

# State of Illinois Employee Health Care Plan Summary Plan Description

Plan Number 160000  
State of Illinois Health Plan Members

July 1, 2011  
OPEN ACCESS III SPD

HealthLink<sup>®</sup>  
— A WELLPOINT COMPANY —



## TABLE OF CONTENTS

<b>SUBJECT</b>	<b>PAGE</b>
Introduction.....	2
Eligibility, Enrollment & Effective Date.....	4
Benefits – General.....	4
Summary of Benefits .....	11
Covered Medical Expenses.....	12
Exclusions and Limitations.....	18
Continuation of Coverage.....	24
Qualified Medical Child Support Orders (QMCSO).....	24
Coordination of Benefits.....	24
Claim Procedures .....	27
Complaints and Appeals .....	27
Subrogation/Third Party Liability.....	29
Termination of Coverage .....	31
Miscellaneous Provisions.....	31
Definitions.....	33
Notice of HIPAA Privacy Practices.....	40
General Plan Information.....	44

## INTRODUCTION

You have chosen to be covered under the State of Illinois Health Benefits Plan. The State of Illinois has a contractual arrangement with HealthLink, Inc. and its subsidiary, HealthLink HMO, Inc., the Claims Administrator, to access two Provider contracted networks, to provide Medical Management services and to provide claims administration. (HealthLink does not require selection of a primary care physician. However, you are required to designate a primary care physician on the State of Illinois eligibility website when enrolling with HealthLink.) Referrals are not required prior to obtaining services from specialty physicians. You do not have to choose to be in Tier I (HMO) or Tier II (PPO). You are free to seek services from physicians, facilities or other health care providers at any time. Your benefits for each service are determined by whether the service provider falls within your Tier I (HMO), Tier II (PPO) or Tier III (out of network) level. You will realize your highest level of benefits when seeking services from a Tier I (HMO) service provider. Please be advised when utilizing a Tier III (out of network) provider, charges will be subject to usual and customary amounts.

This booklet is a Summary Plan Description (SPD) of the benefits available to you and your dependents. If your particular circumstances are not described, you may contact HealthLink, Inc. Customer Service toll-free at 1-800-624-2356 for:

Benefit Inquiries	Claim Inquiries
Provider Participation Status	Replacement ID Cards
Directory Requests	Inquiries on Medical Bills Received

The Medical Management department can be reached toll-free at 1-877-284-0102 with inquiries regarding pre-certification authorization. A complete list of services requiring pre-certification authorization is located at [www.healthlink.com](http://www.healthlink.com). To access the list, select the "Providers" tab and then "Utilization Management". For inquiries about Behavioral Health services, please telephone 877-284-0102 and select Option 3 for Behavioral Health. Services requiring pre-certification authorization include:

- All Inpatient Admissions
- Partial hospitalizations and Intensive Outpatient Treatment for Behavioral Health Services (mental and substance abuse)
- Selected Outpatient/Ambulatory Services and Diagnostic Imaging (Ambulatory)
- Selected Ancillary Services
- Selected Durable Medical Equipment
- Specialty Infusion Drugs (see list on the HealthLink website)

Medical benefits for State of Illinois enrolled individuals are provided through an Open Access III Plan, administered by HealthLink HMO, Inc., the Claims Administrator. With the Open Access III Plan, you have three choices each time you seek medical care:

- The highest level of benefit is provided for covered services when you receive care from a HealthLink HMO contracted network Provider (Tier I benefits or HMO benefits).
- If you receive care from a Provider in the HealthLink PPO contracted Provider network, you will pay a deductible and a percentage of the covered expenses for many types of care (Tier II benefits or PPO benefits).
- You may also receive care from an out-of-network Provider, but you will pay a higher deductible and a greater share of the covered expenses (Tier III benefits or out-of-network benefits).

When you enroll in the Plan, you can request a customized HealthLink Provider directory, based on a mile radius around a specified zip code or a specific county, that lists contracted Tier I (HMO) and Tier II (PPO) network Providers. Keep in mind that a Provider may be included in the Tier I (HMO) list but not in the Tier II (PPO) list, or vice versa.

You and your dependents will be provided a HealthLink Open Access III identification (ID) card which will identify you as a HealthLink Open Access Enrollee, eligible to receive services in accordance with this Plan.

Be sure to show your HealthLink Open Access III ID card at the time of service. If you must cancel an appointment, please call the doctor's office in advance. If you do not, the Provider may charge you a cancellation fee which is not covered under this benefit Plan.

HealthLink Tier I (HMO) and Tier II (PPO) contracted physicians/hospitals will file claims directly with HealthLink for covered services. A contracted Provider may bill you directly for a customary billed charge for services that were not covered under the Plan.

The State of Illinois has the sole discretionary authority to interpret the Plan and to determine all questions arising in the administration, interpretation and application of the Plan. The State of Illinois may delegate part of its authority and duties as it deems necessary and desirable.

# WELCOME TO THE STATE OF ILLINOIS OPEN ACCESS III PLAN UTILIZING THE HEALTHLINK CONTRACTED NETWORKS

## Section I – Eligibility – Enrollment – Effective Date

- A. Eligibility** – Individuals must meet the Illinois Department of Central Management Services requirements for eligibility and changing coverage. For more information, contact your Insurance Representative or the Illinois Department of Central Management Services to determine whether or not you or your dependents are eligible for coverage.

## Section II – Benefits – General

- A. HMO Benefits** – To receive the Tier I (HMO) level of benefit, the service must be performed by a Tier I (HMO) contracted physician or any other HealthLink Tier I (HMO) contracted network specialist, contracted hospital, or other contracted service Provider, unless otherwise expressly stated in this booklet. You may self-refer for treatment provided by a Tier I HealthLink HMO contracted Provider and/or specialist without obtaining a referral. The HMO benefit is the highest level of benefits in the Open Access III Plan.

There is no deductible for Tier I (HMO) services. The Plan pays 100% of the allowable covered expenses. Refer to the Summary of Benefits (page 11) for more information.

The co-pay is the fixed dollar amount you pay for Tier I (HMO) physician office visits, emergency room use and certain other services. Refer to page 11 for more information.

- B. Tier II (PPO) and Tier III (Out-of-Network) Benefits** – If you choose to receive care from a contracted HealthLink Tier II (PPO) Provider and/or an out-of-network Provider, you must pay a deductible. The deductible is the amount you pay each Plan year in covered expenses before the Plan begins to pay benefits. After the deductible is satisfied, the Plan pays its coinsurance: 90% for Tier II HealthLink PPO contracted Providers and 80% for Tier III out-of-network Providers. The Enrollee is responsible for 10% coinsurance on covered services provided by a Tier II HealthLink PPO contracted Provider and 20% coinsurance on covered services provided by an out-of-network Tier III Provider.

For Tier II HealthLink PPO contracted Providers, the Plan's coinsurance rate is applied to the contracted charge between HealthLink and the contracted Provider. For out-of-network Tier III Providers, the Plan's coinsurance rate is applied to the Usual and Customary (U&C) charges. These are determined by charges for health care that are consistent with the average charge for identical or similar services in a certain geographic area. The out-of-network Provider is any Provider or facility that does not have a contractual agreement with HealthLink. If your out-of-network Provider charges more than the Usual and Customary amount, you must pay the excess amount in addition to your deductible and a percentage of the covered expenses. Once you have reached the out-of-pocket maximum shown in the Summary of Benefits, the Plan will pay 100% of most covered expenses for the rest of the Plan year.

- C. Co-pay** – Your co-pay is the fixed amount you pay for Tier I (HMO) physician office visits, physician specialist office visits, emergency room and certain other services. Most Providers expect to collect the co-pay at the time the services are provided. Co-pays are listed in the Summary of Benefits.
- D. Deductible** – The deductible is the amount you must pay each Plan year in covered expenses before the Plan begins to pay benefits. **Deductibles apply separately to the covered expenses incurred by each person during one Plan year.** Deductibles are listed in the Summary of Benefits. (Tier II (PPO) and Tier III (out-of-network) deductible maximums cross-accumulate.)
- E. Annual Out-of-Pocket Maximum** – For care provided by a HealthLink Tier II (PPO) contracted or out-of-network Tier III (out of network) Provider, you pay a percentage of the covered expenses, called coinsurance, after the deductible. The out-of-pocket maximum limits the amount you could pay for covered medical expenses incurred during one Plan year. Once your coinsurance share of covered medical expenses for one person reaches the individual out-of-pocket maximum in one Plan year, excluding the deductible, the Plan will pay 100% of covered expenses incurred by that person for the remainder of the year. The family out-of-pocket maximum is the sum of all coinsurance amounts paid for all family members per Plan year. After the family out-of-pocket maximum is met, the Plan will pay 100% of covered expenses incurred by any family member for the rest of the year. (Tier II (PPO) and Tier III (out-of-network) out-of-pocket maximums cross-accumulate.)

The out-of-pocket maximum includes only the percentage share of covered expenses you pay (coinsurance). It does not include:

1. Deductibles;
2. Co-pays for all services;
3. Any amounts above Plan maximums;
4. Any amounts above Usual and Customary (U&C) charges (out-of-network only);
5. Medical expenses not covered by the Plan;
6. Penalty for non-pre-certification for out-of-network Providers;

The Summary of Benefits shows annual out-of-pocket maximums for Tier II (PPO) contracted and Tier III (out-of-network) benefits.

- F. Medical Management** – An important feature of the Plan is the Medical Management program. The Medical Management program does not restrict you or your covered dependents from obtaining necessary medical care; nor does it interfere with emergency situations. It is intended to help you and your covered dependents become better, more informed consumers of health care and to assist you and your covered dependents in obtaining medically necessary care under the circumstances. Medical Management is not the practice of medicine or a substitute for the judgment of your physician. If a particular course of treatment or medical service is not certified, it means that this Plan will not consider that course of treatment as appropriate for maximum reimbursement or benefits under the Plan.

