the number on the back of your Health Alliance Identification Card or at HealthAlliance.org/Pharmacy. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov or HSQACSC@doh.wa.gov.

Benefits
Health Alliance administers pharmacy benefits through a national pharmacy benefit manager. Many independent pharmacies and most national chains are Participating pharmacies. Prescription drugs may be obtained through any in-network or out-of-network retail or in-network or out-of-network mail order pharmacy. Health Alliance shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or Out-of-Pocket Maximum associated with the individual's health insurance when the covered prescription drug does not have a generic or therapeutic equivalent; when the prescription drug has a generic or therapeutic equivalent, but the member has obtained access to the drug via prior authorization, step therapy, or the exception request process; or when an exception request for the medication or appeal of a denied exception request is still pending. To find out if a pharmacy is a Participating pharmacy, call Health Alliance at the number listed on the back of your Health Alliance Identification Card. Any cost sharing amount paid by you or on your behalf by another person for a covered prescription drug shall be applied toward your Deductible, Copayment or Coinsurance specified on the Description of Coverage and/or the SBC for prescription drugs obtained at a Participating and Non-Participating pharmacies.

Members are eligible to receive up to a 7-day emergency supply, or the minimum packaging size available at the time the emergency fill is dispensed, of some formulary drugs which require Prior Authorization if the dispensing pharmacy cannot reach the Health Alliance Northwest Health Plan pharmacy department via phone due to it being after hours; or if the pharmacy department is available to respond to the phone call, but cannot reach the prescriber's office to request the information necessary to complete the Prior Authorization review due to it being outside their office hours, and an answering service is not available to contact the prescriber or a member of their staff after hours. Members are responsible for all appropriate deductibles, copays, or coinsurance associated with the emergency supply. For complete lists of eligible and ineligible drugs visit HealthAlliance.org/Pharmacy.

You must present your Health Alliance Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Deductible, Copayment and/or Coinsurance at the time it is filled. If you do not present your Health Alliance Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement, you may submit your itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager's address noted on the back of your Health Alliance Identification Card.

Prescription Drugs prescribed by a Provider, in connection with Medically Necessary services are covered for Members subject to the following terms, conditions and limitations.

Prescription Drugs obtained from a Non-Participating pharmacy in conjunction with Emergency Services are covered subject to the terms, conditions and limitations listed below.

Prescription Refill Synchronization
Prescription refill synchronization is the allowance to refill one or more maintenance medication(s) on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications. For a complete

listing of the covered medications, you can view the prescription Drug Formulary at HealthAlliance.org/Pharmacy.

Member cost share will be adjusted based on the quantity of medication filled for the purpose of synchronization of medications. This would include discounting the cost share by 50% if less than a 15-day supply of the medication is filled.

Schedule II, III or IV controlled substances, drugs that have special handling or sourcing needs that require a single designated pharmacy to fill or refill the prescription, and drugs that cannot be safely split into short-fill periods to achieve synchronization are excluded from refill synchronization.

If you have more than one maintenance medication prescription that you fill at different times and would like to synchronize them to be able to fill them at the same time each month, please contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.

Prior Authorization
Some prescription drugs require Prior Authorization from Health Alliance and certain criteria be met by you. Drugs that require Prior Authorization are noted on the prescription Drug Formulary. The requirements for Prior Authorization are based on scientific and medical evidence and are updated regularly based on new research, guidelines or treatment advances. Prior Authorization criteria can be found at hally.com.

Most requests for Prior Authorization will be reviewed within five calendar days. The review could may take longer if we need additional information from your Physician. If your Physician marks your request as urgent, it will be reviewed within 48 hours.

If your Physician feels that the criteria are not appropriate for your unique situation, they may request an exception to the requirements.

Newly released prescription drugs require Prior Authorization for at least six months from the date of launch until the drugs have undergone review by the Health Alliance Pharmacy and Therapeutics Committee.

Your Physician may obtain a Prior Authorization Request Form online at hally.com or by contacting Health Alliance directly. Prior Authorization can be verified by calling Health Alliance at the number listed on the back of your Health Alliance Identification Card. If Prior Authorization is not obtained, Health Alliance will not provide coverage and you will be required to pay the full cost of the drug.

Prescription Drug Formulary
A prescription drug formulary, or "formulary," is a list of covered prescription and over-the-counter drugs. You can use the formulary to determine if a drug requires Prior Authorization, step therapy, or has a quantity limit. The formulary also shows you the tier placement for each drug. These tiers will help you estimate how much you will pay each time you fill a prescription. The formulary is split into six tiers.

Drug Tier	**Includes**
Preventive	Preventive care drugs
Tier 1	Preferred generics
Tier 2	Non-preferred generics
Tier 3	Preferred brand name
Tier 4	Non-preferred brand name
Tier 5	Preferred specialty pharmacy and medical
Tier 6	Non-preferred specialty pharmacy and medical

This tiered system accomplishes two important goals. First, it provides Members and their prescribers with access to a wide variety of treatment options. Second, it allows the plan to assign drugs a cost sharing that accurately reflects the drug's benefit and cost when compared to other formulary products that treat the same condition.

The drugs listed in the Health Alliance formulary are reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee meets six times per year, or every two months, to determine changes to be made to the formulary. Newly available prescription drugs may be added to the formulary after they are reviewed by the Committee. Prescription drugs may also be moved to a higher or lower cost-sharing tier, or removed from the formulary, based on recommendations of the Pharmacy and Therapeutics Committee. If a drug moves to a higher tier or is removed from the formulary then you will be notified at least 60 days prior to the change so that you can discuss with your Physician any lower tier or formulary alternatives available to you. If your Physician decides it is appropriate, an exception to tier requirements may be requested through the Health Alliance Pharmacy Provider Portal or by using the Prior Authorization Request Form that is linked at hally.com. Not all drugs are eligible for tier exception.

Step Therapy
Some prescription drugs on the Health Alliance Drug Formulary require one or more different, equally effective drug or drugs to be used first. You may qualify for an exception to this requirement if your Physician decides that the prerequisite drug is not appropriate. An exception to step-therapy requirements may be granted if one of the below is met:

- Documentation that the prerequisite drug is contraindicated, is likely to cause an adverse reaction, or is likely to be ineffective based on the patient's unique characteristics.
- Documentation that patient has tried the prerequisite drug or another drug that works by the same mechanism of action and it was discontinued because of an adverse reaction or ineffectiveness.
- Physician can show that patient is currently experiencing a positive therapeutic outcome on a prescription drug, and changing to the prerequisite drug is likely to cause adverse effects or harm.
- Documentation that the prerequisite drug is not medically appropriate because its use is expected to create a barrier to the patient's adherence; negatively impact a comorbid condition of the patient; cause a clinically predictable negative drug interaction; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

Formulary Exception
Some prescription drugs are not included on the Health Alliance Drug Formulary. Non-formulary drugs have covered formulary alternatives in most instances. Coverage of non-formulary drugs requires a request for a formulary exception from your Physician. The formulary exception request must explain the reason covered formulary alternatives cannot be used. A formulary exception can be requested through the Health Alliance Pharmacy Provider Portal or by using the Prior Authorization Request Form that is linked at hally.com. Members may qualify for a formulary exception if they meet one of the below requirements:

- The medication provides clinically superior outcomes compared to all currently available agents based upon review of the published literature.
- Documentation that the patient has tried all currently available formulary agents in the same therapeutic class and they have been ineffective or are expected to be ineffective based on characteristics of the patient and the characteristics of the medication.
- Documentation of allergic reactions or contraindication to all currently available formulary agents in the same therapeutic class.
- Physician can show that the patient is currently experiencing a positive therapeutic outcome on a prescription drug, and changing to an available formulary alternative would cause clinically predictable adverse effects or harm.
- Documentation that the currently available formulary alternatives are not medically appropriate because their use is expected to create a barrier to the patient's adherence; negatively impact a comorbid condition

of the patient; cause a clinically predictable negative drug interaction; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

Most requests for formulary, Prior Authorization, and step therapy exception will be reviewed within 72 hours. The review could may take longer if we need additional information from your Physician. If your Physician marks your request as urgent, it will be reviewed within 24 hours.

To access the most up-to-date version of our Health Alliance Northwest Formulary, go to HealthAlliance.org/Pharmacy, or call Health Alliance at the number listed on the back of your Health Alliance Identification Card. Some plans' pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a prescription drug is included in the formulary and whether the drug will be covered at the Preferred Generic Tier, Non-Preferred Generic Tier, Preferred Brand Tier, Non-Preferred Brand Tier, Preferred Specialty Tier or Non-Preferred Specialty Tier Prescription Drug level of coverage as listed on the Description of Coverage and/or the SBC.

Preventive Drugs
As part of the wellness benefit, preventive drugs are covered under the prescription Drug Formulary. Preventive drugs are covered at no charge when prescribed by a Participating Provider and obtained at a Participating Pharmacy. Preventive drugs received from a Non-Participating pharmacy are subject to the Prescription Drug Copayments or Coinsurance listed on the Description of Coverage.

For a listing of preventive drugs, see "Wellness Care" under "What is Covered" and/or the Health Alliance Drug Formulary. In addition to the preventive drugs listed here, coverage will also include any other preventive drugs approved by the United States Preventive Service Task Force (USPSTF) that may be upgraded to Grade A or B during the Benefit year. The drugs listed in the Health Alliance formulary are also reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee.

