State of Illinois

Employee Health Care Plan
Summary Plan Description

Plan Number 160001
State of Illinois Local Government Health Option

Effective
July 1, 2023

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SECTION I—WELCOME TO THE STATE OF ILLINOIS OPEN ACCESS III PLAN

You have chosen to be covered under the State of Illnois Local Government Health Option (*Plan*). The State of Illinois has a contractual arrangement with *HealthLink, Inc*. to access two (2) provider contracted *networks*, to provide Medical Management services, and *claims* administration.

Your benefits for each service are determined by whether the service provider falls within *Tier I* (HMO), *Tier II* (PPO) or *Tier III* (*out-of-network*) level. Please remember to review *your* benefits as some services are not covered under the *Tier III* (*out-of-network*) level of benefits. *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 *maximum allowed amount*.

This booklet is a Summary Plan Description (SPD) of the benefits available to *you* and *your dependents*. If *your* particular circumstances are not described here, *you* may contact *HealthLink* Customer Service toll-free at 1-877-379-5802.

Read your benefit materials carefully. Before *you* receive any services *you* need to understand what is covered and excluded under *your* benefit *Plan*, *your* cost sharing obligations, and the steps *you* can take to minimize *your out-of-pocket* costs.

Review *your Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts *you* actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminates. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements.

This summary plan description contains a summary in English of *your* plan rights and benefits under the State of Illnois Health Benefits Plan. If *you* have difficulty understanding any part of this summary plan description, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

A. Quick Reference Information Chart - For Help or Information

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator	State of Illinois, Department of Central Management Services
Medical Management Administrator • *Pre*-Certification, Concurrent Review, and Case Management • Medical *Claim* Pre-Service *Appeals*	Healthlink, Inc. P.O. Box 7186 Boise, ID 83707 1-855-240-3695
Third Party Administrator • Medical *Claim* Post-Service *Appeals* • Eligibility for Coverage • Plan Benefit Information	Healthlink, Inc. P.O. Box 7186 Boise, ID 83707 1-877-379-5802
HMO/PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Healthlink, Inc. 1-877-379-5802 **www.SOI.healthlink.com**
Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for Out-of-*Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail** CVS/Caremark Phoenix, AZ, 85072-2136 1-877-232-8128 **www.caremark.com** **Mail Order** CVS/Caremark P.O. Box 94467 Palatine, IL 60094-4467 **www.caremark.com**
Employee Assistance Program (EAP) • EAP Counseling and Referral Services	ComPsych Corporation 455 N Cityfront Plaza Drive Chicago, IL 60611 1-833-955-3400 1-800-697-0353 **https://www.guidanceresources.com/groWeb/login/login.xhtml** **Member Web ID Code:** Stateofilllinois
Flex Vendor • Flexible spending account	ConnectYourCare P.O. Box 622317 Orlando, FL 32862-2317 **www.connectyourcare.com**

COBRA Administrator • Continuation Coverage	Morneau Shepell 134 N. LaSalle Street Suit 2200, Chicago, IL 60602 1-844-251-1777 **www.MyBenefits.illinois.gov**

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

State of Illinois, Department of Central Management Services

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.

Service of legal process may be made upon the *Plan Administrator*.

D. Authorization for Release

By accepting coverage under the *Plan*, each *plan participant*, 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 *plan participant*, to furnish the *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 *plan participant*. 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 *plan participant'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*.

E. 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 *plan participants*, *dependents* and beneficiaries, present and future.

F. 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*.

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. Reimbursement to the Claims Administrator, on Behalf of the Plan Sponsor

The *plan participant* agrees to refund the *Claims Administrator*, any benefit payment the Claims Administrator, made to the *plan participant* or on the *participant's* behalf for a *claim* paid or payable under any Workers' Compensation or *employer's* liability law.

1. Even if the *plan participant* fails to file a *claim* through a Workers' Compensation or *employer's* liability law, and the *participant* could have received payment through such a law if the *participant* had filed, reimbursement must still be made to the *Claims Administrator*. The *Claims Administrator* has the right of setoff against future *claims* in all cases.
2. The *Claims Administrator* has the right to correct benefit payments paid in error. Contracted providers and the *plan participants* 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.

I. 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 *plan participant* pursuant to a *Qualified Medical Child Support Order*.

J. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Claims Administrator* to pay *claims*
7. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

K. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust Agreement (if any).

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that either:

1. the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents
2. the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in their own discretion

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

L. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

M. Fiduciary Duties

A *fiduciary* must carry out their duties and responsibilities for the purpose of providing benefits to the *employees* and their *dependent(s)* and defraying *reasonable* expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so

N. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Claims Administrator*. The *Plan* is not insured.

O. Plan Name

The name of the *Plan* is the State of Illnois Local Government Health Option.

P. Type of Plan

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The State of Illnois Health Benefits Plan is structured as an ERISA exempt plan under ERISA Section 4(b).

Q. Plan Year

The *plan year* is the twelve (12) month period beginning July 1 and ending June 30.

R. Plan Effective Date

July 1, 2023

S. Plan Sponsor

The *employer* is the *Plan Sponsor*.

T. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* to assist the *Plan Administrator* with *claims* adjudication.

Healthlink, Inc.
P.O. Box 7186
Boise, ID 83707
1-877-379-5802

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*.

U. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination.

SECTION II—ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

All issues of *employee*, retiree, and *dependent* eligibility; enrollment, and effective dates are determined by the Illinois Department of Central Management Services (CMS). Individuals must meet CMS requirements for eligibility and enrollment. For more information, contact *your* Group Insurance Representative or CMS to determine whether *you* or *your dependents* are eligible for coverage, when they can enroll and their respective effective and termination dates.

B. Termination of Coverage

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.

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.

C. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff

A person may remain eligible for a limited time if active, full-time work ceases due to disability, *leave of absence,* or layoff. This continuance will end as follows:

1. for disability leave only: the date the *employer* ends the continuance
2. for *leave of absence* or layoff only: the date the *employer* ends the continuance

While continued, coverage will be that which was in force on the last day worked as an active *employee*. However, if benefits are reduced for others in the class, they will also be reduced for the continued person.

D. Continuation During Family and Medical Leave

Regardless of the established leave policies mentioned above, this *Plan* shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under FMLA, the *employer* will maintain coverage under this *Plan* on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period.

If *Plan* coverage terminates during the *FMLA leave*, coverage will be reinstated for the *employee* and their covered *dependents* if the *employee* returns to work in accordance with the terms of the *FMLA leave*. Coverage will be reinstated only if the person(s) had coverage under this *Plan* when the *FMLA leave* started, and will be reinstated to the same extent that it was in force when that coverage terminated.

