HIGHLIGHTS OF THE NGFA7 MEDICAL PLAN

Intended for Summary Purposes only. *For complete details, refer to the Summary of Coverage and Benefits (SBC) included with this package.*

Plan Features	Cost to Member In-Network Provider*
Annual Deductible	None
Out-of-Pocket Maximum	Standard: $2,000 Individual/$4,000 Family Office Visit Copay: $1,100 Individual/ $2,200 Family
Preventive Care Check-ups, immunizations, screenings	No charge *
Physician Office Visit	$20 PCP / $25 Specialist copay
Prenatal/Postnatal Care	$20 PCP / $25 Specialist copay to confirm pregnancy; no charge for subsequent visits
Chiropractor	$25 copay/visit (Limit 34 visits/calendar year)
Outpatient Hospital Services, Procedures and Surgery	$150 copay/visit
Inpatient Hospital Services and Surgery	$500 copay/admission
Emergency Services *Emergency Room and Ambulance services should only be used for medical emergencies*	Emergency Room: $100 copay (waived if admitted) Ambulance: No charge Urgent Care Facility: $25 copay
Preventive and Diagnostic Laboratory Services	No charge *
X-Ray Services	No charge
Outpatient Hi-Tech Radiology	$100 scan copay
Home Health Care	No charge
Durable Medical Equipment Must be pre-certified by Care Centrix	No charge
Physical, Speech, Occupational, Cardiac Therapy	$25 copay/visit (Limit 60 days/calendar year)
Skilled Nursing Care	No charge (Limit 120 days/calendar year)
Hospice	No charge
Behavioral Health/Substance Abuse Care Outpatient	$20 copay/visit
Behavioral Health/Substance Abuse Care Inpatient	$500 copay/admission
OUT-OF-NETWORK COVERAGE	
Deductible: $250 Individual/$500 Family **Coinsurance/Balance Billing:** Plan pays 70% of Maximum Allowable Amount (MAA). Member is responsible for 30% coinsurance and any difference between provider's charge and the MAA (balance billing). **Out-of-Pocket Maximum:** $4,000 Individual/$8,000 Family	

**** Preventive care and laboratory services are not covered for out-of-network providers.***

NOTES TO SCHEDULE

COST-SHARING

Coinsurance for out-of-network providers: The Plan pays the designated percentage of the *Maximum Allowed Amount (MAA)* which may not be the same as charges billed by the provider. The member will be responsible for the amount not paid by the Plan. .

Deductible: The amount the member must pay before the Plan will begin to pay for covered services.

Out-of-Pocket Maximum: Deductible and coinsurance amounts will accumulate toward the out-of-pocket maximum. Penalty amounts for failure to comply with managed care rules will not accumulate toward the out-of-pocket maximum.

OFFICE VISITS, PREVENTIVE CARE AND LABORATORY SERVICES

Physicians' Office Visits: All services must be billed as part of the Office Visit to be covered by a single Plan Office Visit copay or Plan coinsurance amount.

Preventive Care: Preventive care is only covered in-network. Preventive care includes Routine Physical Examinations, Well Baby/Child Check-Up/Immunizations, Gynecological Service and Routine Mammography including 3-D Mammograms. A list of the current preventive care services is located at the end of this tab.

Chiropractic Care: There is a maximum allowance of 34 visits per calendar year. Diagnostic X-ray services provided by a Chiropractor will **not** be covered unless the Chiropractor is contracted by CIGNA to provide such services.

Laboratory Services: Laboratory services performed at an out-of-network laboratory will not be covered.

HOSPITAL, OUTPATIENT AND EMERGENCY CARE

Ambulance Services: Services will always be paid on an in-network basis, if the transportation is medically necessary. If transportation is determined to be not medically necessary, it will be covered subject to the Plan Deductible and Plan Coinsurance.

Inpatient Hospital Care and Medical Visits: Includes care while admitted to a hospital, rehabilitative facility, skilled nursing facility, extended care facility and inpatient mental health and substance abuse facility.

Maternity Care: When using a network provider, there is a copayment for the initial visit to confirm pregnancy and coinsurance for the inpatient delivery. All remaining charges are covered 100% by the Plan.

When using an out-of-network provider, the participant will pay coinsurance after the deductible as noted on the Schedule of Benefits.

[**Important note**: Under federal law, group health Plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable), in which case, the Plan will pay for a shorter stay. Also, the Plan may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In any case, Plans and issuers may not require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours).]

Inpatient Newborn Care: There is no separate out-of-network deductible for the newborn at the time of birth.

Organ Transplant: For in-network services, when the transplant is approved by CIGNA and the services are rendered at a "Lifesource Center" facility, there is a maximum $10,000 travel services benefit available for travel to a Lifesource Center.

- *Out-of-Network:* Services will be paid subject to the Plan deductible and Plan coinsurance, up to the maximum allowed amount. There is no travel services benefit for out-of-network treatment.

Surgical Expenses: Inpatient and outpatient (or same-day) surgery will be subject to Plan coinsurance. Surgery performed in a physician's office will be subject to the Plan copayment at either the PCP or Specialist rate.

- *Out-of-Network:* All surgery must be pre-certified and will be subject to the Plan deductible and Plan coinsurance.

CONTINUED CARE

Reconstructive Surgery Following Mastectomy: Under the Women's Health and Cancer Rights Act, when a person receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles, if any, that apply to other Plan benefits.

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

Short Term Therapy including Occupational, Physical, Cardiac, Pulmonary and Speech: Claims will be paid to a maximum of 60 days per calendar year. Treatment will be monitored on an on-going basis. Outpatient short-term rehabilitation copayment applies, regardless of place of service, including the home.

Therapy days provided as part of an approved home health care plan will accumulate toward the Outpatient Short Term Rehabilitation Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day, but separate copayments will apply to the services provided by each provider.

Skilled Nursing or Extended Care Facility: Maximum of 120 days per calendar year including skilled nursing facility, rehabilitation hospital and sub-acute facilities.

Hospice Care: Will be covered for both in-patient and out-patient services.

OTHER COVERED MEDICAL EXPENSES

Abortions: The Plan covers both elective and non-elective procedures whether performed at inpatient or outpatient facilities.

Temporomandibular Joint (TMJ) Dysfunction: There is a $1,000 lifetime maximum for these services. In-network services are subject to Specialist copay for each office visit.

- *Out-of-Network:* Benefits will be subject to Plan deductible and Plan coinsurance with a $1,000 Lifetime Maximum.

If you have any questions about your benefits under this Plan, please call the Allegiant Care office at 1-800-258-9732.

OUTPATIENT CARE

OPEN ACCESS PROGRAM

You may receive benefits through a network of primary care physicians (PCP) and preferred providers. By using these network providers, you will receive benefit payments at a higher rate. In addition, network providers are responsible for obtaining authorization for services that require pre-certification, *e.g*. hi-tech imaging, outpatient therapy.

Except for preventive and laboratory services, you still have a choice over where you get medical care, but you will pay more for care when you use an out-of-network provider. In addition, you will be responsible for obtaining authorization for services that require pre-certification. You must contact CIGNA Member Services (1-800-244-6224). If you fail to get pre-certification, you will be subject to a $250 penalty in addition to any deductible and coinsurance and this penalty will not be applied toward your deductible or annual out-of-pocket maximum.

IN-NETWORK OFFICE VISITS

When you or a covered dependent visits a network provider, you will pay the copay stated on the Schedule of Benefits (which will not be applied to your out-of-pocket maximum if you have one) and the Plan will pay the balance of the charges.

TELEHEALTH SERVICES PROGRAM

- Members have the convenience of using Telehealth and can speak to a medical doctor one-on-one for any non-emergency medical concerns for themselves or a covered dependent.
- Telehealth provides on-demand 24/7/365 access to a network of licensed, board-certified U.S. based doctors (including pediatricians).
- Members can speak directly to a provider on the phone or via the internet for the PCP copay.
- The service is provided by MDLIVE and AMWELL (American Well). Both vendors have mobile apps, webpages and toll-free phone numbers available. Visit www.mdlive.com and www.americanwell.com for more details. Information is also available at www.cigna.com.

OUT-OF-NETWORK SERVICES

When you or a covered dependent uses an out-of-network provider for services, benefits are paid subject to both the Plan deductible and Plan coinsurance stated on the Schedule of Benefits.

OUT-OF-NETWORK EMERGENCIES

Out-of-network emergency care will be provided on an in-network basis. When you receive emergency care from an out-of-network provider, the Plan will review the emergency care given and determine the benefits you receive based on that review. Each emergency case is reviewed separately.