**Note: Failure to obtain pre-certification from HealthLink for out-of-network Providers will result in a reduction in benefits of \$500 per hospital confinement or course of treatment or therapy.**

1. Regardless of the Provider chosen, the Plan requires advance notice and pre-certification authorization of all planned inpatient hospital admissions and some outpatient services. If a contracted physician is supervising care for you or your covered dependent, in most instances he or she will call, on your behalf, our Medical Management department to request pre-certification. It is your responsibility to make sure that out-of-network providers follow this procedure; however, if you utilize a HealthLink contracted network Provider, it would be his or her responsibility to make sure any certifications are handled by his or her office prior to the care being rendered. Remember, if you do not pre-certify care received from out-of-network Providers, benefits may not apply to the charges.
2. The Medical Management program includes:
  - a. Pre-certification of the medical necessity of non-emergency hospital admission before needed services are rendered;
  - b. Partial hospitalization and Intensive Outpatient Treatment;
  - c. Retrospective review of the medical necessity of the listed services provided on an emergency basis;
  - d. Concurrent hospital stay review for medical necessity; and
  - e. Pre-certification of the medical necessity for certain outpatient/ambulatory services and selected ancillary services.
  - f. A certification decision made within 2 business days of receipt of the medical necessity information.

If a request for medical necessity review does not meet the criteria for certification, a physician reviewer will review the request and make a recommendation. If the care does not meet medical necessity criteria, a notice will be issued stating adverse medical necessity recommendation. It will explain if any internal guidelines, policies or clinical review criteria were used to make the determination. Upon request, you may receive a free copy of this information and an explanation of the clinical rationale for the decision; and

You have the right to appeal. See Section IX *Complaints and Appeals* for detailed information regarding the process.

3. Please contact our Medical Management department for prior authorization or pre-certification.

**G. Emergency Services** – Emergency services are covered no matter where you receive care. When you need medical care immediately, first try to contact your primary care physician and follow the physician's advice. If this is not possible and you have a medical emergency, immediately seek emergency services from the nearest hospital emergency room or urgent care center. Contact your physician the next business day to coordinate any follow-up care.

An emergency service includes health care items and services furnished or required to screen and stabilize a medical emergency.

Medical emergency is defined as the sudden, unexpected onset of a health condition with symptoms so severe that a prudent layperson, possessing an average knowledge of health and medicine, would believe that immediate medical care is required. Examples include, but are not limited to:

1. Placing the person's health in significant jeopardy;
2. Serious impairment to a bodily function;
3. Serious dysfunction of any bodily organ or part;
4. Inadequately controlled pain;
5. With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

For emergency services, your covered expenses are reimbursed if your care is provided at a contracted network or out-of-network facility. You are responsible for the ER co-payment under all levels of care. However, this co-payment is waived if you are admitted as an inpatient and you remain in the hospital for more than twenty-three (23) hours. All emergency conditions as outlined above are paid at the Tier I (HMO) level of benefits, regardless of where the care is received or who provides the care. This also includes ambulance Providers. The benefit tier applicable to the contracted hospital at which emergency room services are provided will apply to the services provided by contracted hospital-based Providers at that hospital.

If you are admitted to an out-of-network hospital as a result of an emergency, you, a family member or hospital staff personnel must call HealthLink's Medical Management department toll-free at 1-877-284-0102 within the next business day.

**Note: Urgent care facilities billed with Revenue Code 456 (which is an urgent care facility charge and not an emergency room charge) will be subject to the office co-pay instead of the ER co-pay.**

- H. Preventive Care** – 100% benefit for recommended preventive services provided in-network; as defined by federal law, under the Wellness Benefit the Plan will pay 100% of the cost of certain services provided by a HealthLink network physician or other HealthLink Provider if the services are preventive services recommended under guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (the Guidelines). The 100% benefit will include routine physical exams, some routine screening tests, immunizations and counseling to promote health and prevent health problems, as prescribed in the Guidelines. When provided by a network Provider, all preventive services recommended by the Guidelines will be paid by the Plan without deductibles, co-pays or coinsurance.

**These services are covered only when rendered by a Tier I (HMO) or Tier II (PPO) contracted physician, hospital or other health care professional.**

**Note: Preventive care benefits can be provided only for charges your contracted physician identifies as routine. Services for which a diagnosis is provided or symptom indicated will be paid in accordance with regular Plan benefits.**

- I. Behavioral Health Services** – This is a covered benefit both in- and out-of-network. You may go to any Provider you choose and receive psychiatric services, and alcohol and substance abuse care.

**Note: Pre-certification authorization is required for all inpatient, partial hospital admissions and Intensive Outpatient (IOP) programs. (2 partial hospitalizations sessions equal 1 day of inpatient care) whether rendered by a contracted or out-of-network provider.**

Authorization for Services – Calling the Behavioral Health Department toll free at 1-877-284-0102, Option 3, begins the authorization process for services outlined above to avoid penalties for non-authorization of benefits. In an emergency or a life threatening situation, call 911 or go to the nearest hospital emergency room. You must call the Behavioral Health Department within 48 hours to avoid a potential penalty. A licensed Behavioral Health professional will conduct a review to determine whether treatment meets medical necessity criteria and appropriateness of care. If treatment is authorized, services are eligible for benefit coverage. Services determined not medically necessary will not be eligible for coverage.

1. Inpatient services must be authorized prior to admission or within 48 hours of an emergency admission. Authorization is required with each new admission.
2. Partial hospitalization and intensive outpatient treatment must be authorized prior to admission.

**Note: All of the above services require authorization or a \$500 penalty or denial of services may be incurred for out-of-network providers.**

Outpatient Care for Behavioral Health Services – Treatment received as an outpatient or in a doctor's office will be treated the same as any other illness and considered a specialist co-pay.

Inpatient Care for Behavioral Health (Psychiatric Services) – The Plan will pay benefits as it does for any other Inpatient care.

Inpatient Care for Behavioral Health (Alcohol/Substance Abuse) – The Plan will pay benefits as it does for any other Inpatient care.

- J. Maternity Care** – Maternity services provided by Tier I (HMO) contracted Providers have a co-pay of \$50 once per pregnancy plus an inpatient admission co-pay of Tier I \$275, Tier II \$325 or Tier III \$425. All services provided by Tier II (PPO) contracted Providers and out-of-network Providers are subject to deductible and coinsurance, as well as Tier II and Tier III inpatient admission co-pays. Only one co-pay is applicable for both mother and newborn (well baby care). If a female is pregnant when she becomes a Participant in this Plan, coverage is effective upon enrollment. Newly enrolled Members who are in the third trimester of pregnancy will be allowed continuity of care provided by their current obstetrician. Pre-certification of maternity care is not required.

HealthLink conducts concurrent medical necessity review if the Enrollee is hospitalized more than 3 days for vaginal delivery or more than 5 days for cesarean section delivery. If a non-contracted Provider or facility is rendering the services, HealthLink's Medical Management department will notify Network Management for a possible negotiation of the non-contracted Provider or facilities fees. Call HealthLink's Customer Service department for additional information.

**Note: Under the Newborns and Mothers Health Protection Act of 1996, hospital stays may not be limited to less than 48 hours for vaginal deliveries and not less than 96 hours for a cesarean section, except under special circumstances.**

**K. Routine Vision Benefits** – Not provided through the HealthLink Open Access Program.

**L. Chiropractic/Spinal Manipulation** – Coverage for this benefit has a \$20 co-pay at Tier I, benefits at 90% after the deductible for Tier II, and 80% after the deductible for Tier III. There is a 25-visit limit regardless of tier levels accessed.

**M. Hearing Services** – Coverage for diagnostic hearing exams performed by a network audiologist are covered up to \$150 and hearing aids are covered up to \$600 every 3 Plan years.

**N. Infertility Benefits** – Benefits are provided for the diagnosis and treatment of infertility. Infertility is defined as the inability to conceive after one consecutive year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Diagnosis and treatment of infertility are provided after documentation is received from the physician that includes the patient's reproductive history with test results, information pertaining to conservative attempts to achieve pregnancy, and the proposed plan of treatment with CPT codes. **This information must be received prior to beginning infertility treatment to ensure maximum benefits.**

Benefit coverage is provided only if the Plan Participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this Plan. (See page 36 under definition of Infertility.) Coverage for assisted reproductive procedures includes, but is not limited to:

1. Artificial Insemination (In-Vivo), In-Vitro Fertilization (IVF) and similar procedures which include but are not limited to: Gamete Intrafallopian Tube Transfer (GIFT), Low Tube Ovum Transfer (TET), and Uterine Embryo Lavage.
  - a. A maximum of 3 artificial insemination (In Vivo) procedures per menstrual cycle for a total of 8 cycles per lifetime.
  - b. A maximum of 4 procedures per lifetime except that if a live birth follows a completed oocyte retrieval, then coverage shall be required for a maximum of 2 additional completed oocyte retrievals. Such coverage applies to the covered individual per lifetime of that individual, for treatment of infertility, regardless of the source of payment. Following the final completed oocyte retrieval for which coverage is available, coverage for 1 subsequent procedure used to transfer the oocyte or sperm to the covered recipient shall be provided. For any of the following: In-Vitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.

- c. Eligible medical laboratory costs associated with sperm or egg donation by a donor are considered covered under the Plan. (If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count against the Member as 1 completed oocyte retrieval.)

**Note: See *Exclusions & Limitations* for additional information about Infertility Benefits.**

- O. Autism – Effective January 1, 2009** – Provided for individuals younger than age 21, benefits include coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders. **(Effective July 1, 2010 no maximum will be outlined for Autism but will be treated the same as any other condition.)** This benefit will be subject to the regular medical co-pay, deductible and coinsurance provisions of the Plan.

Upon request to the Provider from the Payor, a Provider treating the Member for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. If treatment is anticipated to require continued services to achieve demonstrable progress, the Payor may request a treatment Plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, and the anticipated outcomes stated as goals, and the frequency by which the treatment Plan will be updated. Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists. (See *Definitions* for additional information.)

- P. Forced Providers** – are hospital-based providers that the patient cannot choose. The charges of certain Forced Providers will be considered at the same benefit level as the hospital facility in which services are rendered if the provider services would fall under the Tier III level of benefits. The Forced Provider benefit applies only to the following inpatient or outpatient hospital facility charges:
  - Inpatient hospital professional fees for radiology, pathology or anesthesiology
  - Outpatient hospital professional fees for radiology, pathology or anesthesiology

Note: This provision does not apply to providers in an office visit setting or any setting other than inpatient or outpatient hospital facilities.