E. 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 *plan 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.

If this *Plan* receives a *QMCSO* for one (1) or more of *your* children, *your* Group Insurance Representative (GIR) will notify *you* and each child affected by the order.

If *you* receive the *QMCSO* as part of *your* divorce decree or as a result of a paternity suit, contact the Group Insurance Representative (GIR) immediately after receipt of *your* decree. Contact *your* Group Insurance Representative (GIR) or *HealthLink* Customer Service for additional information.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. *emergency services* provided by *non-network* providers or facility
2. covered services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan*.

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, *emergency services* are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the *emergency services* you receive are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services

4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice not later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network cost-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the median plan *network* contract rate that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*.

D. Appeals

If you receive *emergency services* from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services):

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can receive the following:

1. cost sharing information that you would be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on a *non-network* provider's services based on the *network's* reasonable estimate based on what the *network* would pay a *non-network* provider for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator*, and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

SECTION IV—MEDICAL NETWORK INFORMATION

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

A. 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.

1. 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
2. *Claims* submitted will have *co-payments*, *deductibles*, and other amounts, which are the *plan participant's* responsibility, calculated without regard to such allowances, fees, incentives, adjustments, settlements, and, in some cases, discounts.
3. 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 *plan participants* or contracted providers.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require *you* to select a *primary care physician* (*PCP*) to coordinate *your* care, and *you* do not have to obtain a referral to see a specialist.

You do not need prior authorization from the *Plan* or *Claims Administrator*, or from any other person (including *your PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** *Emergency* services are covered no matter where *you* receive care. When *you* need medical care immediately, first try to contact *your* primary care doctor 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 facility*. Contact *your physician* the next business day to coordinate any follow-up care.

   An *emergency* service includes healthcare 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:

   a. placing the *plan participant*'s health in significant jeopardy
   b. serious impairment to a bodily function
   c. serious dysfunction of any bodily organ or part
   d. inadequately controlled pain

e. with respect to a pregnant *plan participant* 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 *plan participant* 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*.

Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for notifying *HealthLink*, Inc. for a review of any *claim* that meets this definition.

2. **Forced Providers.** Are hospital-based *physician* that the *plan participant* cannot choose. If services received from a forced provider fall under the *Tier III* level of benefits, certain charges may be considered at the same benefit level as the *hospital* or facility in which services are rendered. The forced provider benefit applies only to the following *inpatient* or *outpatient hospital* facility charges:
    a. *inpatient hospital* professional fees for hospitalists, radiology, pathology, or anesthesiology
    b. *outpatient hospital* professional fees for hospitalists, radiology, pathology, or anesthesiology

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *non-network* services and billing.

D. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

Healthlink, Inc.

1-877-379-5802

www.SOI.healthlink.com

All locations

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-877-379-5802

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with *HealthLink, Inc.* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by *HealthLink, Inc.* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this summary plan description.

B. Tier I (HMO Benefits), Tier II (PPO), and Tier III (Out-of-Network) Services

Medical benefits for *plan participants* in the State of Illinois Health Benefits *Plan* are provided through an *Open Access III Plan*, administered by *HealthLink*, Inc. With the *Open Access III Plan*, *you* have three (3) choices each time *you* seek medical care:

a. The highest level of benefit is provided for covered services when *you* receive care from a *HealthLink HMO* contracted *network* provider (*Tier I*/HMO benefits).

b. 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* PPO benefits).

c. *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*/*out-of-network* benefits). *You* will be responsible for anything over the *maximum allowable amount* for *out-of-network* providers.

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 participant*, eligible to receive services in accordance with this *Plan*.

Be sure to show *your HealthLink* ID card at the time of service. If *you* must cancel an appointment, please call the *physician*'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 doctors, *hospitals*, and other healthcare facilities will file *claims* directly with *HealthLink* for covered services. A contracted provider may bill *you* directly for a customary charge for services that were not covered under the *Plan*.

HMO Benefits

To receive the *Tier I* (HMO) level of benefit, the service must be performed by a *Tier I* (HMO) contracted *physician*, *hospital*, or other healthcare facility unless otherwise stated in this summary plan description. *You* may self-refer for treatment provided by a *Tier I* (HMO) contracted *HealthLink* provider and/or specialist without obtaining a referral. The *Tier I* (HMO) benefit is the highest level of benefits in the *Open Access III Plan*.

Tier II (PPO) and Tier III (Out-of-Network) Benefits

If *you* choose to receive care from a *Tier II* (PPO) contracted provider and/or *Tier III* (*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 *co-insurance*. The *plan participant* is responsible for 10% *co-insurance* on covered services provided by a *Tier II* (PPO) contracted providers and 40% *co-insurance* on covered services provided by a *Tier III* (*out-of-network*) provider.

For *Tier II* (PPO) contracted providers, the *Plan's co-insurance* rate is applied to the contracted charge between *HealthLink* and the contracted provider. For *Tier III* (*out-of-network*) providers, the *Plan's co-insurance* rate is applied to the *maximum allowable amount* charges. The *Tier III* (*out-of-network*) provider is any provider or facility that does not have a contractual agreement with *HealthLink*. If *your Tier III* (*out-of-network*) provider charges more than the

maximum allowable amount, *you* must pay the excess amount in addition to *your deductible* and a percentage of the covered expenses.

C. Schedule of Benefits

The following is a benefit summary of the most frequently utilized benefits. Please refer to Covered Medical Charges for a complete description of covered services.

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

This document is intended to describe the benefits provided under the *Plan*, but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. Please contact the *Plan Administrator* if *you* have questions about specific supplies, treatments, or procedures.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* will be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long *term* acute care facility (LTAC), not custodial care
    c. *inpatient* mental health/substance abuse treatment (includes *residential treatment facility* services)

    The attending physician does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery* (excluding office surgeries, pain injections, and screening colonoscopies)
3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
4. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

    This *Plan* does not cover clinical trials related to other diseases or conditions. Refer to the Medical Benefits section of this document for a further description and limitations of this benefit.
5. specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion), over $3,000 per infusion/injection
6. *durable medical equipment* in excess of $3,000 (purchase price only)
7. *hospice care services*
8. non-emergent air ambulance
9. chemotherapy drugs/infusions and radiation treatments for oncology diseases
10. adoptive cell therapy

Please see the Health Care Management Program section in this document for details.

D. Deductible Amount

There is no *deductible* for *Tier I* (HMO) services. Refer to the **Schedule of Medical Benefits** for more information.