Copayment vs. Coinsurance

- A **COPAYMENT** or **COPAY** is a fixed amount you are required to pay for a covered service, with the Plan paying all remaining costs.
- When you are required to share the cost for services by paying a percentage, your share is called **COINSURANCE.** When the service is in-network, the Plan pays the stated percentage to the provider and you pay the remainder, if any, of the negotiated amount. When the service is out-of-network, the Plan pays the stated percentage of the “Maximum Allowed Amount” to the provider and you are responsible for the remainder of the cost of the service which may be substantial.

INPATIENT CARE

PRE-ADMISSION CERTIFICATION

When using a network provider, the provider will coordinate your pre-admission certification.

If using an out-of-network provider: You must contact CIGNA Member Services (1-800-244-6224) at least seven days before the admission is scheduled. CIGNA nurses will contact your physician and the hospital to ensure that the hospital stay is necessary and appropriate for the medical problem. Should you or a covered dependent be admitted to a hospital on an emergency basis, you must call CIGNA within 48 hours of the admission. If CIGNA is closed, you must report the admission on the next business day; or you also may notify CIGNA during non-business hours by leaving a message on CIGNA's 24-hour answering service.

If you fail to get pre-admission certification, you will be subject to a $250 penalty in addition to any deductible and coinsurance and this penalty will not be applied toward your deductible or annual out-of-pocket maximum.

RETROSPECTIVE REVIEW

When you or a covered dependent receives hospital services without pre-certification or any notice to CIGNA, a thorough review of your stay will take place. During this review, CIGNA may discover treatment that was not medically necessary or appropriate. Benefits may be reduced or even denied because of the review findings; and, if benefits are denied, the expenses you pay will not be applied toward the out-of-pocket maximum. Reviews are conducted on every case of this nature, regardless of whether this Plan was responsible as the primary or secondary payer.

CONTINUED STAY REVIEW

When you or a covered dependent is in the hospital, CIGNA will monitor your treatment plan to determine if the services being provided are medically necessary and appropriate. Managed care nurses will either travel directly to the hospital or discuss the case with the staff by phone. The nurse assigned to the case reviews the medical records during the hospital stay and remains in close contact with your primary care physician, the attending physician and any other medical professionals responsible for the care. The nurse may recommend a different length of stay or level of treatment depending on the results of her conferences with the doctors and staff assigned to the case.

INDIVIDUAL CASE MANAGEMENT

When you or a covered dependent experiences a medical problem involving a serious, chronic condition or extensive inpatient charges, CIGNA will start special individual case management procedures. This process could involve transfer to an alternate facility, home care treatment or other special arrangements. The process helps patients get the care they need in the setting that is most helpful and cost-effective.

DISCHARGE PLANNING

When you or a covered dependent is discharged from the hospital, CIGNA will work with your attending physician to develop a treatment plan to be followed after discharge. The CIGNA nurse also will assist with any special arrangements that may be needed after discharge.

TERTIARY CARE

Tertiary Care is specialized hospital care. In order to receive such care, CIGNA must pre-certify the stay and authorize the hospital as a preferred provider. You will receive benefits on an in-network basis when you follow both steps. Managed care services, as previously described, are provided to all in-network patients who follow the process.

PLAN DEFINITIONS

Anesthesia: The condition produced by the administration of specific agents to achieve the loss of conscious pain response.

Copayment (Copay): A fixed amount a Covered Member or Dependent pays when receiving certain medical services under the Plan.

Coinsurance: The percentage amount shared by the Plan and the member for medical expenses of a Covered Member or Dependent, as stated in the applicable benefit schedule.

Cosmetic Surgery: Surgical procedures performed to improve appearance or to correct a deformity without restoring the bodily function.

Deductible: The dollar amount the member must pay before the Plan will begin to pay for covered services.

Dependent: ***See Eligibility Section***

Hospital: An institution that:

- provides inpatient diagnostic services and treatment of injured or sick persons under continuous physician supervision;
- provides 24-hour nursing care by or under registered graduate nurse (R.N.) supervision;
- is licensed by the agency responsible for regulating hospitals; and
- may not be a place of rest; a place primarily for treatment of tuberculosis, mental or emotional disorders; a place for the aged or substance abusers; or a place for custodial care.

In-Network Services: Those services given by a provider specially contracted with CIGNA HealthCare.

Injury: Bodily harm that results from an accident.

Maximum Allowed Amount: The maximum amount the Plan will pay an out-of-network health care professional for billed services. Members may have to pay any amounts not covered under their plan, including any difference over the Maximum Allowed Amount, to the out-of-network doctor or hospital.

Medical Emergency: A condition considered hazardous to the patient's life, health or physical well-being, including the sudden, unexpected onset of severe symptoms requiring urgent, immediate medical attention. To qualify as an emergency, care must be received within a reasonable amount of time after the onset and failure to receive immediate treatment might place the patient's life in jeopardy and/or cause serious impairment to bodily function. Some examples of medical emergencies are: threatened abortion, acute abdominal pain, airway obstruction, severe allergic reaction, severe asthma attack, coughing up blood, food poisoning, insulin reaction, loss of consciousness, asphyxia, convulsions, frostbite, hemophilia, hemorrhage, hysteria, uncontrolled nosebleed, poisoning or suspected poisoning, rape victim, sunstroke, uncontrolled vomiting.

A medical emergency does not exist because your doctor is not available or your doctor refers you to the emergency room.

Medically Necessary: Services and supplies that are determined to be no more than required to meet your essential health needs; consistent with the diagnosis of the condition for which they are required; consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; required for purposes other than comfort and convenience of the patient or his/her physician; rendered in the least intensive setting that is appropriate for the delivery of health care; and of demonstrated medical value.

Out-of-Network Services: Those services given by a provider not specially contracted with CIGNA HealthCare.

Out-of-Pocket Maximum: The maximum amount paid by the member, after which the Plan will pay 100% of the Maximum Allowed Amount up to any stated maximums in the Plan documents.

Physician: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Dentist (D.M.D. or D.D.S.), Psychologist (Ed.D., Psy.D. or Ph.D.), Podiatrist (Pod.D., D.S.C. or D.P.M.), Chiropractor (D.C.), Optometrist (O.D.), Pastoral Counselor, Social Worker (L.C.S.W. or M.S.W.), Licensed Mental Health Counselor (L.M.H.C.), Licensed Alcohol & Drug Counselor (L.A.D.C.), Licensed Marriage & Family Therapist (L.M.F.T.), Nurse Midwife, Medical Social Worker, Psychiatric-Mental Health Clinical Nurse, Advanced Registered Nurse Practitioner, Occupational Therapist, Physical Therapist, Speech Therapist, Audiologist, or Physician's Assistant. Each must be licensed or certified by the state in which services are rendered and act within the scope of such license.

Primary Care Physician: Doctor that is consulted for well visits, general care and routine illnesses; including Family Practice Physician, Pediatrician, Osteopath and Internist.

Routine Newborn, Nursery Care Charges: Care of newborn children including hospital nursery charges for room and board, miscellaneous nursery expenses, and pediatrician charges for attendance at a cesarean birth, a physical examination for the newborn child in the hospital and inpatient circumcision if performed at the time of birth.

Specialist: All other doctors, including, but not limited to, OB/GYN, Chiropractor, Cardiologist, Dermatologist, Ear/Nose/Throat, Allergist, Orthopedist and Surgeons.

Urgent Care Center: A facility that provides medical, surgical, hospital and related health care services and testing that are not Emergency Services, but that are determined by the Plan to have been necessary to treat a condition requiring prompt medical attention.

- An Urgent Care Center is a cost-effective alternative to a hospital Emergency Room. An Urgent Care Center should be used in the event of non-life threatening illness or injury when your PCP is not available (*i.e.* during non-office hours for a condition that requires care before it is possible to secure an appointment with your PCP) or if you become ill or injured when far enough away from home that it is not possible to secure a timely appointment with your PCP.

- Urgent Care Centers can treat a wide variety of conditions from suturing a laceration to treating a sprain or broken bone.

- If you are unsure whether you should be treated at an Urgent Care Center or the Emergency Room of a hospital, please contact CIGNA's Ask A Nurse 1-800-244-6224 (available 24 hours per day, 7 days per week).

FILING CLAIMS

You will not have to file a claim if you use the services of a network provider.

HOW TO FILE A MEDICAL CLAIM FOR SERVICES PROVIDED OUT-OF-NETWORK

If you use the services of an out-of-network provider (*e.g.* chiropractor or specialist), and if the health care professional is not filing the claim for you, you may submit a claim to CIGNA for reimbursement. **The claim must be submitted within 180 days of the date of service. Claims received more than 180 days after the date of service will not be covered under the Plan.**

Benefits will be determined according to Plan provisions. You should submit the charges even if you are not certain that the expense is covered, as they may count towards your deductible or annual out-of-pocket maximum.

