COVERED BENEFITS AND LIMITATIONS

The following health care services are covered under this Policy subject to the Copayments, Coinsurance, Deductibles and Plan Year Maximum and Lifetime Maximum benefits specified on the Schedule of Benefits. Expenses for health care services are covered only if the services are Medically Necessary for the treatment, maintenance or improvement of your health. Some health care services are subject to Preauthorization by Health Alliance and a determination that criteria have been met. Those services are noted under the "Preauthorization" section of this Policy. Services not specifically listed are not covered.

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 health care services covered under this Policy. Medical policies are available on the Health Alliance website, www.healthalliance.org, under "Medical and Pharmacy Policies", or you can request a paper copy of a medical policy by contacting the Member Services Department at the number listed on the back of your Member Identification Card.

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

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 or by means other than by ambulance.

Ground Transportation – Emergency transportation by ground ambulance is covered for an Emergency Medical Condition when Medically Necessary.

Amino-Based Elemental Formulas

Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome are covered when prescribed by a Physician as Medically Necessary.

Dental Services

Charges incurred and anesthetics provided in conjunction with dental work that is provided in a Hospital or ambulatory surgical treatment center will be covered for children age six and under; individuals with a medical condition that requires Hospitalization or general anesthesia for dental care; or individuals who are disabled.

Diabetic Equipment and Supplies

Blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind and insulin infusion devices, lancets and lancing devices are covered subject to the durable medical equipment Coinsurance or Copayment amount specified on the Schedule of Benefits.

Diagnostic Testing

Diagnostic testing, laboratory tests and pathology services are covered when ordered by a Physician.

Genetic testing and counseling are not covered.

Durable Medical Equipment and Orthopedic Appliances
Corrective and orthopedic appliances (including but not limited to leg braces and knee sleeves) and rental of durable medical equipment for home use (such as wheelchairs, surgical beds and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. Items and supplies provided under this subsection must be prescribed by a Physician. Corrective and orthopedic appliances and devices including but not limited to earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges are not covered. This includes any dispensing fees incurred in obtaining these items.

Ostomy supplies are also covered, but other disposable supplies are not 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 the Member Services Department at the number listed on the back of your Member Identification Card.

Emergency Services
Emergency Services 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 condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The Emergency Services Copayment or Coinsurance is waived if you are admitted to the Hospital when the Plan requires an inpatient Hospital Copayment or Coinsurance. Elective care or care required as a result of circumstance which could reasonably have been foreseen prior to leaving your Service Area will be covered at the Non-Preferred Provider level of benefits.

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

Coverage is provided for inpatient Hospitalization following a mastectomy for a length of time determined by the attending Physician 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 Physician office visit or in-home nurse visit within 48 hours after discharge.

If you are admitted as an inpatient to a Non-Preferred Hospital for an Emergency Medical Condition, you must notify the Member Services Department at the number listed on the back of your Member Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

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.

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 Member 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 will be covered by the Plan. Charges incurred prior to 12:01 a.m. of your Effective Date will not be covered by the Plan.

Inpatient services for rehabilitation and Skilled Care are not covered.

Custodial Care or convalescent care in an acute general Hospital, skilled nursing facility or home is not covered.

Illegal Activities
Emergency or other medical, Hospital or surgical expenses incurred as a result of and related to an Injury acquired while intoxicated or under the influence of any narcotic are covered.

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.

Maternity Care
Maternity care is not covered except for complications of pregnancy.

Physical Therapy Services – Outpatient
Physical therapy for medical conditions directed at improving your physical functioning and are expected to result in significant improvement within two months of commencement are covered up to the limits specified on the Schedule of Benefits.

Medically Necessary physical therapy for the treatment of multiple sclerosis is covered up to the limits specified on the Schedule of Benefits when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis, but only where physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

Rehabilitative therapy services including but not limited to speech therapy, occupational therapy and vocational rehabilitation services are not covered.

Physician Services
Diagnostic and treatment services and wellness care provided by a Physician or under the supervision of a Physician are covered, as specified on the Schedule of Benefits.