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 (1) *plan year*. *Tier II* (PPO) has a separate *deductible* from *Tier III* (*Out-Of-Network*) *deductible* and they do not cross-accumulate. Before benefits can be paid in a *benefit year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

E. Benefit Payment

Each *benefit year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments,* and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

F. Out-of-Pocket Limit

For care provided by a *HealthLink Tier I* (HMO) and *Tier II* (PPO) *contracted provider*, *you* could pay a *co-payment* and/or percentage of the covered expenses, called *co-insurance*, after the *deductible*. The *out-of-pocket maximum* limits the amount *you* could pay for covered medical expenses *incurred* during one (1) *plan year*. Once *your co-payment* and share of covered medical expenses for one (1) person reaches the individual *out-of-pocket maximum* in one (1) *plan year*, including the *deductible*, the *Plan* will pay 100% of covered expenses *incurred* by that person for the remainder of the *plan year* for *Tier I* (HMO) and *Tier II* (PPO) covered charges. The family *out-of-pocket maximum* is the sum of all *co-payment* and *co-insurance* 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 for *Tier I* (HMO) and *Tier II* (PPO) (except for charges that are listed as excluded), which cross-accumulate. *Covered charges* are payable at the percentages shown each *benefit year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached.

The *out-of-pocket limit* includes applicable amounts paid for *deductibles*, *co-payments*, and *co-insurance*.

G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. *You* are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, *you* are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, the *co-insurance* you pay applies towards satisfaction of the *out-of-pocket limit*.

H. Co-Payments

Most providers expect to collect the *co-payment* at the time the services are provided. *Co-payments* are applied on the types of treatment and dates of service indicated on *your* billing statement. Know that consecutive dates of service billed could be applicable to multiple *co-payments* based on the types of treatment billed. *Your co-payment* is the fixed amount *you* pay for *Tier I* (HMO) and some *Tier II* (PPO) *physician* office visits, specialist office visits, *emergency* room, and certain other services. Most providers expect to collect the *co-payment* at the time the services are provided. *Co-payments* are applied on the types of treatment and dates of service indicated on *your* billing statement. Know that consecutive dates of service billed could be applicable to multiple *co-payments* based on the types of treatment billed.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider, per day.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, *your co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Out-of-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *non-network* services and billing.

J. Schedule of Medical Benefits – Healthlink Open Access III Plan Local Government Health Option

	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Deductible, per Plan Year **Annual Plan Deductible must be satisfied for all services.** *Tier II* and *Tier III deductible* amounts do not accumulate towards each other. *Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*.			
Per *plan participant*	$0	$400	$600
Maximum Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.			
Embedded: Per *plan participant*	$7,250		Unlimited
Per *family unit*	$13,750		Unlimited
Family Unit - Embedded Out-of-Pocket Limit If *you* are enrolled in the *family unit* option, *your Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of *your family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.			
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *plan year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable amount (MAA)* 3. charges not covered under the *Plan*			

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
General Percentage Payment Rule	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Ambulance Service	100% *co-insurance*, *deductible* waived			Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance Service, for a further description and limitations of this benefit. ***Pre-certification* is required for non-emergent ambulance.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per hospital stay, course of treatment, per trip, or therapy.
Anesthesia	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Please refer to the **Medical Benefits** section, Covered Medical Charges, Anesthesia, for a further description and limitations of this benefit.
Chiropractic Treatment	$45 *co-payment*	90% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	*Spinal manipulations* performed by other provider types apply to the Chiropractic Treatment benefit level. **Plan Year Maximum:** Twenty-five (25) visits per *plan participant*, includes all services.
Complex Imaging	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes Computed Tomographic (CT) studies, MRI/MRA, and PET scans, excluding services rendered in an *emergency* room setting.
Diagnostic Lab & X-ray	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Dialysis, Outpatient	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Durable Medical Equipment	70% *co-insurance*	60% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required for durable medical equipment in excess of $3,000 purchase price.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy.
Emergency Room	$300 *co-payment/visit*			*Co-payment* is waived if admitted.
Genetic/Genomic Testing and Counseling	100% *co-insurance*	80% *co-insurance* after *deductible*	Not Covered	

Healthlink Open Access III Plan Local Government Health Option

COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
Hearing Care				
Hearing Exam (adult diagnostic)	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes diagnostic tests and hearing aid fittings. **Benefit Maximum:** $150 every twenty-four (24) months per *plan participant*.
Hearing Exam (routine)	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Hearing Aids	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Benefit Maximum:** $2,500 per hearing instrument every twenty-four (24) months per ear per *plan participant*. This maximum does not apply to implantable hearing devices.
Pediatric Hearing Exam (diagnostic)	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes diagnostic tests and hearing aid fittings. **Benefit Maximum:** Diagnostic hearing exams limited to one (1) every three (3) years per *plan participant*. Hearing aids limited to one (1) new set every three (3) years per *plan participant*.
Pediatric Hearing Aids	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Home Health Care	$45 *co-payment / visit*	75% *co-insurance* after *deductible*	Not Covered	Home visits are covered under *Home Health Care*.
Hospice Care	100% *co-insurance*	80% *co-insurance* after *deductible*	Not Covered	*Hospice care services and supplies* for *plan participants* with a life expectancy of less than one (1) year. ***Pre-certification* is required.**
Inpatient Hospital				
Room and Board	$350 *co-payment*	*Deductible*, then $400 *co-payment*, plus 80% *co-insurance*	*Deductible*, then $500 *co-payment*, plus 50% *co-insurance*	***Pre-certification* is required.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy.
Physician Visits	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	

Healthlink Open Access III Plan Local Government Health Option

COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
Inpatient Rehabilitation	85% *co-insurance*	85% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One hundred twenty (120) days per *plan participant*.
LiveHealth Online	$10 *co-payment*	Not Covered	Not Covered	Includes *behavioral health providers*.
Maternity				
Office Visits	$50 *co-payment* per *pregnancy*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	*Dependent* child *pregnancy* is covered. Initial confirmation of *pregnancy*.
Childbirth/delivery professional services	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Included in global maternity fee.
Labor and Delivery	$350 *co-payment*	*Deductible*, then $400 *co-payment*, plus 80% *co-insurance*	*Deductible*, then $500 *co-payment*, plus 50% *co-insurance*	***Pre-certification* is required if stay exceeds forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean delivery.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* confinement, course of treatment, or therapy.
Mental Disorders & Substance Abuse				
Inpatient	$350 *co-payment*	*Deductible*, then $400 *co-payment* plus 80% *co-insurance*	*Deductible*, then $500 *co-payment* plus 50% *co-insurance*	***Pre-certification* is required for inpatient admissions.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. NOTE: There is no benefit coverage for *out-of-network residential treatment centers*. *Out-of-network* professional *claims* for mental health services will be based on billed charges.
Outpatient	**PCP**: $40 *co-payment* **SPC**: $45 *co-payment*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes bereavement counseling, *partial hospitalization*, and *intensive outpatient* therapy. *Out-of-network* professional *claims* for mental health services will be based on billed charges.
Nutritional Counseling	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Please refer to the **Medical Benefits** section, Covered Medical Charges, Nutritional Counseling, for a further description and limitations of this benefit.