A downloadable Medical Claim Form is available at www.cigna.com. An itemized bill must be included with the medical form showing the following information: member name, patient name, date of service, type of service/procedure code, charges for services; health care professional name address and Tax ID number, diagnosis code (ICD format). The Plan reserves the right to request other documents, such as medical records, before processing your claim.

NOTE: Incomplete information will cause a delay in processing your claim. Receipts, balance forward statements or canceled checks cannot be used in place of itemized bills.

Send the CIGNA Medical Claim form and itemized bill directly to:

CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223

When approved, claim payments are made directly to the provider of service unless you submit proof of payment with your claim.

For both in and out-of-network claims, you will be sent a worksheet showing how your benefits were calculated. This is called an "Explanation of Benefits" (EOB).

GENERAL PLAN EXCLUSIONS

The Open Access Plan does not cover expenses for the following:[1]

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war (declared or undeclared).
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
6. Assistance in the activities of daily living, included but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental or investigational or unproven services not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency.
8. Cosmetic surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptoms or psychosocial complaints related to one's appearance (i.e. not medically necessary).
9. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Accupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays (except for hi-tech radiology), examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered, provided a continuous course of dental treatment is started within 12 months of the accident. (Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.)
11. Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines is covered if the services are demonstrated to be safe and effective for the treatment of the condition. However, Gastric Bypass is covered if BMI is greater than 40 or if greater than 35 in the presence of diabetes.
12. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
13. Court-ordered hospitalization or treatment, unless sought by a Participating Physician.
14. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, Gamete intra-fallopian transfer (GIFT), Zygote intra-fallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation

[1] Certain expenses not covered by the Open Access Medical Plan may be covered under other parts of your health and welfare benefit plan, *e.g.*, dental, prescription, vision, hearing, health club etc.

or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

15. Reversal of male and female voluntary sterilization procedures.

16. Charges for sex change surgery.

17. Medical and hospital care and costs for the infant child of a Dependent (unless this infant child is otherwise eligible).

18. Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

19. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

20. Consumable medical supplies other than ostomy supplies and urinary catheters (excluded supplies include but are not limited to bandages, skin preparation, test strips, etc.).

21. Private hospital room and/or private duty nursing, except if ordered for infection control purposes.

22. Personal or comfort items such as personal care kits provided on admission to a hospital, telephone, television, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.

23. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, garter belts, corsets, dentures and food supplements.

24. Hearing aids after age 19 (any device that amplifies sound).

25. Aids or devices that assist with non-verbal communication.

26. Eye examination for the purpose of prescribing corrective lenses or the fitting or actual cost of corrective lenses; eyeglasses, lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).

27. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

28. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs and investigational and experimental drugs.

29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

30. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

31. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

32. Dental implants unless related to accident.

33. Blood administration for the purpose of general improvement in physical condition.

34. Cost of immunizations or medications for the purpose of travel or to protect against occupational hazards and risks.

35. Cosmetics, dietary supplements and health and beauty aids.

36. Nutritional supplements, except for infant formula necessary for the treatment of inborn errors of metabolism.

37. Expenses incurred for medical treatment by a person age 65 or older who is covered as a retiree when payment is denied by Medicare due to treatment not being rendered by a Medicare Provider.

38. Expenses incurred for medical treatment when payment is denied by Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.

39. Services for or in connection with an injury or illness arising out of, or in the course of any employment (past or present), or which is payable under any workers' compensation or occupational disease act or law;

40. Speech therapy is not covered when:

    a. used to improve speech skills that have not fully developed;
    b. considered custodial or educational;
    c. intended to maintain speech communication; or
    d. not restorative in nature.

41. Services not directly related to the diagnosis or treatment of an illness or injury.

42. Care, services and supplies not prescribed by a Physician and/or treatment not provided by a Physician.

43. Services performed by an individual who is not a Physician as defined under this Plan or by an institution which does not meet this Plan's definition of Hospital, Mental Health Facility or Substance Abuse Treatment Facility.

44. Services and supplies that are not considered medically necessary.

45. Charges that are more than the maximum reimbursable charges.

46. Services resulting from an attempt by you or your dependents to commit an unlawful act.

47. Room and board charges for any hospital day determined to not be medically necessary by CIGNA HealthCare as described in the Managed Care Section.

48. Services, medications or drugs for treatment of male or female sexual dysfunction.

49. Home care services provided by anyone who is not a certified home health care professional.

50. Equipment which has personal use in the absence of the condition for which is prescribed including, but not limited to, air conditioners, air purifiers, dehumidifiers, humidifiers, waterbeds, sunlamps and exercise equipment.

51. A child who is not a dependent as defined under this Plan.

52. Learning disorders, educational, academic or N.I.Q. testing.

53. Claims submitted more than one year after the expense is incurred.

54. Covered Medical Expenses after the Annual or Lifetime Maximum Benefit has been exhausted.

LIST OF PREVENTIVE CARE SERVICES WITH NO COST SHARING

INFANTS AND CHILDREN (BIRTH TO 18 YEARS)*

Screening for Newborns	• Hearing loss • Hypothyroidism • Sickle cell disease • Phenylketonuria (PKU) • Gonorrhea preventive medication for eyes of all newborns
Childhood/Adolescent Immunizations	• Diphtheria, Tetanus, Pertussis • Haemophilus influenzae type B • Hepatitis A and B • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Inactivated Poliovirus • Rotavirus • Varicella (chickenpox)
Childhood Screenings	• Medical history for all children throughout development • Height, weight and Body Mass Index (BMI) measurements • Developmental screening for children throughout childhood • Autism screening for children at 18 and 24 months • Behavioral assessment for children of all ages • Vision screening • Oral health risk assessment for young children • Hematocrit or Hemoglobin screening • Obesity screening and weight management counseling for children age 6 or older • Iron supplements for children 6 to 12 months who are at higher risk for anemia • Fluoride supplements for children without fluoride in their water • Lead screening for children at risk of exposure • Dyslipidemia screening for children at higher risk of lipid disorder • Tuberculin testing for children at higher risk of tuberculosis
Additional Screenings for Adolescents	• Depression screening • Alcohol and drug use assessment • Counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents • Cervical dysplasia screening for sexually active young women • HIV screening for adolescents at higher risk

Preventive care services are periodically reviewed and changed under Affordable Care Act guidelines.

ADULTS (19 YEARS AND OLDER)*

Health Screenings for Adults	• Blood pressure screening for all adults • Cholesterol screening for men age 35 and older, women age 45 and older, and younger adults at higher risk • Diabetes screening for type 2 diabetes for adults with high blood pressure • HIV and sexually transmitted infection (STI) screenings for adults at higher risk	
Cancer Screenings	• Breast cancer mammography every 1 to 2 years for women over age 40 • Breast cancer chemoprevention counseling for women at high risk for breast cancer • Breast cancer antigen (BRCA) risk assessment genetic testing for women • Cervical cancer pap test for women • Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy or colonoscopy from age 50 to 75 • Lung cancer screening (ages 55-80 with tobacco use history) • Prostate cancer (PSA) screening for men	
Health Counseling	Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed: • Healthy diet/Weight loss • Tobacco use • Alcohol misuse • Depression • Prevention of sexually transmitted infections (STIs) • Use of aspirin to prevent cardiovascular disease	
Adult Immunizations	• Hepatitis A and B • Herpes Zoster • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella	• Meningococcal • Pneumococcal (pneumonia) • Tetanus, Diphtheria, Pertussis • Varicella (chickenpox)
Screenings for Men	• Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked	
Screenings for Women	• Osteoporosis screening for women age 60 and older, depending on risk factors • Chlamydia infection screening for sexually active women age 24 and younger and other women at higher risk • Gonorrhea and syphilis screening for sexually active women at higher risk • BRCA counseling about genetic testing for women at higher risk	
Specifically for Pregnant Women	• Folic acid supplements for women who may become pregnant • Anemia screening for iron deficiency • Tobacco cessation counseling for all pregnant women who smoke • Syphilis screening for all pregnant women • Hepatitis B screening during the first prenatal visit • Rh incompatibility blood type testing at first prenatal visit and at 24-28 weeks • Bacteriuria urinary tract infection screening at 12 to 16 weeks • Breastfeeding education to promote breastfeeding	

Preventive care services are periodically reviewed and changed under Affordable Care Act guidelines.

VISION BENEFIT

Your health Plan includes a vision benefit. The benefit is administered in partnership with Davis Vision. The Plan provides coverage for routine eye examinations and corrective eyewear. When the benefit is used properly, members and dependents receive routine eye examinations and corrective eyewear at no cost.