**Remember to show your HealthLink ID card anytime you receive care. If you lose your ID card or need additional cards, please call HealthLink Customer Service toll-free at 1-800-624-2356.**

**Note: Because this booklet is a Summary of Benefits provided under this Plan, it does not explain each and every service covered under this Plan. If you have coverage questions, please call HealthLink Customer Service.**

## SUMMARY OF BENEFITS

The following is a benefit summary of the most frequently utilized benefits. Please refer to pages 12-17, Covered Medical Expenses, for a complete description of covered services.

**Important Notice: There are deductibles, annual limits, lifetime maximums, and out-of-pocket restrictions. There are required co-pays, as shown below, and limits to the allowable number of days coverage is available.**

### HealthLink Open Access III Plan – State of Illinois Health Benefit Plans

BENEFIT	TIER I 100% Benefit	TIER II 90% Benefit	TIER III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	Not Applicable Not Applicable	\$600 \$1,200	\$1,500 \$3,500
Annual Plan Deductible <i>Must be satisfied for all services</i>	\$0	\$200 per Enrollee*	\$300 per Enrollee*
<b>HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)</b>			
Inpatient	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Inpatient Psychiatric	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$275 copayment per admission	90% of network charges after \$325 copayment per admission	80% of U&C** after \$425 copayment per admission
Emergency Room <i>Waived if admitted</i>	100% after \$200 copayment per visit	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Outpatient Surgery	100% after \$175 copayment per visit	90% of network charges after \$175 copayment	80% of U&C** after \$175 copayment
Diagnostic Lab & X-Ray	100%	90% of network charges	80% of U&C**
<b>PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)</b>			
Physician Office Visits	100% after \$15 copayment	90% of network charges	80% of U&C**
Specialist Office Visits <i>Includes Behavioral Health providers</i>	100% after \$20 copayment	90% of network charges	80% of U&C**
Preventive Services <i>Including immunizations</i>	100%	100%	Covered under Tier I and Tier II only
Well Baby Care <i>(first year of life)</i>	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment	90% of network charges	80% of U&C**
<b>OTHER SERVICES</b>			
Prescription Drugs	Covered through State of Illinois administered plan, Medco; \$50 deductible applies Generic \$10 Preferred Brand \$24 Non-Preferred Brand \$48		
Durable Medical Equipment	100%	90% of network charges	80% of U&C**
Skilled Nursing Facility <i>120 days per plan year</i>	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$20 copayment	90% of network charges	Covered under Tier I and Tier II only

**Note: Plan co-payments do not count toward satisfying the out-of-pocket maximum or deductible. Annual Plan deductibles must be met before Plan benefits apply. Benefits are measured on a Plan year.**

### Section III - Covered Medical Expenses

The Plan covers the contracted or negotiated rate, or Usual and Customary (U&C) charges applicable typically only to non-participating health care Providers, incurred by a covered individual for the services and supplies in the following list, provided they are performed or prescribed by a licensed physician, are required in connection with the medically necessary treatment of an illness or injury (or are specifically covered preventive care), are pre-certified when required under the Medical Management program, and are not listed in the section called *Exclusions and Limitations*. An expense is incurred on the date the service or supply is actually rendered or received. Covered expenses include the following:

1. Hospital semi-private room and board and general nursing services or special charges for intensive care confinement. If a private room is used, the Plan will only provide coverage for cost of a semi-private room. This benefit requires pre-certification.
2. Other inpatient hospital charges for medical care, services and supplies.
3. Medical care, services and supplies for treatment received as an outpatient at a contracted hospital or contracted urgent care facility or the use of a contracted licensed ambulatory surgical center. Some services may require pre-certification.
4. Contracted physician fees for other medical care and services in the office, home or contracted hospital.
5. A cardiac rehabilitation program, when prescribed by a contracted treating physician and provided through a recognized contracted medical facility.
6. Anesthesia charges from a contracted physician or certified registered nurse anesthetist (CRNA). Services provided by a registered nurse first assistant (RNFA) or certified registered nurse first assistant (CRNFA) if medically necessary and appropriate for care.
7. Nursing charges from a registered nurse (RN), licensed practical nurse (LPN) or certified nursing aide, provided he or she is not a close relative. A close relative includes you and your spouse and the following relations to either of you: parents, brothers, sisters or children. (Custodial services, or services that a family or friend can be trained to perform, are not covered.)
8. Professional service charges for medical care and services provided by a contracted radiologist and contracted pathologist.
9. Maternity coverage is for maternity care provided to a female employee, enrolled spouse of a male employee and enrolled dependent daughter. No coverage is provided for a child of an enrolled dependent daughter.
10. Routine services as defined under "Preventive" in your summary plan description. Routine services must be performed by a Tier I (HMO) contracted Provider or Tier II (PPO) contracted Provider.

11. Human Papillomavirus (HPV) vaccine (including female employees/dependents from age 11 through age 26).
12. Routine hearing screening examination services, provided these services are performed by a Tier I (HMO) contracted Provider or Tier II (PPO) contracted Provider. For additional benefit information for Hearing exam and Aids, refer to "Hearing Services" on page 9.
13. Infertility benefits. **Refer to *Exclusions and Limitations and Definitions* for additional information about infertility benefits.**
14. Short-term speech therapy by a contracted qualified speech therapist to restore speech lost due to surgery, injury or illness other than a functional nervous disorder. If speech is lost due to a congenital anomaly, speech therapy is covered only if previous surgery has been performed to correct the anomaly. This benefit requires pre-certification (60 visits per Plan year).
15. Short-term restorative physical and occupational therapy by a contracted licensed therapist in a home setting or at a contracted facility primarily providing medical care. This benefit requires pre-certification (60 visits per Plan year).
16. Professional ambulance service, when required for local transportation to a contracted hospital or other contracted facility or for transportation to the nearest hospital that is equipped to provide necessary treatment.
17. Diagnostic laboratory and X-ray examinations, including professional fees.
18. Oxygen and the rental of equipment for its administration.
19. Administration of blood or blood components.
20. Radium, radioactive isotopes and X-ray therapy.
21. Dressings, sutures, casts, splints, braces, customized foot orthotics (2 per Plan year) including shoe inserts that are custom made, trusses and crutches, or other specialized medical supplies ordered by a physician, with the exception of dental braces and corrective shoes. This benefit may require medical necessity review prior to purchase.
22. Initial purchase of artificial limbs, eyes, larynx and other orthotic or prosthetic appliances to replace natural limbs or organs. Replacement of a prosthetic appliance due to growth or a change in the person's medical condition or wear which cannot be repaired and is still deemed medically necessary. This benefit may require medical necessity review prior to purchase.
23. Surgically implanted penile prostheses when the dysfunction is related to an injury or illness. **Refer to *Exclusions and Limitations* for more information.**

24. Rental fees, up to the purchase price only if it is expected that the rental costs will exceed the purchase price for the initial purchase only, for the following:
  - a. Wheelchair
  - b. Hospital bed
  - c. Iron lung
  - d. Kidney dialysis equipment
  
25. Rental fees, up to the purchase price only if it is expected that the rental costs will exceed the purchase price for the initial purchase only, for the following:
  - a. Other durable medical equipment that is determined under the Medical Management program to be medically necessary and appropriate and made and used only for treatment of injury or illness or to replace a body function that was lost or impaired due to an injury, illness or congenital anomaly. Pre-certification is required for this benefit.
  
26. Convalescent skilled nursing contracted facility charges for semi-private room and board, as well as general nursing and other medical services customarily provided. Pre-certification is required for this benefit (120 days per Plan year). Confinement in a convalescent skilled nursing contracted facility must begin within 14 days following a hospital confinement of at least 3 days. In addition, the confinement must be necessary for skilled nursing or physical restorative services required to recover from the illness or injury that caused the hospital stay.
  
27. Home health care contracted agency charges for the following:
  - a. Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN).
  - b. Part-time or intermittent home health aide services consisting primarily of caring for the patient.
  - c. Medical supplies, drugs and medicines that would have been covered had the patient remained in the hospital.

Home health care contracted services must be provided under a written treatment plan prescribed by a contracted physician as an alternative to hospitalization. Pre-certification is required for this benefit.

28. Hospice care contracted services received under an attending contracted physician's written hospice care plan for a covered individual whose life expectancy is 1 year or less. Pre-certification is required for this benefit. These services include:
  - a. Inpatient care rendered by a licensed hospice contracted facility when medically necessary.
  - b. Outpatient care billed through a licensed hospice contracted agency for the following services:
    - Physician services
    - Skilled nursing services
    - Home health care services
    - Medicines, drugs and medical supplies
    - Homemaker services
    - Physical, respiratory and speech therapy

29. The following services for human-to-human organ or tissue transplants provided the transplant is medically necessary and not experimental. Pre-certification is required for this benefit. Transplant services are only covered when provided by a Tier I (HMO) contracted Provider or Tier II (PPO) contracted Provider; not covered when provided by an out-of-network Provider. Services include:
- a. Procurement of cells, as long as the transplant has been approved and pre-certification has been completed.
  - b. Donor expenses, as long as the donor is covered by this Plan. (lab services only)
  - c. Donor expenses, if the recipient is covered by this Plan and the donor's health plan will not provide coverage for the donation. (lab services only)
  - d. Transportation, storage, surgery services and any fees for obtaining an organ from a cadaver or tissue bank.
  - e. Transportation and lodging benefit – the Plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to 1 year following the transplant. This benefit is available only to those Plan Participants who have been approved for transplant services from HealthLink. The maximum expense reimbursement is \$2,400 per case. Automobile mileage reimbursement schedule is established by the Governor's Travel Control Board. Lodging per diem is limited to \$70. There is no reimbursement for meals.