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COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
Office Visit				
Primary Care Physician	$40 *co-payment*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	The *co-payment* applies to the office visit only. All other services rendered during the *physician's* office visit are paid at the applicable benefit level.
Specialist (including *behavioral health providers*)	$45 *co-payment*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	*Out-of-network* professional *claims* for mental health services will be based on billed charges.
Organ Transplants	100% *co-insurance*	90% *co-insurance* after *deductible*	Not Covered	Refer to the **Medical Benefits** section for a further description and limitations of this benefit. All other related services will pay under the applicable benefit level. **Travel and Lodging Benefit Limitation:** $2,400 per case (limited to $70 per diem) per *plan participant* and one (1) companion applies for all travel and lodging expenses reimbursed under this *Plan* for approved transplant services from *HealthLink*. Meal reimbursement is not covered. ***Pre-certification* is required.**

Healthlink Open Access III Plan Local Government Health Option

COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
Orthotic Appliances/Foot Orthotics/Prosthetics	70% *co-insurance*	60% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Plan Year Maximum:** Custom foot orthotics, including shoe inserts that are custom-made, are limited to two (2) pairs, per *plan participant*.
Outpatient Observation Stays				
Physician Visits	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Room and Board	$350 *co-payment*	*Deductible*, then $400 *co-payment*, plus 80% *co-insurance*	*Deductible*, then $500 *co-payment*, plus 50% *co-insurance*	
Outpatient Surgery				
Facility	$300 *co-payment* / visit	*Deductible*, then $300 *co-payment* / visit, plus 90% *co-insurance*	*Deductible*, then $300 *co-payment* / visit, plus 50% *co-insurance*	***Pre-certification* is required (excluding office surgeries, pain injections, and screening colonoscopies).** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. *Co-payment* applicable to facility services.
Physician Visits	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Private Duty Nursing	100% *co-insurance*	80% *co-insurance* after *deductible*	Not Covered	
Rehabilitation/Habilitation Therapy				
Physical Therapy Occupational Therapy	$45 *co-payment / visit*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Therapy provided in the home will apply to the *Home Health Care* benefit. **Combined Plan Year Maximum:** Sixty (60) visits per *plan participant*.
Speech Therapy	$45 *co-payment / visit*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Therapy provided in the home will apply to the *Home Health Care* benefit. **Plan Year Maximum:** Sixty (60) visits per *plan participant*.

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COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
Routine Newborn Care	100% *co-insurance*	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Routine newborn care is subject to the newborn's *out-of-pocket limit*.
Skilled Nursing Facility	85% *co-insurance*	85% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One hundred twenty (120) days per *plan participant*.
Urgent Care	$40 *co-payment*			The urgent care visit *co-payment* will apply to the urgent care visit and all other services, including lab and x-rays, performed and billed by the *physician* for the same date of service.
Well Baby Care	100% *co-insurance*	100% *co-insurance*, *deductible* waived	Not Covered	Well Baby Care during the first year of life.

COVERED SERVICES	TIER 1 HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**				
Routine Wellness Care	100% *co-insurance*	100% *co-insurance*, *deductible* waived	Not Covered	Services include routine physical exam, related screening and wellness labs and x-rays, immunizations(except flu shot/flu mist as outlined herein), gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Plan Year Maximum:** One (1) visit per adult *plan participant*. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Flu Shot/Flu Mist	100% *co-insurance*, *deductible* waived			
Breastfeeding Pump	100% *co-insurance*	100% *co-insurance*, *deductible* waived	Not Covered	**Benefit Limitations:** One (1) per *pregnancy*. However, a replacement may be provided if the breast pump breaks or is no longer working and the *plan participant* is still breastfeeding. Manual breast pumps are covered at no charge under the wellness benefit. Electric breast pumps will be covered at the wellness level if deemed *medically necessary*. Breast pump replacement supplies are not covered under the *Plan*.
Contraceptive Services	100% *co-insurance*	100% *co-insurance*, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

K. Schedule of Prescription Drug Benefits - Healthlink Open Access III Plan Local Government Health Option

The *prescription drug* benefits are separate from the medical benefits and are administered by CVS/Caremark. Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Prescription drug charges do not apply to the medical *deductible*.

Prescription drug charges do apply to the medical *out-of-pocket* maximum.

Prescription Drug Deductible, per Plan Year:		
Per *plan participant*	$175	
	NETWORK	**OUT-OF-NETWORK**
Retail Pharmacy Option (30-Day Supply)		
Tier I Drugs	$15 *co-payment*	
Tier II Drugs	$30 *co-payment*	
Tier III Drugs	$60 *co-payment*	
Specialty Drugs	$120 *co-payment*	
Maintenance Choice (90-Day Supply)		
Tier I Drugs	$15 *co-payment*	
Tier II Drugs	$30 *co-payment*	
Tier III Drugs	$60 *co-payment*	
Mail Order Pharmacy Option (90-Day Supply)		
Tier I Drugs	$30 *co-payment*	
Tier II Drugs	$60 *co-payment*	
Tier III Drugs	$120 *co-payment*	
Certain *preventive care prescription drugs* (including generic and brand contraceptives when the generic is unavailable or if the brand name is *medically necessary*) received by a *network pharmacy* are covered at 100% and the *deductible/co-payment/co-insurance* (if applicable) is waived. Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.		

Claims for reimbursement of *prescription drugs* are to be submitted to CVS/Caremark at:

CVS/Caremark
Attn: Claims
P.O. Box 52136
Phoenix, AZ, 85072-2136

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the CVS/Caremark Drug Coverage List, which is incorporated by reference and is available from *your employer* or CVS/Caremark at **www.caremark.com** or 1-877-232-8128.

SECTION VI—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

The *Plan* covers the contracted or negotiated rate, or *maximum allowed amount (MAA)* charges applicable typically only to *non-participating* healthcare providers, *incurred* by a *plan participant* for the services and supplies in the following list. Services and supplies are covered when 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 Health Care Management Program, and are not listed in Medical Plan Exclusions. An expense is *incurred* on the date the service or supply is actually rendered or received. Covered expenses include the following:

1. **3D Mammogram.**
2. **Abortion.** Services, supplies, care, or treatment in connection with an elective abortion, induced miscarriage or induced premature birth will be covered.
3. **Adoptive Cell Therapy. *Pre-certification* is required.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, trip, or therapy.
4. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician*, or in the *physician's* office.
5. **Ambulance.** 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. Inter-facility transport is also available to a *network hospital* after *you* have been stabilized at a *out-of-network hospital*. Charges for services requested for a licensed ground or air *ambulance* service, when the patient is not transported, will not be covered by the *Plan*. Services for chartered flights will not be covered by the *Plan*. ***Pre-certification* is required for non-emergent air ambulance.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, trip, or therapy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
6. **Anesthetics.** Anesthesia charges from a contracted *physician* or certified registered nurse anesthetist (CRNA).
7. **Autism Services.** Provided for *plan participants* younger than age twenty-one (21), benefits include coverage for the diagnosis of *autism spectrum disorders* and for the treatment of *autism spectrum disorders*. This benefit will be treated the same as any other *illness* and is subject to the regular medical *co-payment*, *deductible*, and *co-insurance* provisions of the *Plan*.