SEPARATE FROM MEDICAL COVERAGE
You access your vision benefit using a Davis Vision ID card which you will receive upon gaining eligibility. You do not need to use your medical ID card for this benefit.

NETWORK PROVIDERS
Davis Vision has an extensive network of providers in New England and in other parts of the country. If there is not a Davis Vision provider available in your area (or that of a covered dependent), Davis Vision will locate a provider and assign temporary network status to accommodate you or your dependent. A New England regional Davis Vision Directory is included with your binder. You also may locate a provider by visiting www.davisvision.com.

OUT-OF-NETWORK PROVIDERS
If you choose to use a provider that is not part of the Davis Vision network, you will pay the provider in full for all services. You may then file an individual claim and receive up to a $45 reimbursement for the examination and up to a $55 reimbursement for eyewear. To qualify for reimbursement, the services must have been performed by licensed personnel.

Claim forms are available at www.davisvision.com or by calling Davis Vision at 1-800-999-5431. Claims may be mailed to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

When you use a Davis Vision provider, the provider will handle the claims process for you.

Vision Benefit Fast Facts:

- You must use a Davis Vision provider to receive your free examination and free eyewear.
- The benefit is available once every 24 months for adults and once every 12 months for children age 18 and under.
- You must have your examination and choose your eyewear at one visit through a single provider, whether in-network or out-of-network. Otherwise, your claim may be denied.
- Call Davis Vision's automated eligibility line at 1-800-999-5431. By entering your member information, you can confirm when you or your covered dependents are eligible for benefits. You also may speak with a customer service representative for further assistance.

You may receive a reminder from your provider that you are due for an eye examination every twelve months. Please be advised that after age 19, the Plan only allows one free examination every 24 months. ***Payment for any additional examinations is the responsibility of the member.***

USING YOUR BENEFIT

MAKING AN APPOINTMENT

When you contact a Davis Vision provider to make an appointment, inform the provider that your Plan is administered by Davis Vision and provide your Davis Vision ID number so that the provider can verify eligibility prior to your appointment. If you plan to purchase contact lenses, notify the provider at the time the appointment is scheduled so that time will be allowed for a contact lens examination. **Eyewear will not be covered by the plan if not selected at the time of the examination and from the same provider.**

SCHEDULE OF BENEFITS - Eyeglasses

Member/Dependent	Frequency	Cost to Member (Network Provider)
Routine Eye Examination		
Member and Spouse	Once/24 months	No charge
Adult Dependent (Ages 19-26)	Once/24 months	No charge
Dependent Child (under age 19)	Once/12 months	No charge
Eyeglasses – Davis Vision Collection		
Member and Spouse	Once/24 months	One Free pair (most lens options)
Adult Dependent (Ages 19-26)	Once/24 months	One free pair (most lens options)
Dependent Child (under age 19)	Once/12 months	One free pair (most lens options)
Frames from the Davis Vision Collection are included at no cost. If a frame is selected that is not part of the Davis Vision Collection, the Plan will allow $25 toward the cost of the frame and the member is responsible for the remaining cost. **Ultra Anti-Reflective Coating (ARC)** is an available option for a copay of $12.00 for the first pair of glasses only. Ultra ARC is not available for the second pair. **Ultra Progressive Lenses** are included for the first pair of glasses. If you wish to purchase this option on your second pair of glasses, there will be an $80.00 copay.		
Second Pair of Eyeglasses – Davis Vision Collection		
Member and spouse only	Once/24 months (Must be ordered in same visit as examination and free glasses)	$25 copay + discounted rates for lens options
Safety glasses – MEMBER ONLY	Once/24 months (May be ordered as 2nd pair of glasses in same visit as examination and free glasses)	$25 copay + discounted rates for lens options

CONTACT LENSES

You may purchase contact lenses in lieu of one pair of glasses. If you are purchasing contact lenses, you have a choice of two options:

"PLAN" CONTACT LENSES:

- Lenses that are manufactured by and/or distributed by Davis Vision.
- Standard, soft, daily-wear, disposable or planned replacement contact lenses are available.
- Exam/Evaluation, fitting and follow-up are included.
- If your Plan allows for two pairs of eyeglasses, there will be a $20.00 contact lens copay, if the contact lenses are in lieu of your second pair of eyeglasses.

NON-"PLAN" CONTACT LENSES:

- Lenses that are not manufactured by and/or distributed by Davis Vision.
- A $105 credit will be applied toward non-plan contact lenses. If a doctor fits a member for non-plan materials, the member can designate a portion of their contact lens allowance to pay for the contact lens evaluation so long as the remainder of the contact lens allowance pays for provider-supplied contact lenses. A member may not use the lens allowance amount for a provider examination and apply the remainder of the balance to use at another location or for online orders.

SCHEDULE OF BENEFITS – Contact Lenses

Member/Dependent	Frequency	Cost to Member (Network Provider/Davis Vision Contact Lenses)
Contact Lens Examination[1]		
Member and Spouse	Once/24 months	No charge
Adult Dependent (Ages 19-26)	Once/24 months	No charge
Dependent Child (under age 19)	Once/12 months	No charge
Contact Lenses – Part of Davis Vision Contact Lens Formulary		
Member and Spouse	Once/24 months	One free supply per eye [2]
Adult Dependent (Ages 19-26)	Once/24 months	One free supply per eye
Dependent Child (under age 19)	Once/12 months	One free supply per eye
Contact Lenses – Non-Formulary		
Member and all dependents	Same frequencies as above	Davis vision allows $105 for examination and initial supply of lenses from a participating provider; all other costs are the responsibility of the member

[1] Examination and fitting for contact lenses is separate from routine eye examination for eyeglasses
[2] Quantity varies by name brand; ask your provider for exact quantity included for the type of lenses prescribed. Costs for additional lenses are the responsibility of the member.

Your contact lens prescription is legally valid for one year from the date of the examination. When additional examinations are required, you or your dependent will be responsible for payment.

PLAN NOTES

Davis Vision Collection (Eyeglass frames)
The Davis Vision Collection is the frames that are included at no cost for your first pair of eyeglasses and at copay cost for your second pair when your Plan includes a second pair. Ask the provider to show you the Davis Vision Collection before selecting your frames. If you choose a frame that is not part of the Davis Vision Collection, the Plan will allow $25.00 toward the purchase of the frame and you will be responsible for the balance.

Second Pair of Eyeglasses
Member and spouse may choose a second pair of glasses (frame from the Davis Vision Collection) for a co-payment of $25.00, *e.g.*, dress, reading or prescription sunglasses. Optional frames, lens types or coatings are available for discounted fixed fees. A list of fees is included at the end of this tab. Please consult with your provider for additional options and fees.

Safety Glasses
A member may choose safety glasses as their second pair of glasses when the Plan includes a second pair. Safety glasses are subject to the $25.00 copay plus the cost of any lens options. **Safety glasses are available for the member only.**

Breakage Protection
All Plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. **The warranty does not apply to safety glasses, frames that are not chosen from the Davis Vision Collection or eyeglasses obtained from an out-of-network provider.**

Adult Dependent services (ages 19-26): After age 19 a covered dependent is eligible for one examination and one pair of glasses every 24 months. If the benefits were used when the dependent was age 18 or during the calendar year in which they became 19, the dependent will not be eligible again for 24 months.

Non-Prescription Lenses
The Plan does not cover eyeglasses when the eye examination indicates a prescription is not necessary, *e.g.*, non-prescription sunglasses, or cosmetic contact lenses when a prescription is not necessary, *e.g.*, eye color alteration.

MEDICAL EXAMINATION

If you or your covered dependent has a medical condition that requires a specific eye examination, *e.g.,* glaucoma, diabetes, the individual must seek services from a provider who is part of your medical plan network. However, if this provider conducts a routine eye examination as part of their services, that examination will not be covered by either your medical plan or this vision Plan. **You should tell your medical eye provider that a routine eye examination conducted as part of a medical visit will not be covered by your insurance and ask them not to perform that eye examination.**

FEES FOR OPTIONAL LENS ITEMS
SECOND PAIR OF GLASSES

A member and spouse may select a second pair of eyeglasses at the time of examination when covered by your Plan. If the second pair of eyeglasses is purchased at any other time or location, the benefit will not apply.

The second pair of eyeglasses requires a $25.00 copay plus lens option fees as listed below. Additional charges will apply if the second frame is not from the Davis Vision Collection.