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

Prostheses
Artificial limbs or eyes are covered when Medically Necessary due to an illness or Injury and 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 the Member Services Department at the number listed on the back of your Member Identification Card.

Reconstructive Surgery
Services are covered when performed to correct a seriously disfiguring condition resulting from accidental Injury or incident due to surgery.

Coverage is provided for reconstructive surgery or a prosthetic device following a mastectomy. If no evidence of malignancy, coverage is limited to services provided within two years of the date of the

mastectomy. 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.
- Prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Sexual Assault or Abuse Victims

Hospital and medical services in connection with sexual abuse or assaults that are of an emergency nature are covered. The Copayment, Coinsurance and Deductible amount will be waived.

Urgent Care

Urgent care that requires immediate attention for an unforeseen illness, Injury or condition to prevent serious deterioration is covered when services are provided in an urgent care center or Physician's office. The primary care office visit Copayment or Coinsurance specified on the Schedule of Benefits applies.

Wellness Care

Wellness care includes, but is not limited to:

- **Well-child care and annual physicals** including immunizations are covered. Coverage is limited to one physical per Plan Year for eligible Members over age two.
- **Immunizations** – Medically Necessary immunizations, including but not limited to human papillomavirus vaccine, are covered. Immunizations that can be safely administered without the supervision of health care 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 at least every three years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older is covered.
- **Mammograms** – Screening for the presence of occult breast cancer for all female Members 35 years of age and older through the use of low dose mammography is covered as follows: one baseline mammogram for women 35 to 39 years of age; and one mammogram each year for women 40 years of age and older. For women under age 40 with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, screenings are covered at intervals considered Medically Necessary by the woman's health care Provider. A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue is covered when Medically Necessary as determined by a Physician.
- **PAP Smear** – One cervical smear or PAP smear test each year is covered for females.
- **Prostate-Specific Antigen Tests** – Annual digital rectal exams and prostate-specific antigen tests are covered for asymptomatic men age 50 and over; African-American men age 40 and over; and men with a family history of prostate cancer age 40 and over when authorized by a Physician.
- **Colorectal Cancer Screening** – A screening for colorectal cancer is covered when ordered by your Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Outpatient Surgery/Procedures Copayments or Coinsurance will apply when procedures are performed in an Outpatient setting for which there is an associated facility fee (e.g., colonoscopy).
- **Bone Mass Measurement** – Medically Necessary bone mass measurement and diagnosis and treatment of osteoporosis is covered.

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.

EXCLUSIONS

Services not specifically stated as covered under the "Covered Benefits and Limitations" section are not covered. Additionally, the following services are excluded from coverage under this Policy.

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 Preferred 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.

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.

Experimental Treatments/Procedures/Drugs/Devices

Unless otherwise stated in this Policy, the Plan does not pay benefits for any charges incurred for or related to any medical treatment, procedure, drug or device that is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug or device is the subject of on-going phase I, II or III 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 your condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug or device 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 your condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug or device 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 at the time it is to be provided.
- The medical treatment, procedure, drug or device 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 or device for the treatment or diagnosis of the Member's condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature, 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 or device for the treatment or diagnosis of the Member's condition, disease or illness.

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

Services or supplies 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 Physician or registered clinical psychologist, court-ordered evaluations or treatment, care in lieu of detention or correctional placement, family retreats or marriage counseling is not covered.

Services that are not primarily medical in nature, including but not limited to, traditional mattresses, air filters, Jacuzzis/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.

Other Non-Covered Items
- 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.
- 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 of America, other than Emergency Services.

PRE-EXISTING CONDITION EXCLUSION

Pre-Existing Conditions are not covered. A Pre-Existing Condition exclusion will apply to conditions for which medical advice, diagnosis, care or treatment, including prescribed drugs or medicine, was recommended or received within the 12-month period preceding your Effective Date under this Policy. Properly enrolled newborns, adopted children and children placed for adoption are not subject to a Pre-Existing Condition exclusion.

You will be subject to the Pre-Existing Condition exclusion for the first 12 consecutive months after coverage is effective.