**Please note: Donor search/profiling expenses are not covered by the Plan.**

30. Expenses for a medically necessary mastectomy, including reconstruction of the affected breast(s). Covered expenses also include surgery and reconstruction of an unaffected breast to produce a symmetrical appearance. Coverage is also provided for any physical complications in all stages of the mastectomy (including lymphedemas), and for prosthetics. Also included are post-discharge contracted physician office and home visits to monitor the condition of the patient after discharge. Limitation of 2 mastectomy bras per Plan year due to a mastectomy. Pre-certification is required for this benefit.
31. Diabetes self-management training means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process. This coverage is for contracted physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of an Enrollee with gestational, type I or type II diabetes.
32. Treatment of varicose veins including but not limited to vein stripping, radiofrequency or laser ablation and sclerotherapy if deemed medically necessary.
33. Custom made shoes (diabetic shoes); no more than 1 pair every 5 Plan years. **Individual must have been diagnosed with diabetes for coverage to apply.**
34. Contraceptive expenses include the following:
- a. Oral
  - b. Diaphragm, Lea's Shield, Cervical Cap
  - c. Patch: Ortho Evra
  - d. Depo-Provera injection
  - e. Implant: Norplant and Etonogestrel IUD

35. Compression hose are covered as non-surgical treatment of varicose veins. A diagnosis of varicose veins is required for this benefit, and this is limited to 2 pair per Plan year. In addition, compression hose are covered after a surgical procedure and no longer than 6 months after the procedure with a limit of 2 per covered period.
36. Jobst or Gradient stockings are covered with a diagnosis of lymphedema.
37. Cochlear implants will be covered under the regular medical Plan, not the Hearing Aid benefit, when deemed medically necessary.
38. Nutritional Counseling/Dietitian will include nutritional evaluation and counseling as medically necessary for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when prescribed by a physician and provided by a licensed health care professional (e.g., a registered/clinical dietician). A letter of medical necessity from the prescribing physician is required. Coverage shall be limited to one nutritional counseling session per primary medical condition per lifetime not to exceed 10 classes per session. Conditions for which nutritional evaluation and counseling may be considered medically necessary include, but are not limited to the following:

Anorexia/Nervosa/Bulimia	Celiac Disease	Cardiovascular Disease
Crohn's Disease	Hyperlipidemia	Liver Disease
Malabsorption Syndrome	Metabolic Syndrome	Multiple or Severe Food Allergies
Nutritional Deficiencies	Gastric bypass/lap band	Renal Failure
Ulcerative Colitis	Cancer	High Cholesterol
High Blood Pressure		

Specifically excluded is Nutritional Counseling solely for the management of the following conditions:

- a. Attention-Deficit/Hyperactivity Disorder
  - b. Chronic Fatigue Syndrome
  - c. Idiopathic Environmental Intolerance (casual connection between environmental chemicals, foods and/or drugs)
39. Anesthesia coverage for dental services when the medical condition is significant enough to impact the need to provide anesthesia services and other alternative type of anesthesia, sedation or analgesia are not appropriate and the following requirements exists:
    - a. The individual is a child age 6 or younger.
    - b. The individual is disabled.
  40. If a Member is confined in a hospital and coverage is terminated, benefits will continue until discharge from that facility.
  41. Clinical trials are not covered; however, routine patient care provided in connection with a covered person's participation in approved Phase II and Phase III clinical trials for eligible expenses is covered in the same manner as when such expenses are incurred for non-investigational purposes, provided that the covered person has been diagnosed with a life-threatening disease and the clinical trial is designed with therapeutic intent to improve Participants' health outcomes (not simply to test toxicity or disease pathophysiology).

Covered routine patient care includes:

- a. Items or services that are typically provided in the absence of a clinical trial (e.g., medically necessary conventional care, including but not limited to office visits, consultations, diagnostic tests, hospital charges, non-experimental drugs);
- b. Items or services required for the provision of the investigational item or service (such as administration of a non-covered chemotherapy drug);
- c. Items and services required for the clinically appropriate monitoring of the effects of the treatment, or the prevention of complications, but not services provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient;
- d. Items and services which are medically necessary for the diagnosis or treatment of complications arising from the provision of the investigational treatment.

The Plan does not cover the cost of the investigational therapy, drug, device or procedure that is the subject of the clinical trial or any associated research costs or any other services or items that would not be covered in the absence of a clinical trial. The Plan does not cover expenses for routine patient care provided in connection with any experimental or investigational therapy, drug, device or procedure that is not the subject of an approval clinical trial.

42. Total Parenteral Nutrition (TPN) for pre- or post-surgical patients, or when determined to be medically necessary in order to safeguard the Covered Person's life. A statement of medical necessity from the attending physician must be submitted prior to receiving services in cases that are other than pre- or post-surgical related.
43. Genetic Testing which includes diagnostic testing and counseling when medically appropriate, including but not limited to: Diagnostic testing where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder; Diagnostic testing when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease; Predictive testing if the Covered Person's family history establishes the patient is at risk for a genetic disease, but only if there are accepted treatment alternatives for that condition; Prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother or father has a family history that established that parent is at risk for having a hereditary genetic disorder or if multiple miscarriages have occurred.
44. Vasectomy and tubal ligations are considered a covered benefit; however, reversals are not.
45. Flu Mist is a covered expense.

## **Section IV – Exclusions and Limitations**

No benefits shall be payable under any part of this Plan (unless specifically superseded under any other section of this Plan) with respect to:

1. Services and supplies which are not medically necessary; nor for charges for which the Covered Person is not legally liable, or any expenses which exceed the Usual and Customary (U&C) charges for the geographic area in which the expenses were incurred.
2. Any expenses for any condition or disability, which is due to injury or illness arising out of or in the course of any occupation or employment for wage or profit and which would entitle the covered person to any benefit under a Workers' Compensation act, law or similar legislation, including those situations whereby the Covered Person lawfully chose not to be covered or waived or failed to assert his/her rights under a Workers' Compensation law, act or similar legislation.
3. Any expenses for any conditions or services that are reimbursed by a third party.
4. Any service, procedure or supply not specifically identified as being covered under the Plan.
5. Care of any injury or illness incurred while on active or reserve military duty. Care of any injury or illness resulting from war, declared or undeclared, any act of war or any act of terrorism.
6. Convalescent care, custodial care, sanatoria care, care in residential and non-residential treatment centers and nursing homes.
7. Any expenses for cosmetic surgery. Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental injury, or congenital deformities evident in infancy and/or may become evident as the individual grows and develops, or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.
8. Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback (except when deemed medically necessary), neurofeedback, hypnosis, sleep therapy, employment counseling, return to work services, work hardening programs, driving safety and services, training, educational therapy or non-medical ancillary services for learning disabilities, developmental delays or mental retardation.
9. Marital counseling, family counseling and group counseling.
10. Air conditioners, air purifiers, arch supports, support stockings, batteries/battery charges, corrective shoes, breast pump, specialized baby formula, heating pads, heated humidifiers, hot water bottles, personal care items, wigs and their care, and any other primarily non-medical equipment.

11. Any services provided by immediate family members or household members.
12. Travel, whether or not recommended or prescribed by a physician.
13. Hypnotism, hypnotic anesthesia, acupuncture, acupressure, electric stimulation and massage therapy.
14. Eyeglasses and contact lenses or the examination for prescription and fitting.  
Exception: Coverage will be provided for eye examination, including refractions, when received as a result of a covered medical illness or accidental injury that occurred while covered under the Plan and within 1 year of the accident.
15. Dental injuries that occur as a result of chewing are not covered. Coverage will apply as a result of accidental injury to sound natural teeth if accident occurred while covered under the Plan and within 1 year of the accident. **Dental implants are excluded as a covered expense regardless if the request is due to an accidental injury to the sound natural teeth.**
16. Dental services including treatment for impacted teeth, dental implants or orthodontia related services are not covered. Removal of cysts and/or lesions located in the mouth that would be considered as Medical must be denied by the Dental carrier before being considered for coverage under the medical plan. (Any additional expenses performed or prescribed by a dentist will be considered not covered under your medical plan including but not limited to Sleep Apnea Dental Device.)
17. Expenses incurred for procedures intended primarily to treat morbid obesity, including but not limited to gastric balloons, gastric sleeve, stomach stapling, jejunal bypasses, wiring of the jaw and services of a similar nature, Mason Shunt, banding gastroplasty or intestinal bypass, unless such procedures are medically necessary.
18. Expenses for weight loss programs and clinics regardless of associated medical or psychological conditions. Includes counseling, educational materials, diagnostic testing or monitoring, food, special formulas, food or vitamin supplements, special diets, or supplies associated with weight loss programs.
19. Infertility treatment exclusions that include, but are not limited to: **(See additional information under Section II)**
  - a. Medical or non-medical costs of anyone not covered under the Plan.
  - b. Non-medical expenses of a sperm or egg donor covered under the Plan including, but not limited to:
    - Transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryopreservation and storage of sperm or embryo, or fees payable to a donor.
  - c. Infertility treatment deemed experimental or unproven in nature.
  - d. Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization. (In the event a voluntary sterilization is successfully reversed, infertility benefits shall be available if the covered individual's diagnosis meets the definition of Infertility.)

- e. Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a Plan Participant or not.
  - f. Pre-implantation genetic testing.
  - g. Travel costs
  - h. Infertility treatments rendered to dependents under the age of 18.
20. Orthognathic surgery for correction of deformities of the jaw, unless to correct birth defects of eligible Plan Participants since birth and/or may become evident as the individual grows and develops, or which occurred through accidental injury while covered under this Plan.
21. Services or supplies relating to the diagnosis, treatment and/or appliance for temporomandibular joint disorders or syndromes (TMJ), or myofunctional disorders or other orthodontic therapy.
22. Organ transplants consisting of nonhuman device or artificial organs such as heart, kidney or liver.

**Note: If you are a transplant candidate for any type of organ transplant, consult your HealthLink contracted physician or HealthLink Customer Service department.**

23. Surgical procedures performed on the cornea of the eye to improve vision by changing the refraction. (Including but not limited to Refractive Keratoplasty, Radial Keratotomy including lasik or lasek procedures, and surgery to correct astigmatism after cataract or corneal transplant procedures).
24. Experimental, obsolete or investigative procedures, services, or supplies. Alternative medicine that does not meet generally accepted medical standards.
25. Any charges related to reversal of a prior sterilization; or elective abortion; or any charges related to sex transformation.
26. Blood donor expenses.
27. Lenses (eye glasses or contacts) except initial pair following cataract surgery. (Initial pair of glasses excludes tinting, transition lens and safety lens.)
28. Any services or supplies for which you have no legal obligation to pay.
29. Charges for failure to keep an appointment and any late payment charges.
30. Examinations for or in connection with insurance, employment, extracurricular school activities or any recreational activities. (This exclusion would include sports physicals.)
31. Immunizations required for travel abroad.
32. Items for comfort or convenience, stethoscopes, blood pressure cuffs, warning devices and other types of apparatus used for diagnosis or monitoring.