Optional Item	First Pair	Second Pair
Blended Invisible Bifocal	Included	Dress-Included Safety-$20.00
Progressive Addition Multifocal Lenses *(gradual increase of lens power from top to bottom)*	Included	$80.00
Polycarbonate Lenses: thinner and lighter than regular plastic lenses; offer 100% UV protection and are impact-resistant	Included	$30.00
High Index Lenses: thinner, lighter lenses to accommodate stronger prescriptions	Included	$55.00
Scratch Resistant Coating	SV-Included MF-Included	SV-$15.00 MF-$25.00
Ultraviolet (UV) Coating	Included	$10.00
Anti-Reflective Coating	Included	$33.00
Polarized Lenses: reduce glare from reflective surfaces (i.e. water, metal, glass)	Included	Included
Photogray Extra® Glass Lenses	SV-Included MF-Included	SV-$15.00 MF-$25.00
Plastic Photosensitive Lenses	SV-Included MF-Included	SV-$50.00 MF-$60.00

(SV = Single Vision; MF = Multifocal)

DENTAL BENEFITS
DN6 PLAN

COVERED DENTAL EXPENSES

Allegiant Care does not have a network of contracted dentists. You may go to a dentist of your choice. A Fee Schedule of Covered Procedures is included at the end of this section. The Fee Schedule is updated each calendar year based on the average costs for claims submitted for care for our members. The amount on the Fee Schedule is the maximum amount that the Plan will pay to a provider for each dental code.

- ***Example 1:*** If the Fee Schedule amount indicates the Plan will pay $100 for a service and your provider bills $95.00, the Plan will pay $95.00 and you will owe nothing.

- ***Example 2:*** If the Fee Schedule amount indicates the Plan will pay $100 for a service and your provider bills $120.00; the plan will pay $100.00 and you will be responsible for the remaining $20.00.

Many dental conditions can be treated in more than one way. The Plan helps pay dental expenses, but not based on treatment that is more expensive than necessary. If a condition is being treated for which two or more services included on the list are suitable under customary dental practices, the benefit will be paid based on the listed service that would produce a professionally satisfactory result at the lowest cost.

If a dental service is performed that is not on the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, the listed service(s) that the Plan determines would produce a professionally satisfactory result will be used to determine the payment made to the provider.

Your Dental Plan covers “preventive and diagnostic services,” “basic services,” “major services” and “orthodontic services.”

Preventive Care Includes:

- Periodic oral exams - twice in any calendar year
- Emergency treatment for pain
- Routine cleaning and scaling - twice in any calendar year
- Topical fluoride application - twice in any calendar year, up to age 19
- X-rays
  - Bitewing series - one set each in any calendar year
  - Full mouth or panoramic series - one set each in any 36-month period
- Space maintainers (non-orthodontic) for Covered Dependents up to age 14
- Sealants - one per unrestored permanent molar and bicuspids per lifetime for Covered Dependents up to age 19
- Consultations
- X-rays of individual teeth - as necessary

Basic Care Includes:

- Fillings
- Routine extraction
- Oral surgery, including general anesthesia when medically necessary
  - surgical removal of erupted teeth or impacted or unerupted teeth
  - incision and drainage of abscess
  - alveolectomy
  - alveoplasty with ridge extension
- Periodontics - subgingival curettage or root planning and scaling; gingivectomy; osseous surgery with flap entry and closure
- Endodontics - pulp capping; root canal treatment; apicoectomy
- Stainless steel crowns for Covered Dependents up to age 12

Major Care Includes:

- Inlays
- Onlays
- Crowns
- Pontics
- Fixed or removable bridgework
- Full and partial dentures
- Denture repairs, adjustments, relines (including the addition of a tooth or teeth to an existing denture)
- Recement bridge
- Implant crowns

Orthodontic Care Includes:

- Comprehensive full-banded treatment
- Appliances for tooth guidance - one appliance per individual
- Retention appliances - one appliance per individual
- Benefits are payable at the time treatment begins. The full orthodontic benefit will be paid at the time of banding

SCHEDULE OF DENTAL BENEFITS

Preventive and Diagnostic Care	
Deductible	$0
Plan Pays	The Fee Schedule amount reflects 100% of average provider charges.
Calendar Year Maximum	Unlimited
ACA Pediatric Oral Care[1]	***Same benefit as adult care***
Basic Dental Care	
Deductible	$25 Individual/$50 family (including Basic and Major care); may be satisfied by any combination of covered family members.
Plan Pays	The Fee Schedule amount reflects 80% of average provider charges.
Calendar Year Maximum	Periodontics: $1,000 per individual
ACA Pediatric Oral Care	***Calendar year maximum for Periodontics does not apply***
Major Dental Care	
Deductible	$25 Individual/$50 family (including Basic and Major care); may be satisfied by any combination of covered family members.
Plan Pays	The Fee Schedule amount reflects 50% of average provider charges.
Calendar Year Maximum	Prosthodontics: $1,000 per individual
ACA Pediatric Oral Care	***Calendar year maximum for Prosthodontics does not apply***
Orthodontic Care	
Deductible	$0
Plan Pays	75% of total charges up to $1,500
Lifetime Maximum	$1,500 per Individual
ACA Medically Necessary Pediatric Orthodontic Care[2]	***If care is deemed medically necessary, the plan pays 50% with no maximum benefit.[3]***

***Important note*:** Members must be covered for a minimum of six consecutive months under the DN6 Plan to be eligible for Orthodontic Benefits.

[1] Pediatric Oral Care benefits are limited to dependents that are under the age of 18.
[2] Eligibility for Medically Necessary Orthodontia will be determined using the Handicapping Labio-Lingual Deviation Form.
[3] A dependent who is eligible for Medically Necessary Orthodontia alternatively can choose to use the non-pediatric Orthodontia benefit under which the Plan pays 75% up to a $1,500 lifetime maximum.

DN6 Benefit Restrictions	
Pre-Determination of Benefits	• Any non-emergency prosthodontic or periodontic treatment more than $250 should be submitted to Allegiant Care for pre-determination of benefits prior to services being rendered. • Submission of a pre-determination does not guarantee approval and is subject to eligibility status on the date of service.
Gold Restorations	• Gold restorations (fillings, inlays, onlays and crowns) are covered only if teeth cannot be restored with a less expensive filling material or of the tooth is an abutment to a covered partial denture or fixed bridge.
Missing Teeth	• Benefits will be provided for the replacement of teeth missing prior to the effective date of coverage.
Orthodontic Care	• Members must be covered for at least six consecutive months under the DN6 Plan to be eligible for DN6 Orthodontic Benefits.

PRE-TREATMENT ESTIMATE OF BENEFITS

Getting an estimate of benefits before getting treatment helps to avoid any misunderstanding between the patient, the dentist and the Plan. A pre-treatment estimate of benefits is not required but recommended for services costing more than $250. Here is how it works:

- Have your dentist complete a dental claim and describe what work needs to be done — the "treatment plan;"
- Include any other supporting x-rays or charts;
- Send the pretreatment estimate to Allegiant Care; and
- Allegiant Care tells you and your dentist the estimated amount the Plan will pay.

You should discuss the treatment plan with your dentist before work is started. If the dentist changes the treatment plan, a new estimate of benefits should be submitted as the amount of payment may change.

FILING CLAIMS

WHEN TO FILE A CLAIM

A dental charge is incurred for purposes of filing a claim:

- For an appliance or modification of an appliance — on the date the impression is taken
- For a crown, bridge or gold restoration — on the date the tooth is prepared
- For root canal therapy — on the date the pulp chamber is opened
- For orthodontic services — (initial) on the date teeth are banded or the device is placed in the oral cavity
- For implants — on the date of insertion
- For all other services — on the date the service is rendered

Note: Claims must be filed within one year of the date of service. After one year no benefits will be paid.

HOW TO FILE A CLAIM

- The dentist must submit x-rays for all major and adult orthodontic expenses.
- The dentist must mail the completed claim form to the Plan.

Note: Payment will be based upon the Dental Fee Schedule and Plan Limitations and Exclusions. You and your dentist will receive notification of payment amount or denial.

WHERE TO FILE A CLAIM

- Claims can be mailed to: Allegiant Care, PO Box 4604, Manchester, NH 03108-4604; or, for electronic submission, the dentist can use Payor ID # 38238 and Group # R40.

PRE-EXISTING DENTAL CONDITION LIMITATION

No benefits will be paid for any pre-existing dental condition except for replacement of missing teeth. A pre-existing dental condition is a treatment or service that was started prior to the effective date of coverage under the Plan. Pre-existing conditions also include:

- an appliance or an appliance modification if the impression was made before the patient was covered;
- a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; and
- root canal therapy if the pulp chamber was opened before the patient was covered under this Plan.

COORDINATION OF BENEFITS

All members must submit a Coordination of Benefits (COB) Form showing all covered dependents and all other insurance coverage. Failure to submit the COB Form may result in delay of claim payment. If additional insurance information is not disclosed and claims are paid incorrectly, the member will be responsible for reimbursing the Plan for those claims.