Outpatient Prescription Drug Coverage and Dispensing Limitations

- Outpatient prescription drugs, and diabetic supplies are subject to any applicable limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage and/or the SBC. Copayments or Coinsurance for Outpatient prescription drugs and diabetic supplies apply to any applicable Benefit Year limit specified on the Description of Coverage and/or the SBC. Initial prescriptions and prescription refills are limited to the maximum supply specified in the Outpatient Prescription Drugs section on the Description of Coverage and/or the SBC.
- Prescription inhalants are covered. For a listing of specific drugs please visit our Drug Formulary at HealthAlliance.org/Pharmacy.
- You pay the lesser of the Participating pharmacy's regular charge for the drug or the Deductible, Copayment and/or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage and/or the SBC for each initial prescription or prescription refill.
- The following diabetic supplies are covered and will be subject to the Deductible, Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage and/or the SBC: glucagon emergency kits, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors.
- Coverage will be provided for prescription Contraceptives or their substitutable generic equivalent when prescribed for the purpose of preventing conception, preventing sexually transmitted infections, and which are approved by the FDA. Generic drugs may be placed on any formulary tier. This includes specialty tiers if the drug meets the definition of a specialty drug. The majority of generic drugs are covered under the Tier 1 and Tier 2 benefit when they exist and are available and allowable by applicable state or federal law.
- Preferred brand drugs typically move to a non-preferred brand tier after a generic equivalent becomes available. You may be responsible for the applicable Member payment amount plus the difference in cost

between the brand and generic equivalent if you or your doctor requests the reference brand rather than the generic. Generic drugs have the lowest Member payment amount.

- If a Tier 3 or Tier 4 drug is prescribed and a generic does not exist, you pay the Tier 3 or Tier 4 level of coverage as listed on your Description of Coverage and/or the SBC.
- If a higher tiered drug is determined to be Medically Necessary by your Physician and Health Alliance, you may qualify to pay a reduced-tier copay. To determine if you would qualify, you can contact Health Alliance at the number listed on the back of your Health Alliance Identification Card.
- Injectable syringes are covered when the injectable drug is covered.
- Coverage includes Medically Necessary pain medication for the treatment of breast cancer.
- A limited number of over-the-counter (OTC) medications are covered. A prescription is required from your Physician for covered OTC products and the Deductible, Copayment and/or Coinsurance applies.
- Tobacco cessation pharmacological therapy, as defined by the Health Alliance formulary is covered.
- Health Alliance covers Medically Necessary immune gamma globulin therapy for Members diagnosed with a primary immunodeficiency. Initial authorization will be for no less than three months; reauthorization may occur every six months thereafter. For Members who have been in treatment for two years, reauthorization shall be no less than every 12 months, unless more frequently indicated by your Physician.
- For a 30-day supply or less of medication, you pay the applicable copayment as indicated on the Description of Coverage.
- Coverage is provided for Medically Necessary insulin products; your Copayment and/or Coinsurance will not exceed $35 for a 30-day supply, and is not subject to deductible.
- For a 31–60-day supply of medication, you pay two times the copay applicable to a 30-day supply as indicated on the Description of Coverage.
- For a 90-day supply of a maintenance medication listed on Tier 1, 2, 3, or 4 obtained through an in-network retail or mail-order pharmacy, you pay three copayments as indicated on the Description of Coverage and/or the SBC. For a 90-day supply of a medication on a tier with a coinsurance, you pay the coinsurance for that tier listed on your Description of Coverage and/or the SBC. Specialty medications on Tiers 5 and 6 are not available as 90-day supplies.
- For a 90-day supply of a maintenance medication listed on Tier 1, 2, 3, or 4 obtained through an out-of-network retail or mail-order pharmacy, you pay the coinsurance as listed on the Description of Coverage and/or the SBC. Specialty medications on Tiers 5 and 6 are not available as 90-day supplies.

Outpatient Pharmacy Contraceptives

Your plan covers all prescription or over-the-counter (OTC) contraceptive drugs, devices, and other products, approved by the FDA when filled at a participating pharmacy. All products are available at no out-of-pocket cost to Members. FDA-approved OTC contraceptive products are covered without the need for a prescription order. You may receive up to 12 months of a contraceptive product. Deductibles, copayment or coinsurance, if applicable, will apply if a Member chooses to obtain contraceptives from a non-participating pharmacy. Please refer to your description of coverage (DOC) document for more details. For an OTC contraceptive purchased without a prescription, a Member will be able to submit for reimbursement online through the PBM online at dmrforms.optumrx.com/online-claim-form.

Specialty Pharmacy Drugs

Specialty Pharmacy Drugs are defined as any prescription drug, regardless of dosage form, that requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty Pharmacy Drug on the Health Alliance Drug Formulary:

- Specialized procurement handling, distribution or is administered in a specialized fashion;
- Complex benefit review to determine coverage;
- Complex medical management; or
- FDA-mandated or evidence-based, medical-guideline-determined, comprehensive patient and/or Physician education.

Examples of Specialty Pharmacy Drugs include, but are not limited to biological specialty drugs, growth hormones and cancer specialty drugs. For a complete listing of specialty drugs, you can view the prescription Drug Formulary at HealthAlliance.org/Pharmacy.

Specialty Pharmacy Drugs are available from a specialty pharmacy vendor. Coverage is subject to a prior written order by your Physician and Prior Authorization by Health Alliance.

Health Alliance maintains a list of covered Tier 5 and Tier 6 Specialty Pharmacy Drugs. Tier 5 Specialty Drugs are the most clinically and cost effective, these are also known as Preferred Formulary Specialty Drugs. Tier 6 Specialty Pharmacy Drugs are at a higher cost than Tier 5 and usually have clinically comparable alternatives available at the Tier 5 level. These are also known as Non-Preferred Formulary Specialty Drugs.

This tiered system helps manage costs and provides flexibility for Members who choose a higher-tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of Specialty Pharmacy Drugs.

The drugs listed in the Health Alliance formulary are reviewed and revised at least annually by the Health Alliance Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee meets six times per year, or every two months, to determine changes to be made to the formulary. Newly available Specialty Pharmacy Drugs may be added to the formulary after they are reviewed by the Committee. Specialty Pharmacy Drugs may also be moved to a higher or lower cost-sharing tier based on recommendations of the Pharmacy and Therapeutics Committee. If a drug moves to a higher tier or is removed from the formulary then you will be notified at least 60 days prior to the change so that you can discuss with your Physician any lower-tier or formulary alternatives available to you.

To access the most up-to-date version of our Health Alliance Northwest Formulary, go to HealthAlliance.org/Pharmacy, or call Health Alliance at the number listed on the back of your Health Alliance Identification Card. Upon request, Health Alliance will provide you with information as to whether a Specialty Pharmacy Drug is included in the formulary and whether the drug will be covered at the Tier 5 or Tier 6 specialty drug tier level of coverage as listed on your Description of Coverage and/or the SBC.

Specialty Pharmacy Drugs are subject to any applicable Specialty Pharmacy Drug limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage and/or the SBC. Copayments or Coinsurance for Specialty Pharmacy Drugs apply to any applicable Plan Year Out-of-Pocket Maximum limit specified in the Maximums/Deductibles/Limitations section on the Description of Coverage and/or the SBC.

Prescription Drugs Not Covered

- Non-prescription drugs are not covered, except for covered diabetic supplies, injectable syringes for covered injectable drugs and a limited number of over-the-counter (OTC) medications as stated above.
- When a medication is available both by-prescription-only (federal legend) and as an OTC product, the prescription drug is not covered unless otherwise stated in this section.
- Prescription drugs which are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by Health Alliance, including but not limited to: BOTOX® Cosmetic, psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiants or weight loss medications, anabolic steroids, oral fluoride preparations and hair removal or hair growth-promoting medications. Prescription medications determined to be Medically Necessary for Gender Affirmation Treatment will not be excluded.
- Devices of any type, other than prescription Contraceptive devices, even if such devices may require a prescription, including but not limited to therapeutic devices, artificial appliances, support garments, bandages, etc.

- Dermatologic products (oral and topical) that offer no additional clinical benefit over existing covered alternatives, including but not limited to: Clobex lotion/shampoo, Vanos, Capex, Luxiq, Olux and Solodyn.
- Brand-name formulations that are a combination of two or more existing drugs (prescription or over-the-counter) and that offer no additional clinical benefit compared to taking the individual components (the existing drugs do not have to be commercially available in the same strength as the combination product).
- Prescription-strength benzoyl peroxide and combination products.
- Compounded products in which one or more ingredient is a bulk powder.
- Compounded products, including compounding kits, of two or more commercially available drugs (prescription or over-the-counter) that offer no additional clinical benefit compared to taking the individual components (please note the existing drugs do not have to be commercially available in the same strengths as the compounded product).
- Any drug labeled "Caution—Limited by federal Law to Investigational Use," or experimental or other drugs which are prescribed for unapproved uses. Prescription Drugs for cancer treatment are covered if the FDA has given approval for at least one indication and if they are recognized for the treatment of the indication for which the drug has been prescribed in any one of the following established reference compendia:
  (1) the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network's Drugs and Biologics Compendium; (3) the Thomson Micromedex's Drug Dex; (4) the Elsevier Gold Standard's Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services, or if not in the compendia, recommended for that particular indication in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States or Great Britain.
- Prescription drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or any medication furnished by any other Drug or Medical Service for which there is no charge to you.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before 75% of the previously dispensed supply should have been consumed when taken as prescribed.
- Erectile Dysfunction drugs related to lifestyle enhancement or performance.
- Medications used for treatment of decreased sexual desire (Addyi, Vyleesi).
- Products classified as Medical Food or supplements.
- Non-sedating antihistamines and combinations.
- Any charge for administration of a drug.
- Any drug determined by a Physician, pharmacy or through a retrospective claims review to be abused or otherwise misused by you.
- Medical marijuana is excluded from coverage because it is classified by the federal government as a Schedule I controlled substance, and therefore cannot be prescribed by a healthcare professional.
- V-Go Insulin Delivery Device is excluded from coverage due to a lack of sufficient evidence and conclusions on its safety and efficacy.
- Ketamine IV when used for all off-label indications.
- Drugs that have not been approved as effective by the FDA, including DESI drugs.
- Infertility prescription drugs.
- Any prescription drug purchased or imported from outside of the United States.
- Any prescription drug received outside of the United States, unless received as part of Emergency Services or Urgent Care.