33. Surgical treatment of scarring secondary to acne or chicken pox to include, but not to be limited to, dermabrasion, chemical peels, abrasion and collagen injections.
34. Inpatient services (other than diagnostic X-ray, laboratory and clinical tests) by all Providers in connection with an admission if the Enrollee was admitted primarily for diagnostic reasons and if such services could have been provided adequately on an outpatient basis without endangering the Enrollee's health.
35. Inpatient services provided by all Providers if the Enrollee was admitted primarily for physical therapy or occupational therapy and if such services could have been provided adequately on an outpatient basis without endangering the Enrollee's health.
36. Speech and hearing therapy screening examinations for services received under any program offered by any governmental body or division thereof.
37. Services provided by a registered nurse first assistant (RNFA) or certified registered nurse first assistant (CRNFA) except when deemed medically necessary and appropriate for care.
38. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with diagnosis of diabetes. In addition, if these services are deemed medically necessary for non-professional performance if the service would be hazardous for the Member because of an underlying condition or disease; or routine foot care if performed as a necessary and integral part of an otherwise covered service (i.e., treatment of warts, or debriding of a nail to expose a subungual ulcer; or debridement of mycotic nails if undertaken when the mycosis dystrophy of the toenail is causing secondary infection and/or pain, which results or would result in marked limitation of ambulation and required the professional skills of a physician.
39. Foot orthotics not custom-molded or fitted to the foot.
40. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, non-hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps, or any other services or items determined by the Plan to be for personal convenience. Ceiling lifts and overhead lifts (portable and semi-portable that attach to a ceiling track system) would be non-covered if prescribed to address accessibility limitations of the home.
41. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).
42. For private room charges in excess of the established semi-private room and board charges regardless of any medical necessity such as isolation.
43. Occlusion guard and/or occlusion guard to replace C-PAP machine when traveling out of the country.
44. Repair services on durable medical equipment.

45. For replacements due to negligence or loss of an item.
46. Scooters, Tedhose or paraffin bath are not covered.
47. Any condition, disability or expense resulting from or sustained while engaged in an illegal occupation or commission of or attempted commission of an assault or a felonious act; provided that these exclusions will not apply if the injury resulted from an act of domestic violence or a medical condition (including both physical and/or mental health conditions).
48. Any condition, disability or expense resulting from an injury caused by participating in a civil insurrection or riot.
49. Any charges for care or treatment provided or furnished by the United States government or the government of any country, except to the extent that United States federal law requires the Plan to provide benefits for such care or treatment. (For treatment in VA Facilities, the law generally requires the Plan to provide benefits for a covered individual who does not have a service-connected disability.)
50. Vacuum erection devices are not covered.
51. Any charges for treatment, services or supplies related to the pregnancy (including complications of pregnancy) or maternity care of dependent children.
52. Any charges for services received or supplies purchased outside of the United States, unless the Covered Person is a resident of the United States, and the charges are incurred while traveling on business or for pleasure and meet the guidelines under the Plan as being covered and meeting medical necessity guidelines. Services will not be covered for anyone traveling outside the United States specifically to have a surgical procedure performed.
53. Any charges for artificial insemination, in vitro fertilization or embryo or fetal implants, or other assisted reproduction techniques, except as provided under "Infertility".
54. Any charges incurred by any person not covered under the Plan as an Employee or Dependent, including, but not limited to, charges for services provided to a surrogate mother or to the biological mother of a child adopted by an Employee. This shall not preclude payment for covered donor expenses for covered transplant procedures as outlined under Donor expenses.
55. For rest, convalescence, custodial care, or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.
56. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.

57. For court-mandated services, if they are not a covered service under this Plan or not considered to be medically necessary by the Plan Administrator.
58. For treatment and services rendered in a setting other than direct patient-provider contact. (Telemedicine is not covered)
59. For any legal fees incurred by Members in relation to the benefit Plan and its administration.
60. For services rendered by a doctor of Naprapath, MBBS (bachelor of medicine/bachelor of surgery), CBBT (certified cognitive behavioral therapist), CNOR, LMT ATC (certified athletic trainer) DMN (doctor of ministry), CN (doctor of neuropathy) or certified weight trainer.
61. For facility fees billed by day programs under the Plan (Physical therapy or medical care will need to be billed separately. If not, no coverage will be allowed. This would include services from a covered Skilled Nursing Facility or custodial care unit on an outpatient basis only; inpatient services would still be denied if utilizing a non-contracted Provider.)
62. For costs incurred in the search or profiling of a transplant donor.
63. Any charges that are considered over Usual and Customary (U&C) for out-of-network Providers. **Further explanation of what Usual and Customary (U&C) is will be found in the glossary under *Definitions*.**
64. Residential treatment centers regardless of diagnosis or condition.
65. Any costs or services for Holistic medicine.

## **Section V – Continuation of Coverage**

Upon termination from this Plan, you and your enrolled Dependents may be eligible for continuing coverage. Please see your Insurance Representative or contact the Illinois Department of Central Management Services for more information.

## **Section VI – Qualified Medical Child Support Orders (QMCSO)**

A "qualified medical child support order" is a child support order from a court of competent jurisdiction, or State Child Care Agency, which requires that an employee benefit plan provide coverage for a Dependent child or a Participant if the plan normally provides coverage for dependent children. Typically these types of orders are generated as a part of a divorce proceeding or a paternity action.

- A. If this Plan receives a QMCSO for 1 or more of your children, your Insurance Representative will notify you and each child affected by the order.
- B. If you receive the QMCSO as part of your divorce decree or as a result of a paternity suit, contact the Insurance Representative immediately after receipt of your decree.
- C. Contact your Insurance Representative or HealthLink Customer Service for additional information.

## **Section VII – Coordination of Benefits (COB)**

### **Overview**

Often, because both husband and wives work, members of a family are covered under more than one plan. Your Plan has adopted coordination of benefit rules to avoid duplication of coverage – two Plans paying benefits for the same allowable expenses. When you or your Dependents are covered by more than one Plan, these rules determine the order in which the Plan pays benefits.

- A. The amount of benefits payable under this Plan will take into account any coverage you or your Dependent has under another plan. For purposes of COB, the term "Plan" is defined as any Plan that provides medical care coverage including the following:
  - 1. Any group or individual insurance Plan including Health Maintenance Organizations (HMO);
  - 2. Any governmental Plan, except the Illinois Medical Assistance Program (Medicaid);
  - 3. Any "no-fault" motor vehicle plan. This term means a motor vehicle plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law;
  - 4. As required by law;
  - 5. The Plan does not coordinate benefits with private individual insurance plans, elementary, high school and college accident insurance and Medicaid.

- B. The term "allowable expense" means any medically necessary covered service for which part of the cost is eligible for payment by this Plan or one of the Plans defined above.
- C. Amount paid when benefits are coordinated including Medicare – you must report any other coverage for reimbursement of your allowable expenses. The primary Plan, which pays first, will pay the benefits that would be payable under the terms of the Plan in the absence of a coordination of benefits provision. The secondary Plan will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary Plan will not exceed the greater of:
- 100% of the total allowable expenses, or
  - The amount of benefits it would have paid had it been the primary plan.
- D. Which Plan Pays First – The Plan follows the National Association of Insurance Commissioners (NAIC) model regulations. These regulations dictate the order of benefits determination. The rules are applied in sequence. If the first rule does not apply, the sequence is followed until the appropriate rule that applies is found. The order is as follows:
1. If other Plan is primary, benefits under the Plan will be determined in the following manner:
    - a. The Plan will first determine what would have been paid in the absence of any other coverage.
    - b. If a balance due remains after the primary carrier has paid, the Plan will pay that balance *up to* the maximum amount allowed.
  2. The Plan that covers the Plan Participant as an active Employee/Dependent is primary over the Plan that covers the Plan Participant as a Dependent.
    - a. The Plan that covers the Plan Participant as an active Employee (not as a laid-off Employee or Retiree) is primary over the Plan that covers the Plan Participant as a laid-off Employee or Retiree.
    - b. If the Plan Participant is covered as an active Employee or Dependent under more than one Plan, and none of the above rules apply, then the Plan that has been in effect the longest is primary, back to the original effective date under the Employer group, whether or not the insurance company has changed over the course of coverage.
  3. Dependent Children of Parents Not Separated or Divorced
    - a. Birthday Rule – the Plan covering the parent whose birthday falls earlier in the calendar year is the primary Plan.
    - b. If both parents have the same birthday, the Plan that has provided coverage longer is the primary Plan.  
Birthday refers only to the month and day in a calendar year, not the year in which the person was born.

**NOTE: Some Plans not covered by State law may follow the gender rule for dependent children. This rule states that the father's coverage is the primary Plan. In the event of a disagreement between two Plans, the gender rule applies.**

4. Dependent Children of Separated or Divorced Parents  
If a child is covered by more than one group Plan and the parents are separated or divorced, the Plans must pay in the following order:
  - a. The Plan of the parent with custody of the child;
  - b. The Plan of the spouse of the parent with custody of the child;
  - c. The Plan of the parent not having custody of the child.

**NOTE: If the terms of a court order state that one parent is responsible for the**

**health care expenses of the child, and the health Plan has been advised of this responsibility, that Plan is primary over the Plan of the other parent.**

5. Dependent Children of Parents with Joint Custody
  - a. The birthday rule applies to dependent children of parents with joint custody.
  