DENTAL BENEFITS AFTER COVERAGE ENDS

Coverage does not include services or supplies furnished after dental coverage ends even if an estimate of benefits has already been made; provided however, that benefits will be paid for the following procedures, but only if work is already in process when coverage ends and your dentist completes the service within 90 days of the end of coverage:

- an appliance or modification of an appliance
- a crown, bridge or gold restoration
- root canal therapy

DENTAL BENEFIT LIMITATIONS

Limitations to the Dental Plan include the following:

1. Periodic oral exams are covered twice in any calendar year.
2. Prophylaxis, routine or periodontal, is covered twice in any calendar year.
3. Topical application of fluoride is covered twice in any calendar year for Covered Dependents up to age 19.
4. Bitewing x-rays are covered once in any calendar year.
5. Full mouth x-rays and panoramic x-rays are each covered once in any 36-month period.
6. Space maintainers are covered for Covered Dependents up to age 14.
7. One sealant treatment per unrestored permanent molars and bicuspids are covered per lifetime for Covered Dependents up to age 19.
8. Replacement of an existing partial by a new partial or replacement of an existing full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth are covered only if the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable.
9. Periodontic services are limited to $1,000 per calendar year, prosthetic services are limited to another separate $1,000 per calendar year.
10. Multiple restorations (fillings) on one surface shall be considered a single procedure.
11. Crowns are covered once every five years and only if the tooth cannot be adequately restored with a filling material such as amalgam.
12. A full denture is covered in the same arch once every five years.
13. Denture relinings are covered once every three years; denture rebasings are covered once every five years.
14. Orthodontic appliances are covered to the lifetime maximum shown on your Schedule of Benefits.
15. Stainless steel crowns are covered for Covered Dependents up to age 12.
16. When scaling and root planing is done on a "per quadrant basis," each quadrant will be covered once in any 12 -month period.
17. Root canal therapy is limited to once per lifetime per tooth.
18. Mouth guards, night guards, occlusal guards, and athletic guards are covered once in a five-year period.
19. Implants are not a covered benefit of the plan.
20. Implant abutments are not a covered benefit of the plan.

Note: If an expense is covered under the Dental Plan **and** under another part of the Plan, the benefit paid under the dental portion of the Plan will be equal to the excess benefit not paid by any other of our Plans.

DENTAL BENEFIT EXCLUSIONS

In addition to the General Plan Exclusions, the Dental Plan does not cover expenses for the following:

1. Services or supplies not described as covered expenses in the Schedule of Dental Benefits.
2. Any charge incurred prior to the Plan member or dependent's effective date of coverage under this Plan.
3. Pre-existing dental conditions as defined herein.
4. Dental services for a child who is not a dependent as defined under this Plan.
5. Covered Dental Expenses after the Annual Maximum Benefit/Lifetime Maximum Benefit has been exhausted.
6. Any charge incurred after termination of coverage under this Plan (except as specifically provided herein).
7. Any charge for failure to keep a scheduled dentist appointment.
8. Any charge for completing claim forms.
9. Instruction supplies for dietary or nutritional counseling, oral hygiene or dental plaque control.
10. Services or supplies which are not necessary or do not meet accepted standards of dental practice (including experimental procedures).
11. Any duplicate dental service or appliance, including the replacement of lost, missing or stolen devices or appliances.
12. Orthodontic treatment while the person is not covered under this dental plan; orthodontic services incurred prior to being covered under the Dental Plan for at least six months.
13. Appliances or restoration, other than full dentures, used mainly to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion.
14. Diagnosis or treatment of temporomandibular joint (TMJ) dysfunction.
15. Care, services, supplies or treatment not prescribed or provided by a dentist (as defined herein) or dental hygienist under the supervision of a dentist (exception: in the State of Maine, a cleaning by a licensed hygienist will be covered).
16. Fluoride rinses or any "over-the-counter" drug which can be purchased without a prescription.
17. Emergency exam charges when done in conjunction with a procedure (except x-rays) on the same visit.
18. Personalization or characterization of teeth or dentures.
19. Prescription drugs, premedications and/or related analgesia.
20. Denture relining within three months of initial placement.
21. A crown not required for the restoration of a tooth.
22. Periodontal splinting.
23. Gold restorations when a less expensive restorative material can be used satisfactorily.
24. Services or supplies received from a hospital are considered medical rather than dental.
25. Periodontal scaling and root planing, when provided on the same day of treatment as a prophylaxis, will have benefit payment appropriately adjusted.
26. The same surface of a tooth restored during any 12-month period is not covered unless there are extenuating circumstances.

27. Periodontal postoperative consultations and evaluation.
28. Pulp vitality tests.
29. Temporary full or partial dentures, bridges and crowns.
30. Fixed bridges or removable cast partials for Covered Persons up to age 16.
31. Specialized techniques, including precision attachments, or overdentures.
32. Only the number of pontics needed to fill an area where abutment teeth have moved to partially close an endentulous area.
33. Additional abutments needed due to abnormal conditions.
34. Diagnostic models/photographs, except for orthodontic treatment.
35. Appliances, procedures or restoration to correct congenital or developmental malformations or dentistry for cosmetic purposes.
36. Replacement or repairs of space maintainers and orthodontic appliances.
37. Altering or restoring vertical dimension.
38. Equalibration/occlusal adjustments.
39. Indirect pulp caps.

PRESCRIPTION DRUG BENEFIT

The Plan includes a prescription drug benefit that is administered through Allegiant Rx, which is part of Allegiant Care, in partnership with Express Scripts® (ESI).

In administering the benefit, Allegiant Rx applies the limitations and guidelines for use and dosing established jointly by the United States Food and Drug Administration (FDA) and the drug manufacturers. Prescriptions that fall outside those limitations and guidelines will not be filled without a Prior Approval (PA). In addition, in some instances, drugs that have less expensive therapeutic equivalent alternatives may be subject to the PA process. The Plan also has dosing limitations for certain "lifestyle" medications such as those used for ED (erectile dysfunction). Always consult with the **Allegiant Rx Pharmacy Customer Service Center at 1-866-888-0103** if you have any questions concerning co-payment(s) or any limitations or restrictions that may apply to your medications.

COPAYS

The amount you pay to fill a prescription will depend on the type of drug, *i.e.* brand, generic or preventive, and where the prescription is filled, *i.e.* retail or mail order.

Drug Type (Retail Purchases)	Co-Payment per Prescription
Generic Drugs	$15.00
Brand Name Drugs *No generic substitution available*	$25.00
Brand Name Drugs *Generic substitution available*	$25.00 + difference between cost of brand name and generic substitution

Drug Type (Mail Order Purchases)	Co-Payment per Prescription
Generic Drugs	$15.00
Brand Name Drugs *No generic substitution available*	$25.00

GENERIC VS. BRAND

You will pay less for a generic prescription than for a brand name. Be sure to ask your doctor, whenever you get a new prescription, if the prescription is a generic. If not, ask if a therapeutically equivalent medication may be as effective and available in the generic form.

If you wish to fill a prescription for a brand name medication for which there is a generic available, you will not be able to fill the prescription at mail order and you must pay the initial $25 brand name copay plus the difference in cost between the generic medication and the brand name. In some instances, this could be a substantial cost.

PREVENTIVE MEDICATIONS

Contraceptives and certain types of medications are considered "preventive" and are covered without a copay. The list of preventive medications is established by the Federal government and may change over time. If you have any questions regarding these medications, please call the Allegiant Rx Customer Service Center.

RETAIL PURCHASES

Retail benefits are available at most major pharmacies, **except Wal-Mart, Sam's Club and Walgreens,** as well as most independent pharmacies**.** Please present your Allegiant Rx/ESI Pharmacy card and ask the pharmacist to confirm their participation before filling your prescription. You may also visit www.myAllegiantRx.com, sign in and click "locate a pharmacy."

You are limited on your retail purchase to a 30-day supply or 100 units, whichever is less.

Allegiant Rx Customer Service Center
1-866-888-0103

MAIL ORDER PURCHASES

All mail-order prescriptions will be processed through Allegiant Rx/ESI.

To best use your mail order option, please visit www.myAllegiantRx.com and create your own account. You may also complete and return the forms found in your Welcome Kit. Envelopes are provided for each form for your convenience.

Once you create an account, you will be able to fill and renew prescriptions, track delivery, update credit card information and receive renewal reminders (after signing in). If you do not have internet access, you may call **1 (866) 888-0103 to reach the Allegiant Rx Customer Service Center** for assistance. While you are not required to create an account to fill prescriptions at mail order, you are encouraged to do so.

ESI will dispense up to a 90-day supply of a drug, subject to the prescription written by your physician and to the Allegiant Rx limitations. Purchasing maintenance medications through mail-order will save you money.