Drug Limitations
Certain prescription drugs may be subject to drug limitations based on FDA-approved dosage recommendations and the drug manufacturer's package size. The purpose of these limitations is to encourage safe and cost-effective

use of drug therapies. If your Physician decides the limitations are not appropriate for your unique situation, they may request an exception to the quantity limitations through the Health Alliance Pharmacy Provider Portal or by using the Prior Authorization Request Form that is linked at hally.com.

WHAT IS NOT COVERED (Exclusions and Limitations)

The following services are excluded from coverage under this Policy.

Bariatric Surgery for Severe Obesity
Bariatric surgery for severe obesity is not covered.

Blood Processing
Costs related to the processing and storage of blood and its components from a person designated as a donor are not covered.

Circumstances Beyond the Control of Health Alliance
To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Health Alliance results in the facilities, personnel or financial resources of Health Alliance and/or any of its Participating Providers being unavailable to provide or arrange for the provision of a covered service in accordance with the requirements of this subsection, Health Alliance is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event.

Convenience or Comfort Items
Convenience or comfort items are not covered. These items include, but are not limited to grab bars, tub transfers, seat lifts, raised toilet seats, telephones and televisions.

Cosmetic Surgery
Surgery for cosmetic purposes and not primarily for reasons of Medical Necessity is not covered. This includes, but is not limited to rhinoplasties, breast reductions, blepharoplasties, liposuction and removal of skin tags and lipomas when not done primarily because of Medical Necessity. Surgery and treatments required as part of Gender Affirmation Treatment will not be excluded.

Counseling
Charges for social counseling or marital counseling are not covered.

Custodial Care or Convalescent Care
Custodial Care or Convalescent care in an acute general Hospital, Skilled Care Facility or in the home is not covered.

Dental Services
Dental services are not covered unless specifically addressed as covered in this Policy. Services related to Injuries caused by or arising out of the act of chewing are also not covered. Removal of wisdom teeth is not covered. Hospitalizations for Dental work are not covered unless the hospitalization is necessary due to a medical condition. For covered dental services, see “Dental Services” and “Oral Surgery” under “What is Covered.”

Disposable Items
Self-administered dressings and other disposable supplies are not covered.

Durable Medical Equipment, Orthopedic Appliances and Devices
The following corrective and orthopedic appliances and devices are not covered: earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not covered unless you would be bed- or chair-confined without such equipment. This includes any dispensing fees incurred in obtaining these items.

Experimental Treatments/Procedures/Drugs/Devices/Transplants
Unless otherwise stated in this Policy, such as coverage for "Approved Clinical Trials," the Plan does not pay benefits for any charges incurred for or related to any medical treatment, procedure, drug, device or transplant that is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug, device or transplant is the subject of ongoing phase I, phase II, phase III or phase IV clinical trials or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the FDA, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community in the state of Washington at the time it is to be provided.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.
- Organ Transplants will be deemed experimental or investigational if the Office of Healthcare Technology Assessment within the Agency for Healthcare Policy and Research, as part of the federal Department of Health and Human Services (HHS) determines that such procedures are either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
- If Health Alliance has made a written request or had one made on its behalf by a national organization, for determination by HHS as to whether a specific organ transplant procedure is clinically acceptable, and the organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is deemed to be experimental or investigational.

In making their determination that a medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature and discussion with medical experts and other technological assessment bodies designated by Health Alliance. Each review will be on a case-by-case basis regarding coverage of a requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness.

Health Alliance will provide the supporting documentation upon which the criteria are established to a Member upon receipt of a written request. Health Alliance will not withhold this supporting documentation as proprietary information.

Eyeglasses, Contacts and Refractory Treatment
Eyeglasses, contact lenses, contact lens evaluations and fittings, for adults ages 19 or older, are not covered unless there is a diagnosis of cataract or unless otherwise stated in this Policy. For covered items and services, see "Vision Care" Under "What is Covered." Lens tinting, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses are not covered. Refractive eye surgery, including but not limited to refractive keratectomy, radial keratotomy and laser-assisted in-situ keratomileusis (LASIK), is not covered.

Fitness
Any program designed for overall physical fitness or membership to fitness facilities for the same purpose is not covered. Not included in this exclusion is rehabilitative therapy.

Governmental Responsibility
Care for disabilities connected to military service for which you are legally entitled and for which facilities are reasonably available to you, or for conditions that state or local laws require be treated in a public facility, unless legal liability exists, are not covered.

Hearing Aids
Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered. Any service, supply or treatment for the rehabilitation of hearing impairment is also not covered.

Hypnotherapy
Charges for treatment and services related to hypnotherapy are not covered.

Illegal Activities
Charges for any service, supply or treatment that arose out of or occurred while you were engaged in an illegal occupation or in the commission of or attempt to commit a felony are not covered.

Infertility Services
The following services are not covered:

- Artificial Insemination.
- In Vitro Fertilization, Uterine Embryo Lavage, Embryo transfer, Gamete Intrafallopian Tube Transfer, Zygote Intrafallopian Tube Transfer and Low Tubal Ovum Transfer.
- Assisted Reproductive Technologies (ART), meaning the treatments and/or procedures in which the human Oocytes and/or sperm are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART coverage includes prescription drug therapy used during the cycle where Oocyte Retrieval is performed.
- Outpatient prescription drugs and Specialty Pharmacy Drugs for the treatment of Infertility.
- Reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits will be available if the Member's diagnosis meets the definition of Infertility. Coverage is not provided for the diagnostic services needed to confirm a successful reversal.
- Payment for services rendered to a Surrogate uterine carrier.
- Costs associated with cryopreservation and storage of sperm, eggs and Embryos.
- Costs of an egg or sperm donor.
- Travel costs from the Member's home address as filed with Health Alliance, and/or travel costs not Medically Necessary, or mandated, or required by Health Alliance. Health Alliance will not provide coverage for Infertility services that are deemed to be experimental or investigational as supported by the written determination of the American Society for Reproductive Medicine or the American College of Obstetrics. Health Alliance will cover diagnostic Infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from Infertility treatment considered experimental.
- Infertility treatments rendered to Dependents under the age of 18.
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- Donor Embryos.

Institutional Care
Institutional care that is for the primary purpose of controlling or changing your environment, or maintenance care, Custodial Care, domiciliary care, Convalescent care or rest cures is not covered.

Obesity
Charges for special formulas, food supplements, special diets, minerals, vitamins or Physician and Non-Physician-supervised weight loss programs are not covered. Treatment or products for obesity, food addiction or weight reduction are not covered.

Reversal of Sterilization
A surgical procedure to reverse voluntary sterilization is not covered.

Services That Are Not Medically Necessary
Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.

Vocational rehabilitation services or other services or supplies, other than Basic Healthcare Services, which are not Medically Necessary for the treatment, maintenance or improvement of your health, are not covered.

Care ordered or directed by individuals other than a licensed medical professional, Physician or registered clinical psychologist, family retreats or services with a diagnosis of marriage counseling unrelated to mental health conditions are not covered.

Services that are not primarily medical in nature, including but not limited to traditional mattresses, air filters, whirlpool tubs/spas, swimming pools, exercise equipment, gym memberships, air conditioners, adaptive device/filters for residential heating and air conditioning systems, car seats and educational services unless specified elsewhere in the Policy, are not covered.

Skin Lesions
Skin lesion removal primarily for cosmetic reasons rather than for Medical Necessity is not covered.

Supplemental Drinks/Vitamins/Weight Gain Products
Over-the-counter supplies or products taken to supplement caloric intake, not primarily medical in nature and not used as the sole source of nutrition, are not covered.

Other Non-Covered Items

- Unless otherwise stated within this policy, any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.
- Any service, supply, treatment, diagnosis or advice for which you are not legally required to pay.
- Any service, supply or treatment prohibited by the laws of the United States or the state where the expense was incurred.
- Any care, treatment, service or supply furnished by a facility owned or operated by a state or national government. Charges are covered if you have a legal obligation to pay for the care or treatment or if the United States has the authority to recover or collect the reasonable cost of such care or service.
- Any Injury or illness arising out of or occurring in the course of your job for wage or profit and which is covered by Worker's Compensation or similar law. If your Worker's Compensation claim is denied, you are required to submit the denial to Health Alliance within 90 days.
- Charges for appointments scheduled and not kept (missed appointments).
- Charges incurred before you became covered under the Plan or after you terminate from the Plan.
- Complications arising directly from rightfully excluded conditions.
- Services provided by a non-licensed professional.
- Services furnished or billed by a Provider that has been disbarred by the federal government.
- Any service, supply or treatment received outside of the United States, other than Emergency services or Urgent Care.

APPEALS

Appeals are divided into two categories: administrative decisions or denials of coverage based on Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness. You or any person you have chosen as your authorized representative, including your Physician or other healthcare Provider or attorney may request an appeal within 180 days of receiving the initial denial notice by calling the Member Relations Department at 1-800-500-3373, via facsimile at 1-217-902-9708 or by writing to the Member Relations Department, Health Alliance Northwest Health Plan, 3310 Fields South Drive, Champaign, Illinois 61822. The party filing the appeal may send us written comments, documents, records or other information regarding your appeal.

Administrative Review
Appeals for administrative decisions will be reviewed by a committee or an individual not involved in the initial denial and who does not work under the authority of the initial decision maker. Health Alliance will notify the party filing an appeal within three business days of any additional information that is required to evaluate the appeal. Health Alliance will notify the party filing the appeal in writing of its decision within 14 days from the date Health Alliance receives all the information requested to complete the review.