- E. Eligibility for Medicare benefits begins when the Plan Member turns age 65.
  1. **All retired Employees/Dependents, as well as actively employed with any other Employer must enroll in Medicare Parts A & B when first eligible.**
    - a. If the Employee/Dependent does not enroll in Medicare Part B when first eligible, this Plan will pay as if the Employee/Dependent has Medicare Part B benefits. If Medicare Part B is not purchased at age 65, Medicare will impose a 10% penalty for each year it was not purchased.
    - b. Employees/Dependents actively working elsewhere with other group health coverage through that Employer must enroll in Medicare Part A but may delay enrollment in Medicare Part B until the loss of other insurance coverage and/or the loss of other employment.

#### Under Age 65 – Medicare Due to Disability

Employees/Dependents younger than age 65 and receiving Social Security benefits or Railroad Retirement Board disability benefits will automatically be enrolled in Medicare Parts A & B after 24 months. If the Employee/Dependent does not remain enrolled in Medicare Part B, the Plan will pay as if the employee/dependent has Medicare Part B benefits.

Individuals may qualify for Medicare in a number of ways including age, disability and end-stage renal disease. The issue of whether Medicare pays first, referred to as the primary Payor, depends on the employment status of the Member, the reason for receiving Medicare, and in the case of Dependents, the relationship of the Dependent to the Employee or Retiree.

**Important: Questions regarding eligibility and enrollment for Medicare should be directed to the Social Security Administration.**

## **Section VIII – Claim Procedures**

- A. As a Participant in the HealthLink Open Access III Plan, you will rarely have to file a claim. Typically, the HealthLink contracted Providers will file claims on your behalf directly with HealthLink.
- B. You may need to submit a claim for reimbursement for such items as ambulance services, durable medical equipment, private duty nursing, emergency care outside the HealthLink service area or whenever you are required by the Provider to pay at the time the services are rendered. Always get an itemized copy of any bill that you pay. You may obtain claim forms from HealthLink, Inc. In order to receive reimbursement, the following information is required:
  - 1. Patient's name, address and ID number
  - 2. Date of service
  - 3. Procedure and diagnosis codes
  - 4. Billed amount for each procedure code performed
  - 5. Provider name, address and tax ID number
- C. Time Limits for Filing – HealthLink HMO, Inc., the Claims Administrator, must receive proof of a claim for covered services no later than 1 year from the date of service.

## **Section IX – Complaints and Appeals**

- A. Complaints – If you have a complaint about any medical or administrative matter related to services provided in connection with this Plan that is not resolved by your HealthLink Provider, please call HealthLink Customer Service at 1-800-624-2356 or write to HealthLink-Appeals, P.O. Box 411424, St. Louis, MO 63141-1424.
- B. Review of Appeals – Appeals are divided into two categories: administrative claim denial decisions or denials of coverage based on medical necessity. You may file an appeal of either of these within 180 days from the date of the decision or denial. The party filing the appeal for an administrative decision must call HealthLink Customer Service at 1-800-624-2356 or write to HealthLink-Appeals, P.O. Box 411424, St. Louis, MO 63141-1424. The party filing the appeal for a denial of coverage based on medical necessity must call HealthLink Medical Management at 1-877-284-0102 or write to Grievance and Appeals, HealthLink, Inc., P.O. Box 411424, St. Louis Mo, 63141-1124. HealthLink will notify the party filing an appeal, within 3 business days, of any additional information that is required to evaluate the appeal.
- C. Administrative Review – Appeals for administrative decisions will be reviewed by HealthLink. HealthLink will notify the party filing the appeal in writing of its decision within 15 business days from the date HealthLink receives all the information requested to complete the review. If you are not satisfied with the resolution of any administrative decision, you may request a FINAL DETERMINATION by writing to Central Management Services, Group Insurance Division, 201 East Madison, Springfield, Illinois 62702.

- D. Medical Necessity Review – You, your contracted HealthLink Provider or other health care Provider may request an appeal for denial of coverage of health care services. A clinical peer not involved in the denial of coverage of health care services will review the appeal. Reports and supporting documentation will be forwarded within 30 days from your request to the clinical peer. A decision will be made within 5 days after receipt of all necessary information. HealthLink will provide oral and written notification of the decision to all parties involved in the appeal.
- E. Expedited Medical Necessity Review – An expedited review may be requested orally or in writing if you, your contracted HealthLink Provider or other health care Provider involved in the appeal believes that the denial of coverage of health care services could significantly increase risk to your health. The party requesting the review may write to Grievance and Appeals, HealthLink, Inc., P.O. Box 411424, St. Louis MO, 63141-1424, or call HealthLink Grievance and Appeals at 1-877-284-0102, Monday through Friday, from 8:00 a.m. to 5:00 p.m. On Saturday or Sunday, the party may call 1-877-284-0102 to leave a message that includes a telephone number of the party to contact. A clinical peer not involved in the original decision to deny coverage of health care services will review the appeal. The party requesting the review will be contacted within 24 hours for information that is required to evaluate the appeal. A decision will be made within 24 hours after receipt of the required information. HealthLink will provide oral and written notification of the decision to all parties involved in the appeal.
- F. External Review of Medical Necessity Appeals – You, your contracted HealthLink Provider or other health care Provider may request an external review if you are not satisfied with the resolution of the initial appeal of a medical necessity denial of coverage for a health care service. HealthLink will facilitate the process for appeals.
1. Medical Necessity Review – An external review may be requested in writing within 30 days after receipt of notification that your appeal for approval of coverage of health care services has been denied. The request should be addressed to Grievance and Appeals, HealthLink, Inc., P.O. Box 411424, St. Louis Mo, 63141-1424. HealthLink's Grievance and Appeals department will forward all records and supporting documentation to an external independent review organization within 30 days of your request. A decision will be made within 5 days after receipt of all necessary information. HealthLink will provide oral and written notification of the decision to all parties involved in the appeal.
  2. Expedited Medical Necessity Review – An expedited review may be requested orally or in writing if you, your contracted HealthLink Provider or other health care Provider involved in the appeal believes that denial of coverage of health care services could significantly increase risk to your health. The party requesting the review may call HealthLink's Grievance and Appeals Department at 1-877-284-0102, Monday through Friday from 8:00 a.m. to 5:00 p.m. On Saturday or Sunday, the party may call 1-877-284-0102 to leave a message that includes the telephone number of the party to contact. Written requests should be addressed to Grievance and Appeals Department, HealthLink, Inc., P.O. Box 411424, St. Louis MO, 63141-1424. The party requesting review will be contacted within 24 hours of appeal submission for information required to evaluate the appeal. When all the information is received, it will be forwarded to an external independent review organization. A decision will be made within 24 hours after receipt of the required information. HealthLink will provide oral and written notification of the decision to all parties involved in the appeal.

## Section X – Subrogation/Third Party

### Liability Overview

The Plan will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. The Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

However, the Plan will provide benefits otherwise payable under the Plan, to or on behalf of its Covered Persons, but only on the following terms and conditions:

- A. In the event of any payment under the Plan, the Plan shall be subrogated to all of the Covered Person's rights of recovery against any person or entity. The Covered Person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The Covered Person shall do nothing after loss to prejudice such rights. The Covered Person shall cooperate with the Plan and/or any representatives of the Plan in completing such documents and in providing such information relating to any accident as the Plan by its representatives may deem necessary to fully investigate the incident. The Plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the Covered Person.
- B. The Plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the Covered Person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the Plan.
- C. The Plan, by payment of any proceeds to a Covered Person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the Covered Person or a representative. The Covered Person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the Plan secure said lien.
- D. The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the Covered Person as a result of the injuries sustained, including but not limited to the following:
  1. Payments made directly by a third party tort-feasor or any insurance company on behalf of a third party tort-feasor or any other payments on behalf of a third party tort-feasor.
  2. Any payments, settlements, judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
  3. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as the result of negligence or alleged negligence of a third party.
  4. Any Workers' Compensation award or settlement.

- E. The parents of any minor Covered Person understand and agree that the State's Plan does not pay for expenses incurred for injuries received as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor Covered Person are conditional upon the Plan's express right of reimbursement. No adult Covered Person hereunder may assign any rights that such person may have to recover medical expenses from any tort-feasor or other person or entity to any minor child or children of the adult Covered Person without the express prior written consent of the Plan. In the event any minor Covered Person is injured as a result of the acts or omissions of any third party, the adult Covered Persons/parents agree to promptly notify the Plan of the existence of any claim on behalf of the minor child against the third party tort-feasor responsible for the injuries. Further, the adult Covered Persons/parents agree, prior to the commencement of any claim against the third party tort-feasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tort-feasor or other person or entity to the Plan, or at their election, to prosecute a claim from medical expenses on behalf of the Plan. The adult Covered Persons/parents further agree that in the event they elect to prosecute a claim for medical expenses that any recovery shall not be diminished under any theory of common fund and that the provisions of this section shall specifically apply hereto. In default of any obligation hereunder by the adult Covered Persons/parents, the Plan is entitled to recover the conditional benefits advanced plus costs, (including reasonable attorney's fees), from the adult Covered Persons/parents.
- F. No Covered Person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the Plan.
- G. The Plan's right of recovery shall be a prior lien against any proceeds recovered by a Covered Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- H. No Covered Person under the Plan shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- I. The Plan shall recover the full amount of benefits paid hereunder without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
- J. The benefits under this Plan are secondary to any coverage under no-fault, medical payments or similar insurance.
- K. This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.

## **Section XI – Termination of Coverage**

- A. Termination of Employee and Dependent Coverage – An Employee's and/or Dependent's coverage will cease as of the date and for the reasons specified in the State of Illinois Benefits Handbook.
- B. Benefits Upon Plan Termination – If this Plan terminates and there is no successor Plan, all remaining assets shall be used to provide Plan benefits and to pay administrative costs incurred as a result of such termination.