Diabetic Supplies

Diabetic supplies are only covered through mail order. Have your doctor write a 90-day prescription with three refills and submit in the same manner as you would for your maintenance medications.

Please register online at www.myAllegiantRx.com

OUT-OF-POCKET MAXIMUM

Your prescription benefit has a separate out-of-pocket maximum. The out-of-pocket maximum is a cap that limits each year what members and families will pay for copays. If the maximum is reached for an individual and/or family, the Plan covers all prescription costs for the remainder of the year.

The maximums are as follows: $2,500 Individual/$5,000 Family

Please note: In calculating the maximums, only the initial $25 copay will count against the cap if a brand name drug is filled when a generic is available.

SPECIALTY DRUG PURCHASES

To provide certain specialty drugs that treat complex disease states, Allegiant Rx has partnered with Accredo. Specialty pharmacies such as Accredo cover a limited number of prescriptions that are indicated for certain medical conditions. Some examples of these conditions include Cancer, Hepatitis C, Cystic Fibrosis, Hemophilia, HIV/AIDS, Crohn's Disease and Multiple Sclerosis.

Accredo's team of patient service representatives, care coordinators, nurses and pharmacists maintain regular contact with patients to help best manage treatment. They specialize in patient education, administration and delivery of drugs, and they provide a comprehensive approach to managing specialty therapy for optimal use and patient safety.

Accredo will ship these medications directly to you. The copay for specialty drugs is $25. To process a specialty prescription, you must provide Accredo with a credit card or other payment information.

Please note that medications dispensed through Accredo are limited to a 30-day supply.

For more information on ordering your specialty medication
Please contact Allegiant Rx
1 (866) 888-0103

BIO-SIMILAR MEDICATIONS

Bio-similar medications are FDA approved drugs that are therapeutically equivalent to the original specialty drug. Bio-similars are the specialty drug equivalent of generic medications.

As new bio-similar drugs become available and a member wishes to fill their prescription with the original specialty drug, the member may be responsible for the brand copay plus the difference in cost between the original medication and the bio-similar.

LIFE INSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT

Life insurance provides financial protection to you or your family members in the event of your death or the death of a covered dependent. This benefit is provided at no additional cost to you and will be effective during the time in which you are an active member of the Plan.

LIFE INSURANCE BENEFIT AMOUNTS

Member Death Benefit	**$25,000**
Spouse Death Benefit	**$5,000**
Child Death Benefit[1]	**$2,500**
Accidental Death/ Dismemberment (Member only)	**$25,000**

NAMING YOUR BENEFICIARIES

Upon your initial enrollment in the Plan, you will be required to complete a Beneficiary Form to name a person or persons to receive the life insurance benefit in the event of your death. You may update your beneficiary selections at any time.

If you do not name a beneficiary, the life insurance would go to the next of kin in this order: Spouse; if no spouse, to the children; if no children, to the parents of the deceased; if none of the previous are living, to your estate.

In the event of the death of an eligible spouse or child, the member is the sole beneficiary. ***The Plan does not pay a death benefit for a former spouse even if the former spouse continues to be eligible under the Plan.***

FILING A CLAIM

- In the event of a member's death, the spouse, children or other family member must notify Allegiant Care. A completed claim form and a certified copy of the death certificate will be required to process the claim.
- In the event of the death of a covered dependent, the member must notify Allegiant Care. A completed claim form and a certified copy of the death certificate will be required to process the claim.

WHAT IS AD&D INSURANCE?

AD&D stands for "Accidental Death and Dismemberment Insurance." AD&D coverage is available **only for the active member**. AD&D provides a benefit to your beneficiary in addition to your life insurance benefit in the event of your accidental death. In this case, your beneficiary will be required to submit a certified copy of the death certificate listing the final cause of death, along with any accident report(s) that may be available.

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[1] A dependent child is eligible for a benefit either to 19 years of age or to 23 years of age if the child is a full-time student.

AD&D coverage also provides benefits directly to the member for serious injury as the result of an accident. Such injuries include:

Loss of . . .	Percent Paid
Both hands	100%
Both feet	100%
Sight in both eyes	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
One hand, one foot or sight in one eye	50%
Loss of speech or hearing in both ears	50%
Thumb and index finger of the same hand	25%

Seat Belt Benefit. If the member suffers accidental death such that an AD&D benefit is payable under the Plan and the accident causing death occurs while the member is operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seat belt or, the Plan will pay an additional benefit of $10,000.

Air Bag Benefit. If a Seat Belt Benefit is payable and if the member is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the Plan will pay an additional $10,000.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

EXCLUSIONS

The Plan does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at intentionally self-inflicted injury;

2. sickness, disease or infections of any kind, except bacterial infections;

3. travel or flight in or on (including getting in or out of, or on or off) any vehicle used for aerial navigation on a regular schedule between established airports, if the Insured Person is: a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or c. riding as a passenger in an aircraft owned, leased or operated by the member's employer;

4. declared or undeclared War, or any act of declared or undeclared War;

5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority; provide however, that loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.;

6. the member being under the influence of drugs or the intoxication of the member or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a Physician; or

7. the member's commission of or attempt to commit a crime.

LIFE INSURANCE AND AD&D BENEFIT REDUCTION

If a member is actively working beyond the age of 69, the Life Insurance and AD&D benefits are reduced as age increases.

On the date the member becomes . . .	Benefit is reduced to . . .
Age 70	$12,500
Age 75	$7,500

CONVERSION PRIVILEGE

MEMBER

The member may convert his or her Life Insurance under the Plan to an individual policy if such insurance, or any portion of it, ends, by applying to the Plan's Group Insurer within 31 days after such insurance ends and by paying the first premium. No Evidence of Insurability will be required if the member converts to an individual policy under this Conversion Privilege.

Entitled to Convert
The member is Entitled to Convert his or her Life Insurance only if:

1. the member ceases to be covered by the Plan;

2. the Plan terminates, provided the member has been covered under the Plan for at least five consecutive years immediately preceding such termination; or

3. the Plan is amended to terminate coverage for the group to which the member belongs, provided he or she has been covered under the Plan for at least five consecutive years immediately preceding such termination.

Amount of Converted Life Insurance
If the member's coverage terminates because he or she is no longer an eligible member of the Plan, the amount of Life Insurance that he or she will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Plan.

If the member's Life Insurance ends because the Plan is amended to terminate coverage for the group to which the member belongs, or if the Plan terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Plan at the time insurance ends, less any amount for which the member becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

DEPENDENT

An Eligible Dependent may convert his or her Dependent Life Insurance under the Plan to an individual policy if such person's insurance, or any portion of it, ends, by applying to the Plan's Group Insurer within 31 days after such insurance ends and by paying the first premium. No Evidence of Insurability will be required if the member converts to an individual policy under this Conversion Privilege.

Entitled to Convert
An Eligible Dependent is Entitled to Convert his or her Life Insurance only if:

1. the member ceases to be covered by the Plan;

2. the member dies;

3. the person ceases to qualify for coverage as an Eligible Dependent, as defined in the Plan;

4. the Plan terminates, provided the Eligible Dependent has been covered under the Plan for at least five consecutive years immediately preceding such termination; or

5. the Plan is amended to terminate coverage for the group to which the Dependent belongs, provided he or she has been covered under the Plan for at least five consecutive years immediately preceding such termination.

Amount of Converted Life Insurance
If the Eligible Dependent ceases to be eligible for insurance under the Plan, the amount of Life Insurance he or she will be Entitled to Convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Eligible Dependent's Life Insurance ends because the Plan is amended to terminate coverage for the group to which the Dependent belongs, or if the Plan terminates, the amount of Life Insurance the Dependent will be Entitled to Convert will be the lesser of: (a) the amount of Life Insurance in force under the Plan at the time his or her insurance ends, less any amount for which he or she becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

LEGAL DEFENSE BENEFIT

The Benefit

The Plan will pay a covered member's legal fees for the following matters arising directly from a "duty related incident" as defined below.

- Defense of criminal charges, including all hearings or appearances before any court of Federal, State or local government, in which the covered member is the defendant.
- Advice, consultation and preparation for a grand jury investigation hearing involving a covered member.
- Defense of all civil lawsuits.
- Defense of administrative proceedings arising from incidents involving a member of the public.

Definitions

"Duty Related Incident" means an actual or alleged act or omission of the covered member that occurs, while coverage is in effect and while the covered member is acting within the scope of his or her authority as a law enforcement officer for which criminal charges or civil or administrative actions are brought against the covered member. A duty related incident can occur on or off duty.

"Legal Action" means a lawsuit, proceeding, criminal charge(s) or other legal or administrative action resulting from a duty related incident.