Medical Necessity, Appropriateness, Healthcare Setting, Level of Care or Effectiveness Review
Appeals for denial of coverage of healthcare services will be reviewed by a Clinical Peer not involved in the denial of coverage of healthcare services. Health Alliance will notify the party filing an appeal within three business days of any additional information that is required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any other healthcare Provider who recommended services within 14 days after receipt of all necessary information, but no later than 30 calendar days after receipt of the request for an appeal. When a service or treatment is experimental or investigational Health Alliance will make a decision and notify you, your authorized representative, Physician and any other healthcare Provider within 20 days after receipt of all necessary information, but no later than 30 calendar days after receipt of the request for an appeal.

If you have exhausted the internal appeals process, you have the right to request that decision be reviewed by an independent review organization; see "External Review of Appeals."

Expedited Medical Necessity Review
You, your authorized representative, Physician or other healthcare Provider may request an appeal for denial of urgent care services that require Prior Authorization. A Clinical Peer not involved in the original decision to deny coverage of healthcare services will review the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any other healthcare Provider who recommended services by telephone within 24 hours of receipt of all requested information, but no later than 72 hours after receipt of the request for an appeal. Health Alliance will provide written notification within 72 hours of the decision.

If the appeal of your Prior Authorization request is denied and you have exhausted the internal appeals process, you have the right to request that decision be reviewed by an independent review organization; see "External Review of Appeals." If you have a medical condition where the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the requested healthcare services are denied and the denial concerns an emergency admission, availability of care, continued stay, or healthcare service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based on the determination that the requested service or treatment is experimental or investigational and your healthcare Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review; see "External Review of Appeals" and "Expedited Medical Necessity Review."

External Review of Appeals
For denials made on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, you, your authorized representative, your Physician or other healthcare Provider or attorney may request an external review by an independent review organization (IRO) if you are not satisfied with the Health Alliance resolution of the denial of coverage for healthcare services and you have exhausted the internal appeal process. This is at no cost to you. Health Alliance will send the information provided to the IRO for review, which may be provided to you or your Provider upon request. You will have five business days to submit any additional information to the IRO. The IRO will send you their written decision within 15 days after receiving the necessary information or within 20 days after the IRO receives the request.

You may contact the Office of the Insurance Commissioner's Consumer Hotline toll free at 1-800-562-6900; or the Statewide Health Insurance Benefits Advisors (SHIBA), Office of the Insurance Commissioner, P.O. Box 40256, Olympia, Washington 98504; or at www.insurance.wa.gov.

Except in the case of an expedited review at the initial urgent Prior Authorization request denial, you must exhaust the internal review process before a request for an external review can be made.

You will also be considered to have exhausted the internal review process if:

- You have not received our written decision on your internal appeal within 30 days; see "Appeals" and "Medical Necessity, Appropriateness, Healthcare Setting, Level of Care or Effectiveness Review;"
- You have not received our written decision on your expedited internal appeal within 72 hours; see "Appeals" and "Expedited Medical Necessity Review;" or
- Health Alliance agrees to waive the internal review exhaustion requirement.
- If you request in writing a grievance against Health Alliance and you do not receive an explanation with a specific description of its basis, if any, for asserting that the grievance should not cause the internal claims and appeals process to be deemed exhausted within 10 calendar days.

Medical Necessity, Appropriateness, Healthcare Setting, Level of Care or Effectiveness Review
A written request for external review may be submitted within six months after receipt of notification that your Prior Authorization request or the appeal for approval of coverage of healthcare services has been denied. Assignment of an independent review organization will be made within three business days of determining your request is eligible for an external review or within 24 hours if it is an urgent review. The independent reviewer will make a decision within 15 days after receipt of all necessary information, or within 20 days after receiving the referral, whichever is earlier. In exceptional circumstances where information is incomplete, the determination may be delayed until no later than 25 days after receiving the referral. The independent reviewer will provide written notification of its decision to all parties involved in the appeal.

Type of Notice or Extension	Timing
If your Prior Authorization request or the appeal for approval of coverage is denied, you must submit your request for external review within:	6 months
If Health Alliance determines that your request is ineligible for an external review, Health Alliance will notify you why your request is ineligible or incomplete within:	1 business day
The Office of the Insurance Commissioner will assign an independent review organization after determining your request is eligible within:	3 business days
You and your authorized representative must provide any additional information to the independent review organization from the date you receive notice within:	5 business days
The Independent Review Organization will notify you of their determination within:	15 days after receipt of all necessary information, or within 20 days after receiving the referral, whichever is earlier OR within 72 hours if the review is expedited.

Expedited Medical Necessity Review
An expedited external review may be requested orally or in writing if you, your Physician or other healthcare Provider involved in the appeal believe that the denial of coverage of healthcare services or a standard external review would jeopardize your life, your health or your ability to regain maximum function.

COMPLAINTS

If you have a complaint about any medical or administrative matter connected with Health Alliance services that is not resolved by your Physician or clinic or Hospital personnel, call Health Alliance at 1-866-247-3296 or write to the Customer Service Department, Health Alliance Northwest Health Plan, 3310 Fields South Drive, Champaign, Illinois 61822.

You may file a complaint with the Consumer Protection Division, Office of the Insurance Commissioner, P.O. Box 40256, Olympia, Washington 98504. You may also contact the Office of the Insurance Commissioner Consumer Hotline directly at 1-800-562-6900 or Call 1 (360) 725- 7080, Fax to 1 (360) 586-2018 or Email CAP@oic.wa.gov.

TERMINATION

In the event the Employer Group terminates this Policy, all rights to benefits and services will cease on the date of termination. The Employer Group will be responsible for notifying you of termination of this Policy under this subsection.

If you terminate employment with your Employer Group, coverage under this Policy will terminate the last day of the month in which employment ends or as otherwise specified in the Group Enrollment Agreement. If you become ineligible for continued membership in the Employer Group while the Group Enrollment Agreement between Health Alliance and the Employer Group is in effect, you may be eligible for continuation of coverage subject to the provisions stated in the "Continuation of Employer Group Coverage" section.

Health Alliance may terminate your benefits and cancel this Policy immediately for any of the following reasons:

- The Health Alliance Identification Card is provided for use by any person not eligible for covered services under this Policy.
- You no longer live or work in the Service Area.
- Failure to pay the required premium under the "Premiums" section of this Policy, subject to the grace period.
- Any other reasons allowed by state or federal law.

When Medicare is the primary payer, coverage of a Dependent of an active Employee who is enrolled in the Employer Group's Medicare Advantage or Medicare Supplement Plan will terminate on the earlier of:

- The date the Employee is no longer covered under any plan offered by the Employer Group.
- The date he or she no longer satisfies the Dependent eligibility requirements as specified in the "Eligibility, Enrollment and Effective Date of Coverage" section.
- The date of the Employee's death.
- The date on which any required contribution for coverage is not made, subject to any applicable grace period.
- The date the Employer Group eliminates Dependent coverage for all Policyholders.
- The date the Plan is terminated.
- Or any other Termination reason as stated in the "Termination" section of this Policy.

Health Alliance may terminate your rights and the rights of any covered Dependent(s) and cancel this Policy as of your initial Effective Date if you perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact as prohibited by the terms of your Policy. Any such Member, or responsible parent or guardian in the case of a minor, shall be required to reimburse Health Alliance for any and all sums expended on his or her behalf for healthcare services from the Effective Date of coverage to the date of termination, together with reasonable attorneys' fees and expenses incurred in the collection of such sums. You will be provided at least 30 days written advanced notice before Your Policy is rescinded. You have the right to appeal any such rescission.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, which would constitute fraud or intentional misrepresentation of information, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in case of a minor is required to reimburse Health Alliance for any and all sums paid on his or her behalf for healthcare services together with any reasonable attorneys' fees and expenses incurred in collection of such sums.

Coverage of a Dependent child will terminate on the last day of the month in which the Dependent reaches the Limiting Age, or as otherwise specified in the Group Enrollment Agreement. If the Dependent child is incapable of self-sustaining employment by reason of an apparent physical disability and the child is dependent on his or her parent(s) or other care Providers for lifetime care and supervision, the child will continue to be covered as a Dependent child for the duration of the disability and dependency.

Coverage for healthcare services under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy. The obligation of Health Alliance under this Policy is limited to arranging for the provision of the healthcare services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered healthcare services after the effective date of termination. "Effective date of termination," for the purposes of this section, will mean the date Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date you no longer meet the eligibility requirements stated in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

In the event Health Alliance decides to no longer offer particular type of insurance product, the following processes will be followed:

- Health Alliance will notify you and your employer at least 90 days prior to the date that the insurance product is discontinued.
- Health Alliance will offer your employer the option to purchase a plan available that is currently offered.
- If an insurance product is discontinued, Health Alliance would do so uniformly and without regard to any specific employer's claims or Member health conditions.

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when you or your covered Dependent have healthcare coverage under more than one plan. When you are covered by two or more health plans, benefits provided by the other plan will be coordinated with those provided by this Plan.

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your Provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your Provider fail to submit your claim to a secondary health plan within that plans claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your Provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your Providers and plans any changes in your coverage.

Definitions

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    - "Plan" includes: Group insurance, closed panel or other forms of Group or Group-type coverage (whether insured or uninsured), individual or family insurance, closed panel or other individual coverage, medical care components of Group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
    - "Plan" does not include: Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of Group long-term care policies, medical benefits under Employer Group or individual automobile contracts, no-fault automobile insurance (by whatever name it is called) and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

    - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
    - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

- When there are more than two health plans covering the person, the Plan may be primary as to one or more of the other health plans and secondary to different health plan(s).