   Upon request to the *physician* from the *Plan*, a *physician* treating the *plan participant* 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 *Plan* 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.

   Applied Behavioral Analysis (ABA) Therapy and Testing is covered under the *Plan* but is limited to *plan participants* diagnosed with autism.
8. **Blood.** Administration of blood or blood components.
9. **Cardiac Rehabilitation.** A cardiac rehabilitation program, when prescribed by a contracted treating *physician* and provided through a recognized contracted medical facility.
10. **Cataract Surgery.** Services and supplies associated with cataract *surgery*, including the initial purchase of eyeglasses or contact lenses following each *surgery*. Includes basic glasses only and excludes tinting, transition lenses, and safety lenses.

11. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, trip, or therapy.

12. **Chiropractic.** Includes all *medically necessary* services. *Spinal manipulations* apply to the Chiropractic benefit level. Electronic stimulation and massage therapy are covered when performed by a chiropractor. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

13. **Circumcision.**

14. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy.

15. **Complex Imaging.** Charges for complex imaging, including Computed Tomographic (CT) studies, MRI, and PET scans. Charges include the readings of these medical tests/scans. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

16. **Compression Stockings.** Compression hose are covered as non-surgical treatment of varicose veins. A diagnosis of varicose veins is required for this benefit. In addition, compression hose are covered after a *surgical procedure*, no longer than six (6) months after the procedure, limited to four (4) units, or two (2) pair, per *plan participant* per *plan year*.

    Jobst or Gradient stockings are covered with a diagnosis of lymphedema or varicose veins when deemed *medically necessary*. TED hose are not covered.

17. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the *Preventive Care* provision of this *Plan*.

18. **Cord Blood.** Harvesting and storage of umbilical cord blood when *medically necessary*.

19. **Dental Injuries.** Coverage will apply as a result of *accidental injury* to *sound natural teeth* if the accident occurred while covered under the *Plan* and within one (1) year of the accident.

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.

20. **Diabetic Education/Self-Management Training.** This benefit means instruction in an outpatient setting which enables a diabetic *participant* 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.

21. **Dialysis.** *Your out-of-network outpatient* dialysis medical *claims* will be considered at the *maximum allowable amount* reimbursement level. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

22. **Durable Medical Equipment.** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair/Replacement of purchased equipment is covered unless due to negligence or loss of an item. Delivery or set-up charges are not a benefit of the *Plan*.

    ***Pre-certification* is required when the purchase price is expected to exceed $3,000.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    The following items will be considered under the DME benefit:

    a. **Continuous Blood Glucose Monitor.** Includes supplies.

    b. **Insulin Pumps.** Includes supplies.

    c. **Glucometer.**

d. **Sleep Apnea Oral Devices.** Device must meet *medical necessity* guidelines including custom fitting and may not be purchased over-the-counter. If a *network* provider is not found, the device will be handled as *Tier I*; otherwise, the *network* status of the provider will be utilized for processing after the criteria have been met.

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 along with all items that can be purchased or rented for service:

a. wheelchair
b. *hospital* bed
c. kidney dialysis equipment

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 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.

23. **Flu Shot/Mist.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
24. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/*surgical procedures* when *medically necessary* and not otherwise excluded. Includes prescribed or diabetic shoes which are limited to one (1) pair every five (5) years. Custom molded foot orthotics limited as shown in the applicable Schedule of Medical Benefits. Non-custom molded foot orthotics are not covered.
25. **Gender Dysphoria Services.** The *Plan* will cover eligible charges for sex reassignment *surgery* (also known as gender reassignment or gender confirmation *surgery*), which is one (1) treatment option for extreme cases of *gender dysphoria*, a condition in which a person feels clinically significant distress because of a marked incongruence with the person's expressed/experienced gender and assigned gender. Sex reassignment *surgery* is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the *plan participant* to achieve successful behavioral and medical outcomes. Before undertaking sex reassignment *surgery*, important medical and psychological evaluations, medical therapies, and behavioral trials need to be undertaken to confirm the *surgery* is the most appropriate treatment choice for the *plan participant*.

    This information must be received prior to beginning sex reassignment *surgery* to ensure maximum benefits.
26. **Genetic/Genomic Testing and Counseling.** Genetic testing to identify the potential for, or existence of, a medical condition (such as a test for the breast cancer gene). Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Refer to the **Federal Notices** section, Genetic Information Nondiscrimination Act of 2008 (GINA) subsection.

    Genetic Testing which includes diagnostic testing and counseling when medically appropriate, including but not limited to:

    a. diagnostic testing where the *plan participant* is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder
    b. 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
    c. predictive testing if the *plan participant's* family history establishes the patient is at risk for a genetic disease, but only if there are accepted treatment alternatives for that condition
    d. 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

    Coverage under the *Plan* also includes NIPT subject to *medically necessity* criteria. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
27. **Growth Hormones.** Growth hormones are covered when *medically necessary.* Refer to the Medical Plan Exclusions for any applicable exclusions or limitations.

28. **Hearing Services.** Coverage for hearing instruments and related services for all *plan participants* when a hearing care professional prescribes a hearing instrument to augment communication are as outlined below:

    a. **Aural Therapy.** Benefits include aural therapy in connection with covered implantable hearing devices and apply to the applicable benefit level.

    b. **Hearing Aids and Implantable Hearing Devices.** Charges for services and supplies in connection with hearing aids and implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting.

    c. **Hearing Exams.** Both pediatric and adult hearing examinations and other related services when *medically necessary.*

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

29. **Home Health Care.** Charges for *home health care services and supplies* (including medical supplies, drugs, and medicines that would have been covered had the *plan participant* remained in the *hospital*) are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. *Home health care* contracted services must be provided under a written treatment plan prescribed by a contracted *physician* as an alternative to hospitalization.

    a. Benefit payment for nursing by the supervision of a registered nurse (RN), home health aide, and therapy services are subject to the *home health care* benefit as shown in the applicable Schedule of Medical Benefits.

    b. A *home health care* visit will be considered a periodic visit by a *physician*. This includes part-time or intermittent home health aid services consisting primarily of caring for the *plan participant*.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

30. **Home Infusion Therapy. *Pre-certification* is required for specialty infusion/injectables over $3,000 per infusion/injection.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy.

31. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from *home health care* and therapy done in the home.

32. **Hospice Care.** *Hospice care contracted services* received under an attending contracted *physician's* written *hospice care plan* for a *plan participant* whose life expectancy is one (1) year or less. 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:

    c. *physician* services

    d. *skilled nursing care* services

    e. *home health care* services

    f. medicines, drugs, and medical supplies

    g. homemaker services

    h. physical, respiratory, and speech therapy

    ***Pre-certification* is required.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

33. **Hospital Care.** The medical services and supplies furnished by a *hospital* or *ambulatory surgical facility*. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for inpatient admissions.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per hospital stay, course of treatment, or therapy.

    a. Charges for an *intensive care unit* stay do not apply to the semi-private room rate.

    b. Anesthesia coverage and facility charges for dental services when the medical condition is significant enough to impact the need to provide anesthesia services, and when other alternative type of anesthesia, sedation, or analgesia are not appropriate:

        i. The *plan participant* is under age six (6).

ii. The *plan participant* is *disabled* physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.

This benefit does not cover the *dentist's* services.

34. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for organic impotence, based on *medical necessity*. Surgically implanted penile prostheses when the dysfunction is related to an *injury* or *illness*. Vacuum erection devices are not covered.

35. **Infertility.** Benefits are provided for the diagnosis and treatment of *infertility*. Treatment of *infertility* is provided after documentation is received from the *physician* that includes the *plan participant's* reproductive history with test results, information pertaining to conservative attempts to achieve *pregnancy*, the proposed plan of treatment with CPT codes, and any other documentation as needed.

NOTE: 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 description of *Infertility* in the **Defined Terms** section. *Covered charges* for assisted reproductive procedures are outlined below.

Covered benefits include, but are not limited to:

a. testing
b. *prescription drugs* (dispensed by CVS/Caremark)
c. *artificial insemination*
d. *in vitro fertilization*
e. *uterine embryo lavage*
f. *embryo* transfer
g. *zygote intrafallopian tube transfer*
h. low tubal ovum transfer
i. gamete intrafallopian tube transfer
j. intracytoplasmic sperm injection
k. donor sperm and eggs (medical costs, prescriptions, lab)
l. procedures utilized to retrieve oocytes or sperm, and subsequent procedures used to transfer the oocytes or sperm to the *plan participant*
m. associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and *prescription drugs* (through CVS/Caremark) if established as prerequisites to donation by the *plan participant*

Limitations. Coverage is limited to four (4) completed oocyte retrievals per lifetime of the *participant*, except that two (2) completed oocyte retrievals are covered after a live birth is achieved as a result of an artificial reproductive transfer of oocytes. For example, if a live birth takes place as a result of the first completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of three (3) are covered under the law. If a live birth takes place as a result of the fourth completed oocyte retrieval, then two (2) more completed oocyte retrievals for a maximum of six (6) are covered. The maximum number of completed oocyte retrievals that can be covered under the law is six (6). One (1) completed oocyte retrieval could result in many procedures used to transfer the oocytes or sperm (see below). After that, the benefit is maxed out and no further benefits are available under the law.

a. **Intrauterine Insemination (IUI or AI).** Washed sperm is placed into the uterus through a small catheter (no limit).
b. **Intracytoplasmic Sperm Injection (ICSI). Direct** injection of a single sperm into an egg retrieved from the ovary. After injection, the egg is allowed to fertilize in an incubator before being transferred back to the uterus (no limit once egg is retrieved).

c. **Gamete Intra Fallopian Transfer (GIFT).** Direct placement of eggs and sperm into the fallopian tube. Fertilization takes place naturally inside the tube not outside the body (as in 1VF). This procedure requires that a laparoscopy be performed (no limit once is egg is retrieved).

d. **Zygote Intra Fallopian Transfer (ZIFT).** A combination of *IVF* and GIFT; the egg and sperm are fertilized externally and then placed directly into the fallopian tube. This procedure requires that a laparoscopy be performed (no limit once egg is retrieved and includes frozen embryo transfers).

e. **Low Tubal Ovum Transfer (TET).** Eggs are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus (no limit).

f. **Uterine Embryo Lavage (UEL).** Uterus is flushed to recover a pre-implantation embryo (no limit).

NOTE: Oocyte retrievals are per lifetime of the individual. If *you* had completed oocyte retrieval in the past that was paid for by another carrier, or not covered by insurance, it still counts toward *your* lifetime maximum under the law. If an oocyte donor is used, then the completed oocyte retrieval performed on the *donor* shall count against the *plan participant* as one (1) completed oocyte retrieval.

Refer to the Medical Plan Exclusions for any applicable exclusions or limitations.

36. **Maternity.** Maternity care may include tests and services described elsewhere. *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child *pregnancy* is covered. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. Charges for a planned home birth will be considered a covered benefit.

    A single *co-payment* is applicable for both mother and newborn (well-baby care); if the newborn remains after the mother is discharged, a separate *co-payment* will apply. If a female is pregnant when she becomes a *plan participant* in this *Plan*, coverage is effective upon enrollment. Newly enrolled *plan participants* who are in the third trimester of *pregnancy* will be allowed continuity of care provided by their current obstetrician.

    NOTE: Breastfeeding support, supplies, and counseling are also available without cost sharing when services are received from a *Tier I* or *Tier II* provider. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    The care and treatment of *pregnancy* for a *dependent* child is limited to certain *preventive care* services. Refer to the *Preventive Care* provision or visit **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** for a current listing of required *pregnancy* related *preventive care* benefits.

    HealthLink conducts concurrent medical necessity review if the *plan participant* is hospitalized more than two (2) days for vaginal delivery or more than four (4) days for cesarean section delivery. If a non-contracted provider or facility is rendering the services, *HealthLink*'s Medical Management department will notify *HealthLink*'s Network Management department for a possible negotiation of the *non-contracted provider* or facilities fees. Call *HealthLink*'s Customer Service department for additional information.

37. **Medical Foods.** Medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are covered under the *Plan* when *medically necessary*.

38. **Medical Supplies.** Charges for surgical dressings, sutures, braces, splints, casts, trusses and crutches, and other devices used in the reduction of fractures and dislocations with the exception of dental braces and corrective shoes. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces. This benefit may require *medical necessity* review prior to purchase.