"Legal Fees" means the amount charged the covered member for legal services by an attorney, not to exceed the reasonable, usual and customary fee charged by attorneys for a given service in the area where the service is rendered.

"Notice" means a written report of a duty related incident or a legal action made to the Plan. A notice must include sufficient information to identify the covered member and the time, place and circumstances of the duty related incident and the nature of the legal action.

"Covered Member" means a member who is employed as a police officer, sheriff, deputy sheriff, corrections officer, dispatcher or such additional law enforcement employee classifications as determined, in writing, by the Plan.

"Participating Attorney" means a lawyer associated with and/or employed by Regan Associates, Chartered.

"Reimbursable Costs" means filing fees, court costs and transcripts.

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Exclusions

There are no benefits for:

- Acts or omissions that are not duty related.
- The cost of bail bonds, appeal bonds or other bonds.
- The payment of judgments, awards, settlements, fines or penalties of any kind.
- Any duty related incident occurring prior to the effective date of the covered member's eligibility.
- Any duty related incident for which representation is provided by a motor vehicle liability insurance policy.
- Defense of administrative proceedings based on intentional breaches of the rules and regulations of the covered member's employer.
- Any legal action or dispute between a covered member and his or her fellow employees whether law enforcement officers or other governmental employees.

Limitations

Legal fees are fully paid when using a participating attorney. If the covered member uses an attorney who is not a participating attorney, the Plan pays the covered member's legal fees up to the amounts shown in the "Non-Participating Attorney Indemnity Schedule."

With respect to Plan benefits for defense of civil actions, the Plan covers the fees of only one attorney to represent all covered members when covered members are co-defendants with their employer, assuming that the employer has a duty to provide defense and assuming further that there is no substantial legal conflict in the positions of the covered members.

Conditions

When a covered member becomes aware of a duty related incident or a legal action, a report must be given by or for the covered member to the Plan as soon as practicable. Only duty related incidents or legal actions reported to the Plan while coverage is in effect are covered by the Plan.

Covered members have access to a twenty-four (24) hour emergency hotline for assistance for duty related incidents involving the arrest of a covered member or on-duty shootings by the covered member (1-800-322-ATTY).

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Schedule of Benefits

Participating Attorney: Paid in Full

BENEFIT	MAXIMUM BENEFIT
Defense Of Criminal Charges	Paid in full
Advice, Consultation & Preparation For Grand Jury Hearings	Paid in full
Defense Of Civil Lawsuits	Paid in full
Defense Of Employment Disciplinary Proceedings Involving "Official Misconduct" And Not Non-Duty Related Personnel Matters	Paid in full

Reimbursable costs are paid in full. However, the limitation for investigative fees in connection with the above covered matters is $1,000, and the limitation for expert witness fees is $3,500.

Non-Participating Attorneys: Indemnity Schedule

Benefit	Maximum Benefit
Defense Of Criminal Charges • Pleading And Preparation Prior To Trial • Up To $800 Per Day Of Trial	 $10,000 $10,000
Advice, Consultation & Preparation For Grand Jury Hearings	$3,000
Defense Of Civil Lawsuits • Pleading And Preparation Prior To Trial • Up to $800 Per Day Of Trial	 $10,000 $10,000
Defense Of Employment Disciplinary Proceedings Involving "Official Misconduct" And Not Non-Duty Related Personnel Matters	$10,000

In addition to the amounts shown above, reimbursable costs, investigative fees and expert witness fees are covered up to a total of $1,000 combined.

The fees for non-participating attorneys are payable at the rate of $85.00 per hour.

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Plan Period –Territory

The coverage provided by the Plan applies to any legal action brought within the United States of America.

Choice of Counsel

The covered member has the free and unrestricted right to employ an attorney of his or her choice. The Plan has no obligation to recommend counsel and is not a guarantor in any manner of the skill of counsel chosen by the covered member, even if the attorney is a participating attorney.

Relations of the Parties

Attorneys engaged to perform legal services for covered members under the terms of the Plan are not agents or employees of the Plan. An attorney rendering legal services to covered members under this agreement maintains the attorney-client relationship solely with the covered member. The attorney is solely responsible to the covered member for all legal services provided pursuant to this agreement. The Plan will not interfere with or control the performance of the attorney. Information from legal records of covered members and information received by the attorney incidental to the attorney-client relationship is to be kept confidential and, except for the use incidental to the administration of this Plan, will not be disclosed without the consent of the covered member.

Assignment

A covered member's interest under the Plan is not assignable or alienable. The Plan may use amounts payable under the Plan to make direct payments to attorneys who provide covered services to covered members. No amount payable under the Plan at any time is subject in any manner to alienation by assignment of any kind. Any attempt to assign any amount payable under the Plan, whether currently payable or payable in the future is void.

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HEARING REIMBURSEMENT

Your medical plan covers hearing tests and hearing aids for dependents through age 18. For members and dependents age 19 and over, hearing coverage under your medical plan is limited to screenings administered as part of annual well visits/physicals. Because of the importance of hearing health, Allegiant Care provides the following benefit to all eligible members and adult dependents.

Qualifying Members	• Members and covered dependents over age 19
Benefit Coverage	• Hearing evaluations • Purchase of hearing aids • Member may use any provider; there is no In-Network or Out-of-Network designation; however, members can save if they use the EPIC Hearing Health Care network (see below)
Benefit Limitations	• Benefit is 75% of the total out-of-pocket cost with a maximum reimbursement of $1,500.00 (which may include the cost of more than one hearing device) • Benefit is payable once every 5 years
Filing Claims Not Processed Through EPIC	• **MEMBER PAYS PROVIDER** • Submit claim form, itemized invoice and receipt/proof of payment to Allegiant Care, Attn: Hearing Claims • Invoice must include: patient name, date(s) of service, type of service, provider's name/address, itemized charges • Member will be reimbursed as stated above
Further Information	• If you have questions or need further information concerning hearing benefits, contact Allegiant Care at 1-800-258-9732

Please contact Allegiant Care for claim forms (1-800-258-9732)

Partnership with Epic Hearing

Allegiant Care partners with EPIC Hearing Health Care to provide savings for members who use EPIC's nationwide network of hearing aid providers. **You are not required to use EPIC and its providers.** However, if you use EPIC, you can save between 30% and 60% on name-brand hearing aids and products.

If you wish to utilize an EPIC provider, you must contact EPIC prior to making any appointments.

Follow these easy steps:

- Call EPIC and identify yourself as a covered member of Allegiant Care. A counselor will register you and assist in determining your hearing care needs. The counselor will coordinate a referral to a provider located near you.
- Contact the designated provider for an appointment and follow through with an examination and treatment.
- EPIC will pay the provider for the services you receive; will invoice Allegiant Care up to the amount of your available benefit; and will invoice you for any provider charges greater than the amount of your benefit.

Note: Hearing aids purchased through an EPIC provider have a 45-day trial period. At the completion of the trial period, EPIC extends the warranty on the hearing aid to three years and provides a complementary 1-year supply of batteries.

EPIC Hearing Health Care (1-866-956-5400)

HEALTH CLUB REIMBURSEMENT

Qualifying Members	• Members and covered spouses
Benefit Coverage	• $100.00 reimbursement payable after every 6-month period
Benefit Limitations	• Must have been a covered participant during all the 6-month period for which reimbursement is requested • Must have engaged in physical activity an average of three times per week during the 6-month period
Filing Claims	• **MEMBER PAYS HEALTH CLUB/GYM MEMBERSHP** • Submit claim form to Allegiant Care, Attn: Health Club Claims • Form must be signed by a representative of the facility and an attendance log indicating dates of visits must be included with the form • Submission of a claim form without an attendance log may result in a delay in reimbursement or a denial of the claim • Claims must be submitted within one year after the end of the applicable 6-month period
Further Information	• If you have questions or need further information, please contact us at the telephone number shown below.

Please contact Allegiant Care for claim forms (1-800-258-9732)

MASSAGE REIMBURSEMENT

Qualifying Members	• Members and covered spouses
Benefit	• Up to $30.00 per massage
Benefit Limitations	• $1,000 per calendar year per eligible member or spouse
Filing Claims	• **MEMBER PAYS LICENSED MASSAGE THERAPIST** • Submit claim form to Allegiant Care, Attn: Massage Claims • Complete and sign form and include the date(s) of service(s) and a receipt(s) from the provider or facility for the service(s) for which reimbursement is being requested • Have the form signed by the licensed massage therapist providing the service(s) • NOTE: Allegiant Care reserves the right to review the licensing credentials of massage therapist and dates of service • Claims must be submitted within one year from the date of service
Further Information	• If you have questions or need further information, please contact us at the telephone number shown below.

Please contact Allegiant Care for claim forms (1-800-258-9732)