3. "Allowable Expense" means a healthcare service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

    - If a Member is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans provides coverage for Hospital private rooms).
    - If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and Reasonable fee for a specific benefit is not an allowable expense.
    - If a person is covered under two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
    - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable fees and another plan that provides its benefits or services on the basis of a negotiated fee, the primary plan's payment arrangement shall be the allowable expense for all plans.
    - The amount a benefit is reduced by the primary plan because a Member does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, Prior Authorization or when the Member has a lower benefit because he or she did not use a Participating Provider.

4. "Claim Determination Period" means a Benefit Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a plan that provides health benefits to Members primarily in the form of services through a panel of Providers that have contracted with Health Alliance, and that limits or excludes benefits for services provided by other Providers, except in cases of an Emergency Medical Condition or referral by a Provider on the panel.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules
This Plan determines its order of benefits using the first of the following rules that applies:

1. A plan with no provision for coordination with other benefits is considered to pay its benefits before a plan that contains such a provision.

2. **Non-Dependent/Dependent**. The benefits of the plan that covers the person as an Employee or Member (that is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering

the person as an Employee, Member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

3. **Dependent Child/Parents not Legally Separated or Divorced**. Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":

    - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
    - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

4. **Dependent Child/Parents Legally Separated or Divorced**. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

    - The plan of the parent with custody of the child.
    - The plan of the Legal Spouse of the parent with custody of the child.
    - The plan of the parent who does not have custody of the child.
    - The plan of the Spouse of the parent who does not have custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply to any claim determination period or Benefit Year when any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Dependent Child/Joint Custody**. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) above.

6. **Dependent Adult.** If a married Dependent has his or her own coverage as a dependent under a Spouse's plan and has coverage as a Dependent under either or both parent's plan the plans covering the Dependent will follow the order of benefit determination rules outlined in (9) below.

    - In the event that the Dependent's coverage under the Spouse plan began on the same date as the Dependent's coverage under either or both parent's plans, the plans covering the Dependent will follow the order of benefit determination rules outlined in (3) above.

7. **Active/Inactive Employee**. The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as the Employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this requirement will be ignored.

8. **Continuation Coverage**. If a person whose coverage is provided by a federal or state law right of continuation is also covered by another plan, the following will be the order of benefit determination:

    - The benefits of the plan covering the person as a Member, or as that person's Dependent, will pay first.
    - The benefits of the plan providing continuation coverage will pay second.

If the other plan does not contain the order of benefits determination described within this subsection, and if, as a result, the plans do not agree on the order of benefits, this requirement will be ignored.

9. **Longer/Shorter Length of Coverage**. If none of the above rules determine the order of benefits, the benefits of the plan that covered an Employee or Member longer are determined before those of the plan that covered that person for the shorter term.

10. **Secondary Plan to Calculate Benefits.** In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. However, in no event shall the secondary carrier be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the enrollee be responsible for a deductible amount greater than the highest of the two deductibles. The secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings are recorded as a benefit reserve for the Member and must be used by the secondary plan to pay any allowable expenses not otherwise paid, which are incurred by the Member during the claim determination period.

11. If none of the previously discussed rules apply, then the plans are to share the allowable expense equally.

Effect on the Benefits of This Plan
When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. Each benefit is reduced in proportion and then charged against any applicable benefit limit of this Plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

Right to Receive and Release Needed Information
Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Health Alliance may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Health Alliance need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Health Alliance any facts it needs to apply those rules and determine benefits payable. You must fill out the requested form in writing and return via mail to Health Alliance Medical Plans 3310 Fields South Drive, Champaign, Illinois 61822 or by fax to our Recovery Department at 217-902-9786. If no response is received within 45 days from the request, claims may not be considered for payment.

Health Alliance may also request updated information from you annually or when information is received that indicates a change from the information we have on file to verify or update your Coordination of Benefits information. You may fill out and return the request via mail to Health Alliance Medical Plans 3310 Fields South Drive, Champaign, Illinois 61822 or by fax to our Recovery Department at 217-902-9786 or you may contact Health Alliance at the number listed on the back of your Health Alliance Identification Card to respond to these requests. If no response is received within 45 days from the receipt of the request for information, claims may not be considered for payment.

Facility of Payment
A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Health Alliance may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. Health Alliance will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Health Alliance is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to exercise its rights under this provision. This provision applies whether or not the third party admits liability.

Health Alliance may also request information from you based on claims or other information received to verify third party liability information or to verify if a third party is involved. You must fill out the requested form in writing and return via mail to Health Alliance Northwest Health Plan, 3310 Fields South Drive, Champaign, Illinois 61822 or by fax to our Recovery Department at 217-902-9786. This information will be requested within 30 days of receiving the claim or the information. If no response is received 45 days from the date the information was requested, the claim may not be considered for payment.

SUBROGATION

Subrogation is the insurer's and the insured's right to seek reimbursement from a third party that is responsible for incurred charges. When Health Alliance is notified of a third party's liability, we may contact you for additional information. Health Alliance would pay eligible claims and is assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits paid by the Plan for that sickness or Injury, once the Member has been fully compensated. If you recover from a third party and we share in the recovery, we will pay our share of the reasonable legal expenses. Our share is the percentage of the legal expenses reasonable and necessary to ensure a recovery against the third party that the amount we actually recover bears to the total recovery. You are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability. Health Alliance may also request information from you based on claims or other information received if a third party is involved. If no response is received within 45 days from the receipt of the request, claims may not be considered for payment.

PRIVACY AND CONFIDENTIALITY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) together with the Standards for Privacy of Individually Identifiable Health Information aim to safeguard the confidentiality of private information and protect the integrity of healthcare data.

Use of Information
Protected Health Information is used in the normal course of business for underwriting and establishing premiums, processing claims, informing you of your benefits and encouraging participation in health promotion programs. Other ways this information is used include:

- Providing membership rosters to healthcare Providers
- Corresponding with you
- Participating in accreditation, auditing and quality improvement activities
- Participating in disease management studies to improve healthcare
- Providing you with healthcare reminders
- Conducting utilization review, reporting and other medical management activities
- Investigating complaints and appeals
- Establishing and maintaining proper records
- Billing and collection activities

- Fulfilling requests for information about services and benefits

Disclosure of Information
Nonpublic personal and Protected Health Information are disclosed under the following circumstances:

- To you or your authorized representative
- To another party with your signed authorization
- For Plan administration (healthcare operations and payment)
- To persons or companies that perform healthcare operations on behalf of Health Alliance
- Specific information that you agree to disclose (you will be given the opportunity to object)
- Information that has been de-identified (you cannot be identified in the information disclosed)
- Sharing information with government agencies as required by applicable state and federal laws

Health Alliance has policies and procedures in place to protect the confidentiality of your information. All persons or companies acting with Health Alliance or on behalf of Health Alliance are contractually obligated to keep the information confidential and use it only to carry out the services they are contracted to provide. Health Alliance participates in organized healthcare arrangements with Confluence and their affiliates.

Your Rights
Under the privacy regulations, you are granted the following rights with respect to your Protected Health Information:

- Right to access your own Protected Health Information
- Right to amend or correct Protected Health Information that is inaccurate or incomplete
- Right to obtain an accounting of disclosures of your Protected Health Information
- Right to request additional restrictions on the use and disclosure of your Protected Health Information
- Right to complain about our privacy practices
- Right to receive a written privacy notice that explains your rights in further detail

GENERAL PROVISIONS

Benefits
Benefits by this Policy will not be increased by virtue of this coordination of benefits limitation. It will be the obligation of any Member claiming benefits by this Policy to notify Health Alliance of the existence of all other plan contracts, as well as the benefits payable by any other plan contract. Health Alliance will have the right to release and obtain from any Physician, other medical professional, insurance company or other person or organization, any claim information (including copies of records) to pay to any other organization any amount determined to be warranted by this Policy. Health Alliance may recover any overpayment, which may have been made to any person, insurance company, or organization under the provisions of this section. Each Member claiming benefits by this Policy must give Health Alliance any information it needs to pay the claim.

Clerical Error
Clerical error in quoting benefits or in processing or maintaining any record pertaining to the coverage under this Policy, will not invalidate coverage otherwise validly in force or reinstate coverage otherwise validly terminated.

Genetic Information
Health Alliance does not use any information derived from genetic testing and prohibits the use of such information to make any delivery, issuance, renewal or claims payment decisions.

Guaranteed Renewability
Health Alliance will renew benefits under this Policy at the option of the Employer Group. Health Alliance reserves the right to not renew or to discontinue coverage under this Policy and under the Group Enrollment Agreement for one or more of the following reasons:

- Non-Payment of premium by the Employer Group, which includes payments not made in a timely manner
- Acts of fraud or any material intentional misrepresentation by the Employer Group
- Violation of participation or contribution rules under the Group Enrollment Agreement
- Health Alliance ceases to offer coverage in the market

Health Care Benefit Managers
Health Alliance works with companies to provide health plan services. These companies are called health care benefit managers (HCBM). There may be an occasion where representatives from these companies contact you by email or phone for limited purposes. For more information about our health care benefit managers, please visit http://www.healthalliance.org/plan-support-materials.

Health Alliance Identification Card
The Health Alliance Identification Cards issued to you pursuant to this Policy are for identification only. Possession of a Health Alliance Identification Card confers no right to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Policy have actually been paid. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Policy will be charged the Usual, Customary and Reasonable fee, in addition to any other remedies available to the Plan as set forth in this Policy.

Hospitalized on Effective Date
If on your Effective Date under the Plan, you or any of your covered Dependents are inpatients in a Hospital, you are required to notify the Plan at the number on the back of your Health Alliance Identification Card within 48 hours of the Effective Date or as soon as reasonably possible. Medically Necessary charges incurred on or after your Effective Date is covered by the Plan. Charges incurred prior to 12:01 a.m. of your Effective Date will not be covered by the Plan.