39. **Mental Disorders and Substance Abuse.** *You* may go to any provider you choose and receive psychiatric services, alcohol, and substance abuse care. Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. 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. Counseling for the purpose of family problems is covered. In addition, group counseling is covered when billed with an otherwise covered diagnosis. *Inpatient* and *outpatient* treatment for *mental disorders*, (including counseling as previously outlined) will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. Services includes psychiatric day treatment, residential treatment, *partial hospitalization* (two (2) *partial hospitalization* sessions equal one (1) day of *inpatient* care), and *intensive outpatient* programs.

    Bereavement counseling services are covered under the mental disorders and substance abuse benefit. Services by a licensed social worker or a licensed pastoral counselor will be considered a covered provider for purposes of bereavement counseling, subject to all other *Plan* provisions.

    NOTE: *Out-of-network* professional *claims* for mental health services will be based on billed charges. However, there is no benefit coverage for *out-of-network residential treatment centers*.

    ***Pre-certification* is required for inpatient admissions.** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

40. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries. Please see Maternity exclusion for birthing center limitation.

41. **Morbid Obesity.** Expenses *incurred* for procedures intended primarily to treat morbid obesity are only covered when *medically necessary*, including, but not limited to:

    a. bariatric *surgery*
    b. gastric balloons
    c. stomach stapling
    d. jejunal bypasses
    e. wiring of the jaw and services of a similar nature
    f. mason shunt
    g. banding gastroplasty or intestinal bypass
    h. reversals of morbid obesity *surgeries*

    Services include any *medically necessary* counseling required prior to surgical services. ***Pre-certification*** is suggested prior to the services being rendered to make sure *medical necessity* is met. Refer to the Medical Plan Exclusions for Obesity exclusion.

42. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health emergency, as required by federal regulation. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.

43. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain *injury*, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.

44. **Non-Emergent Services Outside of the United States.** The *Plan* covers eligible charges *incurred* outside of the United States for services that are generally accepted as *medically necessary* within the United States. All benefits are subject to the *Plan* provisions and *deductibles*. The benefit for facility and professional charges is paid at the *out-of-network* level. Notification is not required for *medically necessary* services rendered outside of the United States; however, *medical necessity* must be established prior to reimbursement unless it is *emergency* treatment. Payment for the services will most likely be required from the *plan participant* at the time the services are rendered.

    Plan participants must file the *claim* with *HealthLink* for reimbursement. When filing a *claim*, enclose the itemized bill with a description of the services translated to English and the total amount of *billed charges*, along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address, and telephone number.

    Reimbursement in American dollars will be based on the conversion rate of the billed currency on the date services were rendered.

    Generally, *Medicare* will not pay for healthcare obtained outside of the United States and its territories. When *Medicare* does not pay, the *Claims Administrator* becomes the primary payor and standard benefit levels will apply.

45. **Nutritional Counseling.** 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. These services must be prescribed by a *physician* and provided by a licensed health care professional (e.g., a registered/clinical dietitian). A letter of *medical necessity* from the prescribing *physician* is required. Coverage shall be limited to one (1) nutritional counseling session per primary medical condition per lifetime not to exceed ten (10) classes per session. Conditions for which nutritional evaluation and counseling may be considered *medically necessary* include, but are not limited to the following:

    a. anorexia nervosa/bulimia
    b. celiac disease
    c. cardiovascular disease
    d. crohn's disease
    e. hyperlipidemia
    f. liver disease
    g. malabsorption syndrome
    h. metabolic syndrome
    i. multiple or severe food allergies
    j. nutritional deficiencies
    k. gastric bypass/lap band
    l. renal failure
    m. ulcerative colitis
    n. cancer
    o. high cholesterol
    p. high blood pressure
    q. diabetes and pre-diabetes
    r. *autism*

    Nutritional counseling is excluded 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)

46. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:

    a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth

    b. excision of benign bony growths of the jaw and hard palate

    c. external incision and drainage of cellulitis

    d. incision of sensory sinuses, salivary glands, or ducts

    e. removal of all teeth at an *inpatient* or *outpatient hospital* or *dentist*'s office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition

    f. organ transplant preparation

    g. removal of bony impacted teeth

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.

47. **Orthognathic Surgery/LeFort Procedures.** Orthognathic *surgery* to correct birth defects of eligible *plan participants* since birth and/or may become evident as the *plan participant* grows and develops, or which occurred through *accidental injury* while covered under this *Plan*.

48. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided.

49. **Pediatric Autoimmune Neuropsychiatric Disorders (also known as the Charlie's Law).** The *Plan* provides coverage associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome. The covered treatment must include, but is not limited to, use of intravenous immunoglobulin therapy.

50. **Penile Prostheses.** Surgically implanted penile prostheses when the dysfunction is related to an *injury* or *illness*. Refer to the Medical Plan Exclusions for any applicable exclusions or limitations.

51. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed surgeon's *maximum allowable charge*.

    Charges for **multiple *surgical procedures*** will be a *covered charge* subject to the following provisions:

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable charge*, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*.

52. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that *you* obtain on an *outpatient* basis prior to *your* scheduled admission to the *hospital*. *You* should make sure *your hospital* will accept the results of these tests.

53. **Preventive Care.** The *Plan* will pay 100% of the cost of certain services provided by a *HealthLink network provider*, 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 one (1) routine physical exam per *plan year*, some routine screening tests, immunizations, and counseling to promote health and prevent health problems, as prescribed in the Guidelines. Benefits will be provided for *preventive care,* including, but not limited to:

    a. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

    b. **Contraceptives. Includes:** oral, diaphragm, lea's shield, cervical cap, patch: ortho cvra, depo-provera injection, and implants: norplant and etonogestrel IUD.

    c. **Examinations.** Any health examination required to secure school admissions or sports physicals.

    d. **Gynecological Exam, Pap Smear, Colorectal Cancer Screening, and Mammogram.** Cologuard is covered at the routine level only when provided by Exact Sciences. Exact Sciences is a *Tier I* provider.

    e. **Prostate Specific Antigen Test.**

    f. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC), including, but not limited to:

        i. **HPV Vaccine.** Routine vaccination at age eleven (11) or twelve (12) years [vaccination can be started at age nine (9)] or females aged thirteen (13) through forty-five (45) years and males aged thirteen (13) through forty-five (45) years not adequately vaccinated previously. Vaccination is also recommended through age forty-five (45) years for gay, bisexual, and other men who have sex with men, transgender people, and for immunocompromised persons (including those with HIV infection) not adequately vaccinated previously. Ideally, adolescents should be vaccinated before they are exposed to HPV. However, *participants* who have already been infected with one (1) or more HPV types can still get protection from other HPV types in the vaccine.

        ii. **Influenza Vaccine.**

        iii. **Shingles Vaccine.** For *plan participants* age fifty (50) and over.