## **Section XII – Miscellaneous Provisions**

- A. Binding Effect – The Plan, and all actions and decisions hereunder, shall be binding upon the heirs, executors, administrators, successors and assignees of any and all parties hereto including all Participants, Dependents and Beneficiaries, present and future.
- B. Governing Law – The validity of the Plan or any of its provisions shall be determined under, and construed according to the laws of the State of Illinois.
- C. Non-Alienation – No benefit or interest available hereunder will be subject to assignment, alienation, transfer, attachment, execution, garnishment, sequestration or other legal, equitable or other process, either voluntarily or involuntarily, by operation of law or otherwise except as may be expressly permitted herein. The preceding sentence shall also apply to the creation, assignment or recognition of a right to any benefit payable with respect to a Participant pursuant to a Qualified Medical Child Support Order.
- D. Records – The Member shall furnish HealthLink HMO, Inc. with all information and proof that HealthLink HMO, Inc. may reasonably require with regard to any matters pertaining to this Plan.
- E. Authorization for Release – By accepting coverage under the Plan, each Participant (Member), including Dependents, whether or not such Dependents have signed the medical release, authorizes and directs any person or institution that has provided services to the Member, to furnish the Plan, Plan Administrator, HealthLink and all persons providing services in connection with the Plan at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to the Member. This authorization constitutes a waiver of any provision of law for such rights. HealthLink shall not be deemed or construed as an employer or the Plan sponsor for any purpose with respect to the administration or provision of benefits under the employer's benefit Plan. HealthLink shall not be responsible for fulfilling any duties or obligations of the Plan sponsor with respect to the Plan sponsor's benefit Plan.
- F. Reimbursement to HealthLink HMO, Inc., the Claims Administrator, on Behalf of the Plan Sponsor – The Subscriber agrees to refund to HealthLink HMO, Inc., the Claims Administrator, any benefit payment HealthLink HMO, Inc., the Claims Administrator, made to the Subscriber or on the Subscriber's behalf for a claim paid or payable under any Workers' Compensation or employer's liability law.

Even if the Subscriber fails to claim through a Workers' Compensation or Employer's liability law, and the Subscriber could have received payment through such a law if the Subscriber had filed, reimbursement must still be made to HealthLink HMO, Inc., the Claims Administrator. HealthLink HMO, Inc., the Claims Administrator, has the right of setoff against future claims in all cases.

HealthLink HMO, Inc., the Claims Administrator, has the right to correct benefit payments paid in error. Contracted Providers and the Subscribers have the responsibility to return any overpayments including claims made involving fraud to HealthLink. HealthLink has the responsibility to make additional payment if an underpayment is made.

- G. Conformity with State Laws and Benefits Handbook – Laws of the State in which the Plan was issued, or issued for delivery, may conflict with some of its provisions. If so, then those provisions are automatically changed to conform to at least the minimum requirements of such laws. In the event of a conflict between this Summary Plan Description and a specific provision in the State of Illinois Benefits Handbook that is applicable to the Open Access III Plan, the terms of the State of Illinois Benefits Handbook will be followed.
- H. Commission or Omission – No HealthLink contracted Provider will be liable for any act of commission or omission by HealthLink. HealthLink will not be liable for any act of commission or omission by any contracted Provider or Provider's agent or employee, or the Plan Sponsor or the Plan Sponsor's agent or employee.
- I. Incentive and Calculation of Amounts – Some of the Plan's contractors (e.g., HealthLink HMO, HealthLink PPO and others) have contracts with Providers and administrators that allow for discounts, allowances, fees, incentives, adjustments and settlements to be paid to, or retained by, such contractors. These amounts are for the sole benefit of such contractors, who will retain any payments resulting therefrom, or may distribute or share these amounts with Providers, administrators or others. Claims submitted will have co-pays, deductibles and other amounts, which are the Enrollee's responsibility, calculated without regard to such allowances, fees, incentives, adjustments, settlements, and, in some cases, discounts. In addition, some contracted Providers may also participate in incentive and other programs; under which such contracted Providers, administrators and contractors may be entitled to additional payments for effectively managing care and satisfaction of Enrollees or contracted Providers.

### Section XIII — Definitions

- **Accidental Injury** means accidental bodily injury sustained by you, which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. Damage to natural teeth or dental prostheses, which occur during the act of chewing, is not considered an accidental injury.
- **Act** shall mean the State Employees Group Insurance Act of 1971 (5 ILCS 375/1 et seq.) as now or hereafter amended and such rules and regulations as shall be promulgated thereunder.
- **Admission** begins when you become a registered hospital bed patient and continues until you are discharged.
- **Alcoholism and Substance Abuse** means the uncontrollable or excessive abuse of addictive substances and the resultant physiological dependency that develops with continued use, requiring care as determined by a contracted physician or contracted psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.
- **Ambulance** means a vehicle designed and operated to provide medical services and authorized to operate as required by law.
- **Ambulatory Surgical Center** means a contracted facility licensed by the State as an Ambulatory Surgical Center. It must be equipped and operated mainly to perform surgeries that allow patients to leave the facility the same day their surgery is performed. It cannot be equipped for overnight care of patients.
- **Artificial Insemination** means the introduction of sperm into a woman's vagina or uterus by non-coital methods, for the purpose of conception.
- **Autism Spectrum Disorders** means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.
- **Autism Spectrum Disorders Diagnosis** means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologists with expertise in diagnosing autism spectrum disorders.
- **Autism Spectrum Disorders Treatment** shall include the following care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches: (1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist. (2) Psychological care,

meaning direct or consultative services provided by a licensed psychologist. (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection, (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modifications, (v) motor planning, and (vi) sensory processing.

- **Behavioral Health** means the uncontrollable or excessive abuse of addictive substances and the resultant physiological dependency that develops with continued use, requiring care as determined by a physician or psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines. Also includes a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, even if organic origin is believed contributory.
- **Behavioral Health Provider** means an individual professional or group of professional Providers for mental health/substance abuse treatment or institutions which are licensed to provide such covered services under applicable state law.
- **Coinsurance** is a percentage of the covered expenses you are responsible for after the deductible is met.
- **Co-pay or co-payment** means the fixed dollar amount you must pay to a contracted Provider at the time the service is rendered.
- **Covered expenses** means either (a) the actual charge for a covered service, or (b) the amount that the Plan determines is the appropriate charge for a covered service, which, in many cases, will be the contracted rate with a Tier I (HMO) contracted Provider or a Tier II (PPO) contracted Provider for that service, or the Usual and Customary (U&C) charges for that service if the Provider is an out-of-network Provider. The Plan has the sole discretion to determine the covered expense and to select the methodologies for making these determinations. Charges above the covered expense are not covered for benefits. Enrollees are responsible for charges that are not covered expenses, including charges for services that are not covered services. Enrollees are also responsible for covered expenses not paid by the Plan by reason of co-pays, deductibles, coinsurance amounts, and out-of-pocket expense maximum for covered services.
- **Custodial Care** means care that mainly provides room and board (meals). This care is for physically or mentally disabled persons who are not receiving care specifically to reduce the disability to the extent that the person can live outside a hospital or nursing home. Care is considered custodial, no matter where the person lives, if it is non-skilled nursing care; training in personal hygiene; other forms of self-care; supervisory care by a contracted physician or practitioner; or medical services which are given merely as care to maintain

present health and which cannot be expected to improve a medical condition. The fact that the Covered Person is concurrently receiving medical services that are merely maintenance care and cannot reasonable be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

- **Deductible** is the amount that you must pay each Plan year in covered expenses before the Plan begins to pay benefits.
- **Dependent** means a member of the family of the Subscriber as defined by the Act.
- **Disability or Disabled** means the inability to perform the material and substantial duties of the Employee's occupation subject to a Doctor's initial verification and periodic re-certifications as required by the Employer. Dependent disability or disabled means an individual who has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and is expected to last or has lasted for a continuous period of not less than 12 months.
- **Donor** means an oocyte donor or sperm donor.
- **Educational in Nature** means the primary purpose of any drug, device, medical treatment or procedure is to provide the patient with any training in matters that are other than directly medical.
- **Emergency** means the sudden, unexpected onset of a health condition with symptoms so severe that a prudent layperson, possessing an average knowledge of health and medicine, would believe that immediate medical care is required.
- **Enrollee, Covered Individual, Covered Person, Participant or Plan Participant** means an eligible person under the Act who is enrolled in the Open Access III Plan.
- **Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. With respect to an individual, Genetic Information includes information about (a) the manifestation of a disease or disorder in the individual's family members. Genetic Information also includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research which includes genetic services, by the individual or any family members.
- **HealthLink** refers to HealthLink HMO and HealthLink PPO, provided however, that in connection with any contracted services or responsibilities of the Claims Administrator, such term only refers to HealthLink HMO.

- **HealthLink HMO or HealthLink HMO, Inc.** is the Claims Administrator and the HMO Network Administrator for Plan Participants who enroll in the Open Access III Program.
- **HealthLink PPO or HealthLink, Inc.** is the PPO Network Administrator and Medical Management manager for Plan Participants who enroll in the Open Access III Program.
- **HMO Contracted Provider, HealthLink HMO Contracted Network Provider, HMO Contracted Network Provider, Tier I (HMO) Contracted Provider or Tier I Contracted Provider** means a contracted hospital, physician or other medical Provider participating in the HealthLink HMO contracted Provider network as designated by HealthLink HMO, Inc. from time to time.
- **Home Health Agency** means a contracted agency that provides contracted skilled nursing services and other contracted therapeutic services in the patient's home and is certified to participate in the Medicare program.
- **Hospital** means a contracted facility that: a) Operates pursuant to law; b) Provides 24-hour nursing services by registered nurses on duty or on call; and, c) Provides contracted services under the supervision of a staff of one or more contracted physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions. Hospitals are classified as follows: aa) HealthLink participating contracted hospital means a hospital that has a HealthLink HMO or PPO participating hospital contract with HealthLink. bb) Non-participating hospital means a hospital that does not have a HealthLink HMO or PPO participating hospital contract with HealthLink. Hospital does NOT include: Residential or non-residential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; skilled nursing facilities; places that are primarily for the care of convalescents; clinics; physician or practitioner offices; private homes; ambulatory surgical centers.
- **Infertility** is defined as the inability to conceive after 1 year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.
- **Intensive Outpatient Treatment** means a structured array of treatment services including medication monitoring if applicable, evaluation by a psychiatrist if indicated, and coordination of care provided by a multidisciplinary team of Behavioral Health professionals, including at least 3 treatment hours per day at least 3 times per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- **Medically Necessary or Medical Necessity** means health care services, supplies or treatment that are provided or ordered by a contracted physician, are approved under the Medical Management program as required, are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.
- **Member, Employee or Subscriber** means an eligible employee, retiree, or annuitant under the Act who has enrolled in the Plan for the Open Access III Program.