Legal Action
No legal action shall be brought to recover on this Policy before 60 days after written proof of loss has been furnished. No legal action shall be brought to recover on this Policy more than six years after the time written proof of loss was furnished.

Medicare Eligible Beneficiaries
The federal "Medicare Secondary Payor" (MSP) laws regulate how certain employers may offer Employer Group healthcare coverage to Medicare-Eligible Employees and Dependents. Under the MSP laws, Medicare generally pays secondary to the Employer Group health coverage provided under this Policy for the following Medicare-Eligible Beneficiaries:

- Members with end-stage renal disease, during the first 30 months of Medicare eligibility or entitlement.
- Members age 65 and older who are covered under this Plan, due to his or her or his or her Spouse's current employment status with the Employer Group, if the Employer Group has 20 or more Employees.
- Disabled Members under age 65 who are covered under this Plan due to their or a family member's current employment status with the Employer Group, if the Employer Group employs more than 100 Employees.

To assist your Employer Group and Health Alliance in complying with the MSP laws, you must notify your Employer Group promptly if you or any of your covered Dependents becomes eligible for Medicare or has Medicare

eligibility terminated or changed. You must also promptly and accurately complete any requests for information from your Employer Group or Health Alliance concerning your or any of your covered Dependents' Medicare eligibility.

Medicare is the primary coverage for those Medicare-Eligible Beneficiaries to whom the MSP laws do not apply (for example, Retired Employees and their Spouses who are age 65 or older). Benefits for such Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available if the Medicare-Eligible Member enrolled in Medicare and made a proper claim for Medicare payment.

For a Medicare-Eligible Beneficiary to obtain the greatest level of benefit, a Medicare-Eligible Member to whom the MSP laws do not apply should:

- Enroll in Part A and Part B of Medicare.
- Obtain needed healthcare services and items from Providers according to the terms and conditions of this Policy. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.
- Assign his or her claim for Medicare benefits to the Provider. For services received from Providers, this Plan will cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.

If you do not enroll in Part B of Medicare, you will be responsible for the portion of the bills that Medicare would have allowed under Part B coverage.

We encourage you to call Customer Service at 866-247-3296 to speak with one of our Customer Service Representatives with any questions about the benefits available and how to obtain them. For questions regarding Medicare eligibility or benefits, contact the Centers for Medicare and Medicaid Services.

The benefits of this Plan for Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available for such services or items if the Member enrolled in Medicare and made a proper claim for Medicare payment. Refer to the "Terms" section for the definition of Medicare-Eligible Beneficiary.

New Medical Technologies
To keep pace with technology changes and your equitable access to safe and effective care, Health Alliance has established policies and procedures to evaluate new developments in medical technology and its applicability to benefit changes. Professionals with the expertise related to new medical procedures, pharmacological treatments and devices participate in the evaluation of each new technology and the creation of criteria for its applications.

Non-Discrimination
Health Alliance does not make or permit unfair discrimination between Members or potential Members that have like insuring, risk, and other factors and elements. Health Alliance does not refuse to issue any contract, notices of proposed insurance or decline renewal to such contract because of race, color, national origin, disability, age, gender identity, sex, sexual preference, sexual orientation, and/or marital status of the Member or any potential Member.

Notices
Any notice to be given to you under the terms of this Policy by Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to your most recent address shown in the records of Health Alliance. Any notice to be given under the terms of this Policy to Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to Health Alliance Northwest Health Plan, 3310 Fields South Drive, Champaign, Illinois 61822. All notices given in the manner provided for in this

section will be deemed to have been received by the party to whom addressed, five business days after deposit in said post office.

You may notify us of a change of address by calling Health Alliance at the number listed on your Health Alliance Identification Card or by sending the change of address information to the Membership Department, Health Alliance Northwest Health Plan, 3310 Fields South Drive, Champaign, Illinois 61822.

Payment of Claims
The Plan pays benefits or assigns payment of benefits to the healthcare Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. If services are received outside of your network, or outside of the United States, you may be required to pay the Provider at the time services are received, and submit an itemized statement to Health Alliance for reimbursement. You may also be required to submit any payment due by Health Alliance to the Provider. In situations where a monetary conversion is required, conversion will be based on the rate that was in effect on the date of discharge by the Provider or facility. Any claim for reimbursement or bills for covered healthcare services must be submitted within 90 days of the service or as soon as reasonably possible. All claims should be submitted to:

Claims Department
Health Alliance Northwest Health Plan
3310 Fields South Drive.
Champaign, IL 61822

The Plan is not responsible for any claims or bills submitted more than one year after the provision or initiation of the service to which the claim or bill relates. Health Alliance will notify you and your Provider if additional information is needed to process your claim. You, your authorized representative or Provider have 45 days from the receipt of the notice to provide the requested information. The Claim may be denied if the requested information is not received within the time frame given to provide the information.

Unless your Plan receives prior written instruction from you, any healthcare benefits unpaid at your death will be paid to the healthcare Provider rendering the service for which benefits are due or reimbursed to your estate. If benefits payable are $1,000 or less, Health Alliance may pay someone related to you by blood or marriage whom Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Pro-Rata Refund
In the event of the death of the Policyholder, Health Alliance will, upon receipt of notice of the Policyholder's death and a request for a pro-rata refund, supported by a valid death certificate supplied by a party entitled to claim such refund, refund the unearned premium pro-rated to the month of the Policyholder's death. Refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the Policyholder's death. Coverage of persons insured under the same Policy other than the Policyholder shall not be affected by the premium refund provided for in this section nor shall the obligation of such other insureds to pay required premiums be diminished pursuant to this section.

Timely Payment of Claims
All benefits due will be paid upon receipt of proof of loss. If you need any forms or information from Health Alliance for claims submission, Health Alliance will notify you or send you the information upon request within 15 business days. We will notify you within 30 days if additional information is needed. If, after 45 days from the

date additional information was requested, the information remains incomplete, Health Alliance will not consider the claim for payment due, due to lack of information provided.

Other Provisions
The obligation of Health Alliance is limited to furnishing healthcare coverage to Members through contracts with such Providers of care. Health Alliance is not liable, in any event, for any act or omission of the professional personnel of any medical group, Hospital or other Provider of services to Members.
The healthcare coverage provided for in this Policy is not transferable to another party by any Member.

In the event Health Alliance chooses to no longer offer this Plan to Members, you will be notified 90 days prior to the discontinuation of the Plan and given an option to purchase another Plan that is being offered at that time.

In the event Health Alliance chooses to no longer offer any Plan in the market, then notification would be made to you and the Office of the Insurance Commissioner 180 days prior to discontinuation of our products.

CONTINUATION OF EMPLOYER GROUP COVERAGE

You may be eligible to continue your healthcare coverage under this Policy provided you meet the requirements stated below and the terms and conditions of the Group Enrollment Agreement. It is the responsibility of your employer to notify you of your rights to continuation of coverage. You should contact your employer for more detailed information on your rights to continuation of coverage.

Eligibility
You may be eligible for three months of continuation coverage if you are a Member whose coverage under this Policy would otherwise terminate due to termination of the Policyholder's employment (termination of employment cannot be due to a felony or theft at work), termination of membership, or the reduction of the Policyholder's hours and if you:

- Have been continuously enrolled under the Employer Group contract during the entire three-month period ending with the termination date.
- Are not covered under another Employer Group health insurance policy or entitled to Medicare.
- Have not moved outside the Service Area.
- Your Employer Group isn't subject to COBRA.
- You are not eligible for COBRA coverage.

Election
To elect continuation coverage, you must submit a completed application and applicable premium payment to Health Alliance within 30 days after you receive notification of your right to choose continuation coverage.

Termination of Coverage
Continuation coverage under this Policy will terminate if one of the following occurs:

- You exhaust the maximum three-month period.
- You fail to make timely premium payments.
- The Group Enrollment Agreement is terminated.
- You become covered under another Employer Group health insurance policy.
- You become eligible for Medicare.
- You move outside the Service Area.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

This section applies only to Members of an Employer Group with 20 or more Employees.

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their Dependents covered under the Plan will be entitled to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of Employer Group health plan coverage that must be offered to certain Policyholders and their eligible Dependents (called "Qualified Beneficiaries") at Employer Group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Legal Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Retired Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the Legal Spouse, surviving Legal Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Legal Spouse, surviving Legal Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Legal Spouse or Dependent child of the individual will also not

be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Dependent who does not qualify as a Policyholder's tax Dependent under IRS rules is not considered a Qualified Beneficiary.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other Employer Group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another Employer Group health plan.

What is a Qualifying Event?
A Qualifying Event is any of the following if the Plan provided that the Member would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Legal Spouse.

(iv) A covered Employee's enrollment in any part of the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the Limiting Age for dependency under the Plan).

(vi) The employer files for bankruptcy under Title 11 of the U.S. Code and you are a Retired Employee.

If the Qualifying Event causes the covered Employee, or the covered Legal Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Legal Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

If a covered Employee discontinues coverage for his or her Legal Spouse in anticipation of divorce or other Qualifying Event prior to the actual event, when the divorce or other Qualifying Event becomes final, the employer must be notified so the notification can be sent.

If your employer is subject to the Family and Medical Leave Act of 1993 (FMLA), the taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note: that the covered Employee and Dependents will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage?
The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?
The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of their right to elect COBRA continuation coverage.

Qualified Beneficiaries should take into account that a failure to elect COBRA will affect future rights under federal law. Qualified Beneficiaries should take into account the special enrollment rights available under federal law. Qualified Beneficiaries have the right to request special enrollment in another Employer Group health plan for which you are otherwise eligible (such as a plan sponsored by your Legal Spouse's employer) within 30 days after your Employer Group health coverage under the Plan ends because of a Qualifying Event. Qualified Beneficiaries will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their Employer Group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the employer for further information.