- **Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight.
- **Multiple Surgery Guidelines** means when two or more surgeries are performed the Multiple Surgery guidelines will be implemented when calculating covered services. If the surgical procedures are not considered separate and distinct procedures, a reduction in the reimbursement amount is applied. Similarly, if multiple surgeries occurred within the same general operative area and at the same time, reimbursement for duplicative services (e.g., multiple preps, surgical trays, etc.) could constitute waste of Plan funds. This is well-recognized in the health insurance industry and in proper coding and reimbursement guidelines.
- **Non-Participating Provider Reimbursement Method** means services provided by doctors and health care professionals who have not contracted with HealthLink to treat Payors' Members ("Non-Participating Providers"), the amounts that will be allowed for such services ("Non-Participating Provider Reimbursement Amounts") are based on the Payors' Member contracts. These amounts may be subject to deductibles, co-pays, and other limitations under the terms of the applicable Payor's Member contracts. For some Payors' Member contracts, databases ("Ingenix Databases") produced by Ingenix, Inc., a subsidiary of UnitedHealth Group, Inc., are used to determine Non-Participating Provider Reimbursement Amounts. For other Payors' Member contracts, these amounts are determined based on fee schedules supported by the Payors' Member contracts. These fee schedules are based on contracted rates with similar Providers in that service area, Medicare/CMS data and/or pricing specifically requested by a Payor.

Because there is no Provider contract or participating agreement, a Non-Participating Provider has not agreed to a reimbursement rate for services provided to Payors' Members. Therefore, absent a regulation or law, the Non-Participating Provider can bill the Member for the difference between the amounts they charge and the Non-Participating Provider Reimbursement Amount. Members are responsible for paying Non-Participating Providers this difference. Depending on the service, this difference can be substantial.

- **Open Access III Plan, Open Access III Program or Open Access Program** means the group health benefit Plan (and related documents and materials describing the benefits available thereunder) sponsored by the State under which Enrollees are provided various incentives to use Tier I (HMO) contracted Providers and Tier II (PPO) contracted Providers in accordance with the following: a) the benefit tier with the greatest benefits applies when Enrollees utilize contracted Providers who are designated by HealthLink HMO as "Tier I (HMO) contracted Providers", b) the benefit tier that does not contain the least benefits applies when Enrollees utilize contracted Providers who are designated by HealthLink PPO as "Tier II (PPO) contracted Providers", and c) the benefit tier that contains the least benefits applies when Enrollees utilize Providers who are not Tier I (HMO) contracted Providers or Tier II (PPO) contracted Providers.
- **Out-of-Network Provider or Tier III Provider** means a physician, hospital or other medical care Provider that is not designated by HealthLink as a Tier I (HMO) contracted Provider or Tier II (PPO) contracted Provider on the date of service and is subject to Usual and Customary (U&C) guidelines.

- **Partial Hospitalization Program (Mental Health/Substance Abuse)** is an intensive structured setting providing 6 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings and includes evaluation, medical monitoring and regular meetings by a psychiatrist if psychiatric diagnosis is indicated, nursing care if indicated, individual and group therapy, family therapy as indicated, and coordination of care by a multidisciplinary team of Behavioral Health professionals.
- **Physician** means a medical doctor (MD), doctor of dental medicine (DMD), doctor of osteopathy (DO), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of podiatric medicine (DPM), doctor of optometry (OD), consulting psychologist, social worker (MSW, LSW), registered dietitian (RD), and physician's assistant (PA), provided the practitioner is legally qualified, licensed or certified in accordance with the laws of the certification.
- **Plan Year** means July 1 through June 30 and subsequent annual Plan years, unless this Plan is sooner terminated.
- **PPO Provider, HealthLink PPO Contracted Network Provider, PPO Contracted Network Provider, Tier II (PPO) Contracted Provider or Tier II Contracted Provider** means a contracted physician, hospital, or other medical Provider participating in the HealthLink PPO contracted Provider network as designated by HealthLink from time to time.
- **Pre-certification** means the process of having inpatient admissions to hospitals, hospice or convalescent skilled nursing facilities, outpatient surgery, ancillary, all Behavioral Health services and diagnostic services authorized in advance under the HealthLink Medical Management program.
- **Provider Contracted Network** means the contracted hospitals, contracted physicians and other contracted Providers in the HealthLink contracted HMO or PPO network who are participating on the date a particular service or supply is rendered or received.
- **Temporomandibular Joint Dysfunction Syndrome (TMJ)** means a disease or symptoms of the jaw joint(s) and/or symptoms of the associated parts resulting in pain or the inability of the jaw to work properly. Associated parts of the jaw mean those functional parts that make the jaw work.
- **Usual and Customary (U&C) Charge** is the maximum covered expense for services provided by an out-of-network Provider (or facility) of health care services (or supplies). It is be the lesser of the billed charge, or a reasonable compensation amount. The reasonable compensation amount is determined based on the following criteria: a) the complexity or severity of treatment; b) level of skill, experience involved; c) fees usually charged by Providers; d) statistically credible health care services data that is updated annually; e) average cost to deliver care for comparable Providers and similar services; f) prevailing Provider rates adjusted to the general geographic area in which the services were rendered; and g) other factors which determine value of the service.

- **Utilization Review/Pre-Certification** must be performed on all inpatient hospitalizations and Extended care/Skilled Nursing Facility admissions prior to the date admitted except: (a) Emergency admissions, for which notification of admission and request for Utilization Review must be made within 48 hours or the next business day; and (b) admissions for childbirth, for which notification of admission and Utilization Review are required only if the mother requires a hospital stay longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section.

Selected outpatient surgical procedures, diagnostic procedures, ancillary services, durable medical equipment, some infusion drugs and autism spectrum disorders also require pre-certification PRIOR to services being rendered or equipment purchased. Refer to the front of your Summary Plan Description for contact information relative to these services.

Utilization Review is for the purpose of determining the need for and reasonable length of a hospital stay, outpatient surgery, diagnostic procedure, ancillary services, infusion services or durable medical equipment. Utilization Review does not guarantee coverage for the services if any limitations or exclusions of the Plan apply to that service. Failure to comply with Utilization Review requirements will result in benefit reductions and may result in denial of benefits.

- **You, Your or Yours** generally refers to an Enrollee unless the context requires otherwise and, then in such instances, the term is generally only referring to the Employee.

## STATE OF ILLINOIS: NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

HealthLink has been authorized by the State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) to provide comprehensive health care services through contractual arrangements with hospitals and other Providers within the Plan's service area for managed care available under the State Employees Group Insurance Act for State employees, the Local Government Health Program, the Teachers' Retirement Insurance Program and the College Insurance Program. As a Business Associate, HealthLink receives health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act. This Notice of Privacy Practices outlines protected health information held by HealthLink. The term "we" in this Notice means the Bureau, Family Healthcare Services and HealthLink.

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

When we seek help from individuals or entities who are not part of our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule.

### ***How We May Use or Disclose Your PHI***

**Treatment:** We may use or disclose PHI to health care Providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party. We may also use or disclose PHI to contact you and tell you about alternative treatments or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

**Payment:** We use and disclose PHI to process claims and make payment for covered services you receive under your benefit Plan. For example, your Provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.

**Health Care Operations:** We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.

**Appointment Reminders:** Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

**Legal Requirements:** We may use and disclose PHI as required or authorized by law.

**Public Health:** We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

**Health Oversight Activities:** We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.

**Judicial and Administrative Proceedings:** We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your Authorization to disclose your PHI.

**Law Enforcement:** We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

**Avert a Serious Threat to Health or Safety:** We may use or disclose PHI to stop you or someone else from getting hurt.

**Work-Related Injuries:** We may use or disclose PHI to Worker's Compensation or similar programs in order for you to obtain benefits for work-related injuries or illnesses.

**Coroners, Medical Examiners, and Funeral Directors:** We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

**Organ Procurement:** We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.

**Release of Information to Family Members:** In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

**Armed Forces:** We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

**National Security and Intelligence:** We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.

**Correctional Institutions and Custodial Situations:** We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

**Research:** You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

**Fundraising and Marketing:** We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

**Plan Sponsors:** Your employer is not permitted to use the PHI for any other purpose other than the administration of your benefit Plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit Plan that the employer sponsors and in which you participate.

**Illinois Law:** Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

**Your Rights:** You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing in care of HealthLink.

**Restrictions:** You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

**Communications:** You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are "in danger" and we will accommodate your request.

**Inspect and Access:** You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter with the reason and explaining your options. You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

**Amendment of Your Records:** If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to amend. We will send you a letter stating how we handled your request.

**Accounting of Disclosures:** You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one accounting in a 12-month period.

**Copy of Notice and Changes to the Notice:** You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within 60 days of the material change. You can also access a revised Notice on the website: *www.healthlink.com*. From the Member home page, click on *State of Illinois CMS*. Under the Member Access section, click the "Login" button. Click on the "Resources" tab and scroll down to the "Privacy Practices" link.

**Complaints:** If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Office at HealthLink in care of Privacy Office, P.O. Box 411424, St. Louis, MO 63141, or by phone at 800-624-2356. If the respective Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services Privacy Officer at the Office of the Chief Counsel, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C. if you feel your privacy rights have been violated.

**EFFECTIVE DATE: April 14, 2005**

**Bureau of Benefits/Illinois-Privacy Notice to Plan Enrollees 5/25/2011**

## GENERAL PLAN INFORMATION

Plan Name	State of Illinois Employee Health Benefits Plan
Plan Numbers	160000
Plan Effective Date	July 1, 2011
Plan Year Ends	
Plan Sponsor, Plan Administrator, Name Fiduciary and Agent for Legal Services	State of Illinois, Department of Central Management Services
Type of Funding	Self-Funded by the State of Illinois
Claims Administrator	HealthLink HMO, Inc. 877-284-0101
Network Administrator	HealthLink, Inc. 800-624-2356
Medical Management	HealthLink, Inc. 877-284-0102
Behavioral Health Management	HealthLink, Inc. 877-284-0102, Option 3