Is a covered Employee or Qualified Beneficiary responsible for informing the employer of the occurrence of a Qualifying Event?
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the employer has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the Employee,
- commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the Employee in any part of Medicare

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Legal Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify your employer <u>in writing</u> within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided <u>in writing</u> to your employer during the 60-day notice period, any Legal Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to your employer.

NOTICE PROCEDURES

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to your employer. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the Employee*** covered under the plan,
- the ***name(s) and address(es) of the Qualified Beneficiary(ies)***, and
- the ***Qualifying Event*** and the ***date*** it happened.

If the Qualifying Event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under "Duration of COBRA Coverage." That explanation describes other situations where notice from you or the Qualified Beneficiary is required in order to gain the right to COBRA coverage.

Once your employer receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Legal Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying Event. If you or your Legal Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the employer ceases to provide any Employer Group health plan (including a successor plan) to any Employee.

(iv) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(v) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29-months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?
The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18-months after the Qualifying Event, if there is not a disability extension and 29-months after the Qualifying Event, if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36-months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18-months (or 29-months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the Retired Employee ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Legal Spouse, surviving Legal Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36-months after the death of the retiree.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36-months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The employer must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the employer.

How does a Qualified Beneficiary become entitled to a disability extension?
A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the employer with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the employer.

Does the Plan require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the employer and the entity that provides Plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?
If a Qualified Beneficiary's COBRA continuation coverage under an Employer Group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health

plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact your employer or COBRA administrator. For more information on ERISA, including COBRA, HIPAA and other laws affecting Employer Group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.DOL.gov/EBSA.

KEEP YOUR EMPLOYER INFORMED OF ADDRESS CHANGES
To protect your family's rights, you should keep your employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the employer.

TERMS

Capitalized terms used throughout this Policy are defined in this section.

Approved Clinical Trials
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 is approved or funded by a federally funded trial or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

Artificial Insemination (AI)
The introduction of sperm into a woman's vagina or uterus by noncoital methods, for the purpose of conception.

Assisted Reproductive Technologies (ART)
The treatments and/or procedures in which the human Oocytes and/or sperm are retrieved and the human Oocytes and/or Embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where Oocyte Retrieval is performed.

Basic Healthcare Services
Emergency care, inpatient Hospital and Physician care, Outpatient medical services, mental health care and Substance Use Disorder treatment.

Behavioral Health Emergency Services Provider
Provides emergency services in a crisis stabilization unit, or evaluation or treatment facility, directly with other public or private agencies, emergency evaluation and treatment, Outpatient care and timely and appropriate inpatient care to persons suffering from mental health disorders and which is licensed or certified as such by the department of health. A Behavioral Health Emergency Services Provider may also include a Triage Facility, an agency certified to provide medically managed or medically monitored withdrawal management, and/or a mobile rapid response crisis team that is contracted to provide crisis response services in behavioral health.

Benefit Year
The year on which the plan's annual benefits are calculated.

Cardiac Rehabilitation
A medically supervised program that helps improve the health and well-being of people who have heart problems. Rehab programs include exercise training, education on heart healthy living and counseling to reduce stress and help you return to an active life. There are different phases in cardiac rehabilitation care. Please see the Cardiac Rehabilitation section under the "What is Covered" section of this Policy.

Phase I is part of the inpatient days spent while being treated and recovering from a cardiac condition.

Phase II is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated one to three weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

Phase III involves Members who no longer need medical supervision while exercising. These Members may embark on a long-term program of exercise and health maintenance. Such programs are usually undertaken at home or in a fitness center.

Chemical Dependency
Chemical Dependency is defined as an illness characterized by a physiological or psychological dependency, or both, on a controlled substance. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Clinical Peer
A healthcare professional who is in the same profession and the same or similar specialty as the healthcare Provider who typically manages the medical condition, procedures or treatment under review.

Coinsurance
A percentage of a charge you must pay directly to the Provider for services rendered to you by the Provider.

Contraceptives
Devices, drugs, procedures or other methods that are used with intention to prevent pregnancy or conception.

Copayment
A specific dollar amount you must pay for certain covered services at the time and place you receive such services.

Custodial Care
Care furnished for the purpose of meeting Non-Medically Necessary personal needs that could be provided by people without professional skills or training, such as assistance in walking, positioning, dressing, bathing, eating, preparation of special diets and taking medications.

Deductible
The amount you must pay before the Plan benefits begin. A new Deductible will apply each Benefit Year.

Dependent
A child or Legal Spouse of a Policyholder who meets the eligibility requirements of this Policy.

Description of Coverage
An attachment to this Policy that includes, but is not limited to, Copayment, Coinsurance, Deductible amounts, benefit limitations and Out-of-Pocket Maximums for this Health Benefit Plan.

Domestic Partner
A partnership, where at least both persons are 18 years old and at least one person is 62 years old or older, with whom the Policyholder lives in an exclusive, emotionally committed, financially responsible and state-registered relationship.

Donor
An Oocyte Donor or sperm donor.

Drug Formulary
A listing of drugs that your Plan covers.

Effective Date
The date you and your covered Dependents are eligible for benefits under this Policy.

Embryo
A fertilized egg that has begun cell division and has completed the pre-embryonic stage.

Embryo Transfer
The placement of the pre-embryo into the uterus or, in the case of Zygote Intrafallopian Tube Transfer, into the fallopian tube.

Emergency Medical Condition
A medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition placing your health (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.

Emergency Services
Services including, a medical screening and/or behavioral health examination including ancillary services available at the emergency department to evaluate an Emergency Medical Condition, transportation, but not limited to ambulance services, and inpatient and Outpatient services furnished by a Provider qualified to provide such services and needed to evaluate or stabilize an Emergency Medical Condition.

Employee
A person who is an active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer Group
An employer, association, union or other Employer Group who has contracted with Health Alliance to offer healthcare benefits to its Employees.

Episode of Care
Treatment for a new or recurrent condition for which the Member has not been treated by the Provider within the previous 90 days and is not currently undergoing any active treatment.

ERISA (Employee Retirement Income Security Act of 1974)
A federal law that regulates the majority of private pension and welfare Employer Group benefit plans in the United States.

Essential Health Benefits
Benefits covered under the Policy 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, chronic disease management, and pediatric services including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection

and Affordable Care Act of 2010 and any federal and/or state regulations issued pursuant thereto. Essential Health Benefits provided within your Policy are not subject to any annual dollar maximums.

E-Visit
Non face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.

Experimental or Investigational Treatments/Procedures/Drugs/Devices/Transplants
Healthcare treatments, procedures, drugs, devices or transplants are considered experimental or investigational if it is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug, device or transplant is the subject of ongoing phase I, phase II, phase III or phase IV clinical trials or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the FDA, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community in the state of Washington at the time it is to be provided.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.

In making his or her determination that a medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature and discussion with medical experts and other technological assessment bodies designated by Health Alliance. Each review will be on a case-by-case basis regarding coverage of a requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness.

Health Alliance will provide the supporting documentation upon which the criteria are established to a Member upon receipt of a written request. Health Alliance will not withhold this supporting documentation as proprietary information.

Extended Network Provider
A Physician or Provider that is contracted with an outside Health Plan leasing their Providers to provide healthcare services to Members. An Extended Network Provider is not responsible for obtaining Prior Authorization on your behalf.

Family Coverage
The healthcare services arranged for and provided to you and your Dependents under the terms and conditions of this Policy for which the applicable premium has been paid to and received by Health Alliance.

Formulary Drugs
Drugs that are included in the list of medications your Plan covers.

Gamete
A reproductive cell. In a man the Gametes are sperm; in a woman the Gametes are eggs or ova.

Gamete Intrafallopian Tube Transfer (GIFT)
The direct transfer of a sperm/egg mixture into the fallopian tube; fertilization takes place inside the tube.

Genetic Testing
An analysis of human DNA, RNA, chromosomes, proteins or metabolites, if the analysis detects genotypes, mutations or chromosomal changes. Genetic testing does not include an analysis of proteins or metabolites that are directly related to a manifested disease, disorder or pathological condition.

Group Enrollment Agreement
A contract, which this Policy is a part of, between Health Alliance and the Employer Group to offer Employer Group healthcare benefits to its Employees.

Health Alliance Identification Card
A card that is provided by Health Alliance to each Member upon enrollment. Replacement cards may be requested by contacting Health Alliance at 877-750-3517.

Health Benefit Plan
The covered healthcare services, limitations, exclusions and cost sharing amounts as well as the network of Providers made available to Members by Health Alliance Northwest Health Plan under the Group Enrollment Agreement issued to the Employer Group.

Hospital
An institution that meets the following requirements:

- It must provide medical and surgical care and treatment for acutely sick or injured persons on an inpatient basis.
- It must have diagnostic and therapeutic facilities.
- Care and treatment must be given by or supervised by Physicians. Day and night nursing services must also be given and must be supervised by a licensed nurse.
- It must not be operated by a national, provincial or state government.
- It must not be primarily a place of rest, a place for the aged or a nursing home.
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a Hospital as defined by those laws.

Infertility
The inability to conceive after one year of Unprotected Sexual Intercourse or the inability to sustain a successful pregnancy. In the event a Physician determines a medical condition exists that renders conception impossible through Unprotected Sexual Intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal by a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments, the one year requirement shall be waived.

Injury
An accidental physical harm to the body caused by unexpected external means.

In Vitro Fertilization (IVF)
A process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and divided egg is then transferred into the woman’s uterus.

Legal Spouse
The person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. Health Alliance may require documentation of marriage.

Life-Threatening Disease or Condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limiting Age
The age a child is no longer eligible for Dependent coverage on their parent's plan.

Low Tubal Ovum Transfer
The procedure in which Oocytes are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus.

Maximum Allowable Charge
The Maximum Allowable Charge is the maximum amount payable for a covered service determined by Health Alliance based on a percentage of Medicare, including use of a Medicare gap-fill fee schedule, or the average discount Health Alliance has negotiated with Participating Providers. If the amount billed by a Non-Participating Provider is more than the Maximum Allowable Charge, you will be responsible for the difference between the Maximum Allowable Charge and the actual amount billed in addition to Copayments, Coinsurance and Deductibles. Amounts in excess of the Maximum Allowable Charges do not apply to your Plan Year Out-of-Pocket Maximum.

Medical Director
Medical Director means a licensed Physician employed or under contract with Health Alliance to provide services including, but not limited to, utilization management and quality assurance reviews.

Medically Necessary (Medical Necessity)
A service or supply that is required to identify or treat your condition and:

- Is appropriate and necessary for, and consistent with, the symptom, or diagnosis and treatment or distinct improvement of an illness or Injury.
- Is adequate and essential for the evaluation or treatment of a disease, condition or illness.
- Can reasonably be expected to improve your condition or level of functioning.
- Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Is not mainly for the convenience of you, a Physician or other Provider.
- Is the most appropriate medical service, supply or level of care, which can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an Outpatient.

Member (also referred to as "you" or "your" within this Policy)
A Policyholder or a covered Dependent who is entitled to benefits under the Plan.

Mid-Level Provider
A healthcare professional, other than a Physician, that provides patient care in a collaborative practice under the supervision of a Physician.

Newborn
An infant under 28 days old.

Non-Formulary Drugs
Drugs that are not included in the list of medications your plan covers.

Non-Participating Provider
A Physician or Provider that has not entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance Members. Non-Participating Providers may also be known as Out-of-Network Providers.

Non-Preferred Drugs
Formulary drugs for which a Member pays a higher cost share; these drugs usually have a lower cost Preferred Formulary alternative.

Oocyte
The female egg or ovum formed in an ovary.

Oocyte Donor
A woman determined by a Physician to be capable of donating eggs in accordance with the standards recommended by the American Society for Reproductive Medicine.

Oocyte Retrieval
The procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. This procedure is also called ova aspiration.

Out-of-Pocket Maximum
The maximum dollar amount you and/or your family will pay in accumulated Copayments, Coinsurance and Deductible amounts for Basic Healthcare Services during a Plan Year. Amounts paid for non-covered healthcare services and certain other expenses will not apply to the Out-of-Pocket Maximum.

Outpatient
The care or services you or a Dependent receives in a Provider's office, the home, the Outpatient department of a Hospital or freestanding surgical center.

Participating Provider
A Physician, pharmacy, or Provider that has entered into a valid contract with Health Alliance to provide healthcare services to Health Alliance Members. Participating Providers may also be known as In-Network Providers. These Providers would be part of the Health Alliance Northwest Health Plan Network.

Physician
A person licensed to practice medicine in all of its branches under the applicable laws of the state within the United States where the services are provided.

Plan
The program of healthcare benefits covered by this Policy.

Plan Year
Plan Year is the 12-month period beginning and ending on January 1 and ending December 31 of the same calendar year unless otherwise defined by the Group Enrollment Agreement.

Plan Year Maximum Benefit
The total benefits available for certain covered services during a Plan Year for each Member.

Policy
This booklet that is issued to a Policyholder that describes the coverage provided by the Plan.

Policyholder (also referred to as "you," or "your" within this Policy)
A person who is a bona fide Employee, regularly employed on a permanent basis by the Employer Group and enrolled in Health Alliance. A Policyholder must live or work in the Service Area of the Employer Group's plan and is subject to the terms and conditions of the Group Enrollment Agreement.

Post-Stabilization Medical Services
Services provided after an emergency medical treatment to a stabilized Member with the intent to maintain, improve or resolve his or her condition.

Prior Authorization (Prior Authorized)
A review by Health Alliance prior to receipt of services to determine and authorize the coverage level of Medically Necessary services for which the Plan will pay.

Preferred Drugs
Formulary drugs that are considered well suited for most Members.

Prescription Refill Synchronization
The allowance to refill one or more maintenance medication(s) on the same day to eliminate the need for multiple trips to the pharmacy for easier management of medications.

Primary Care Physician
A Participating Physician who spends a majority of clinical time engaged in general practice or in family practice, internal medicine, gynecology, obstetrics or pediatrics. These Physicians are designated in the Provider Directory.

Primary Medical Diagnosis
The main condition or disease causing symptoms or requiring treatment. The first listed condition for treatment.

Private Duty Nursing Service
Private Duty Nursing Services are skilled nursing services provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or a licensed practical nurse (L.P.N.). Private Duty Nursing is typically shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Protected Health Information
All individually identifiable health information maintained or transmitted by the Plan.

Provider
A healthcare Provider (such as a Physician or Mid-Level Provider), healthcare facility and/or corporation licensed under the applicable laws of the state within the United States where the services are provided.

Provider Directory
A list of Participating Providers for your Plan and the area they serve.

Provider Network
A Provider Network is the listing of Physicians, healthcare facilities and other healthcare professionals that are Participating for your Plan. To obtain a listing of Providers in the Health Alliance Northwest Health Plan Network, visit HealthAlliance.org or contact Health Alliance at the number on the back of your Health Alliance Identification Card.

Retrospective Review
A review performed after a claim for benefits is received.

Regular Effective Date
The Effective Date determined for special enrollment periods. If enrollment is requested between the first and fifteenth of the month, then the Effective Date is the first day of the following month after requested enrollment. If enrollment is requested between the sixteenth and last day of the month, the Effective Date is the first day of the second following month after requested enrollment.

Retired Employee
A former active Employee of the employer who retired while employed by the employer and who is covered under the Employer Group's healthcare Plan.

Service Area
The geographic region that contains the counties within which the Plan is authorized to do business.

Your Service Area is determined by where you live or work. Listed below are the counties in which Health Alliance Northwest Health Plan is authorized to do business and/or is offering the Health Alliance Plans:.

- Chelan
- Douglas
- Grant
- Okanogan

Skilled Care
Services that can only be performed by or under the supervision of a licensed nurse or a physical, occupational or speech therapist.

Skilled Nursing Facility
A facility that is primarily engaged in providing to its residents Skilled Care or rehabilitation (physical, occupational or speech therapy) services. Skilled Nursing Facilities do not include convalescent nursing homes, rest facilities or facilities for the aged that primarily furnish Custodial Care.

Small Employer
A person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty Employees, during the previous calendar year and employed at least one Employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-Employee relationship exists.

Specialty Pharmacy Drugs
Any agent that is obtained from a specialty drug Provider because of special handling, storage, administration, monitoring and/or financial requirements.

Store and Forward Technology
Use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person and does not include the use of audio-only telephone, facsimile, or email.

Substance Use Disorder
The following mental disorders as defined in the most current edition of the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association:

- Substance Use Disorders;
- substance dependence disorders; and

- substance induced disorders

Summary of Benefits and Coverage (SBC)
A brief summary of covered benefits and limits for Members and Dependents covered by this Policy. It includes but is not limited to Copayments, Coinsurance, Deductible amounts, benefit limitations and Out-of-Pocket Maximums. The Summary of Benefits and Coverage includes a uniform glossary of terms.

Surrogate
A woman who carries a pregnancy for a woman who has Infertility coverage.

Telemedicine
The delivery of clinical services via synchronous, interactive audio, audio only and video communications systems that permit real-time communication between the Provider and the patient. Services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology. For coverage of audio only services, the member must have an established relationship with the provider. Telemedicine provides remote access for face-to-face services such as consultations, office visits, preventative care, and mental health services. Telemedicine, through technology, replicates the interaction of a traditional in-person encounter between a Provider and a patient.

Triage Facility
An agency certified by the department of health to provide outpatient crisis services.

Unprotected Sexual Intercourse
Sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to oral Contraceptives, chemicals, physical or barrier Contraceptives, natural abstinence or voluntary permanent surgical procedures.

Urgent Care
Care that requires immediate attention for an unforeseen illness, Injury or condition to prevent serious deterioration of a condition. May also refer to a facility known as convenient care, prompt care or express care.

Usual, Customary and Reasonable
A charge that is not more than the normal level of charges made by Providers of covered services in a geographic area. Health Alliance contracts with a national database for charges by geographic ZIP code. Charges from Participating Providers are not subject to Usual, Customary and Reasonable charge limitations because of contractual provisions with Health Alliance.

Uterine Embryo Lavage
A procedure by which the uterus is flushed to recover a preimplantation Embryo.

Virtual Visits
Communication technology-based services when the patient checks in with the healthcare Provider via telephone or other telecommunications device to decide whether an office visit or other service is needed. Virtual visits, including virtual primary care visits, include the service of remote evaluation of recorded video and/or images submitted by an established patient for reviewing patient-transmitted photo or video information conducted via pre-recorded “store and forward” video or image technology to assess whether an office visit or other service is needed.

Washington State Health Benefit Exchange
A resource that allows individuals, families, and small businesses learn about health insurance options, compare plans, choose plans and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage.

Women’s Principal Healthcare Provider
A person licensed to practice medicine in all of its branches under the applicable laws of the state where he or she provides services, specializing in obstetrics and/or gynecology or family practice.

Women’s Principal Healthcare Provider
Services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the Plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

Zygote
A fertilized egg before cell division begins.

Zygote Intrafallopian Tube Transfer (ZIFT)
A procedure by which an egg is fertilized in vitro, and the Zygote is transferred to the fallopian tube prior to the pronuclear stage before cell division takes place. The eggs are harvested and fertilized on one day and the Embryo is transferred at a later time.