    The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

    g. **Preventive Lab and X-Ray.** Screening and wellness laboratory and x-ray services related to routine examinations.

    h. **Sterilization.** Services for tubal ligation or other voluntary sterilization procedures for female *plan participants*.

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

    Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:

    a. https**://www.healthcare.gov/coverage/preventive-care-benefits/**

    b. **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**

54. **Private Duty Nursing.** Charges in connection with care, treatment, and services of a private duty nurse. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

55. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, larynx, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis, but not replacement of such items unless the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable. Mastectomy Bras and Camisoles are considered under the prosthetic devices benefit and are limited to two (2) total items per *plan participant* per *plan year*. This benefit may require *medical necessity* review prior to purchase.

56. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in only the following circumstances:

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part

       Surgical services must be initiated for *plan participants* before the age of nineteen (19).

    b. to **correct** damage caused by an *accidental injury*

    c. **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. Tattooing of skin may be considered *medically necessary* when done as part of a *medically necessary* therapeutic process and performed by a medical provider (i.e. part of *reconstructive breast surgery* or radiation therapy). Also included are post-discharge contracted *physician* office and home visits to monitor the condition of the *plan participant* after discharge.

    Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

57. **Rehabilitation/Habilitation Services.** Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis. Therapy in the home applies to the *outpatient* maximum. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

    a. **Occupational therapy**. Therapy must result from an *injury* or *illness*, and improve a body function. *Covered charges* do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

    b. **Physical therapy.** Benefits include aquatic therapy. Short-term restorative physical therapy by a contracted licensed therapist. Wound debridement services do not apply toward the Rehabilitation Therapy maximum and do not require *pre-certification*.

    c. **Speech therapy**. Short-term speech therapy by a contracted qualified speech therapist to restore speech lost due to *surgery*, *injury*, *surgery* for a covered implantable hearing device, 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.

58. **Retail Clinics.**

59. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

    a. This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:

       i. is a *plan participant* who was covered under the *Plan* at the time of the birth

       ii. enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

    b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.

60. **Safe Harbor Services.** Services rendered by a *Tier III* (*out-of-network*) provider are not covered under the *Plan*.

61. **Second Surgical Opinion.** If *your* doctor recommends *surgery* or other medical treatment, it is often in *your* best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

62. **Skilled Nursing Facility.** Convalescent skilled nursing contracted facility charges for semi-private room and board, as well as general nursing and other medical services customarily provided. Confinement in a convalescent *skilled nursing* contracted facility must begin within fourteen (14) days following a *hospital* confinement of at least three (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. The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:

    a. The patient is confined as a bed patient in the facility.

    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

    c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility.*

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

63. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

64. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the *Preventive Care* provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

65. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for outpatient surgical procedures (excluding outpatient office surgical procedures).** Failure to obtain *pre-certification* for *Tier III* services will result in a $500 penalty per *hospital* stay, course of treatment, or therapy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

66. **Telemedicine.** Telemedicine will be covered when using *Healthlink* product (LiveHealth Online).

67. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.

68. **Transplants.** 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. 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 *plan participant* and one (1) *immediate family* member or support person prior to the transplant and for up to one year (1) 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. Refer to the Medical Plan Exclusions subsection for a further description and limitations of eligible travel expenses for reimbursement.

69. **Varicose Veins.** Coverage includes, but is not limited to, vein stripping, radiofrequency or laser ablation and sclerotherapy if deemed *medically necessary*. 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 two (2) pair per *plan year*. In addition, compression hose are covered after a *surgical procedure*, no longer than six (6) months after the procedure, with a limit of two (2) per covered period.

70. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor.

71. **Vision Benefits.** Benefits are available for vision examinations, including refraction, when performed in conjunction with a medical diagnosis or due to an *accidental injury* that occurred while covered under the *Plan* and within one (1) year of the *accident*.

72. **X-Rays.** Diagnostic laboratory and X-ray examinations, including professional fees.

B. Medical Plan Exclusions

The following list is intended to give *you* a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

1. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupuncture, acupressure, aromatherapy, hypnotism or hypnotic anesthesia, electric stimulation (except as specified herein), massage therapy (except as specified herein), biofeedback, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
2. **Applied Behavioral Analysis Therapy/Testing (ABA).** Except for *autism* or as specified herein.
3. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
4. **Athletic Training.**
5. **Blood Donor Expenses.**
6. **C-PAP.** Replacement C-PAP machine when traveling out of the country.
7. **Charges for Grandchildren.**
8. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a *participating*, *network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care *provider network* unless *out-of-network* benefits are otherwise provided under this *Plan*.
9. **Cosmetic.** Any expenses for cosmetic *surgery*. Cosmetic *surgery* is beautification or aesthetic *surgery* to improve a *plan participant'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.
10. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling with *plan participant's* friends, *employer*, school counselor, or school teacher.
11. **Court-Ordered Treatment.** 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*. This exclusion does not apply to *mental health or substance abuse holds*.
12. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, *custodial care*, convalescent care, custodial care, sanatoria care, 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, childcare, transportation, or homemaker services.
13. **Dental Care.** Normal dental care benefits (including dental implants and braces even if the request is due to an *accidental injury* to the *sound natural teeth*), gum treatments, or oral *surgery* except as otherwise specifically provided herein.

14. **Dental Implants, Impacted Teeth, or Orthodontia.** 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 *Plan*. Any additional expenses performed or prescribed by a dentist will be considered not covered under *your Plan*, including but not limited to:
    a. sleep apnea dental device, except as explicitly stated herein
    b. MAS devices
    c. mandibular advancement splint
    d. mandibular repositioning appliances (MRA)
15. **Dental Injuries (Chewing).** Dental injuries that occur as a result of chewing are not covered.
16. **Developmental Delays.** Non-medical ancillary services for learning disabilities, developmental delays, or mental retardation except when deemed *medically necessary* under autism coverage.
17. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as nutrition therapy, asthma self-management education, and Lamaze.
18. **Employment Counseling.** Employment counseling, return to work services, work hardening programs, driving safety or training.
19. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
20. **Examinations.** Any health examination required by any law of a government or professional or other licenses, except as required under applicable federal law or as noted herein.
21. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit or because the charges are in excess of the *maximum allowable charge*, or are for services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
22. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
23. **Experimental/Investigational.** Care and treatment that is *experimental/investigational* or alternative medicine that does not meet generally accepted medical standards. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this summary plan description.
24. **Facility Fees.** Facility fees billed by day programs under the *Plan*. Physical therapy or medical care will need to be billed separately or 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 will still be denied if utilizing a *non-contracted provider*.
25. **Foot Care.** 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 *plan participants* 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 *plan participant* 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*.
26. **Foreign Travel.** Any charges for services received or supplies purchased outside of the United States, unless the *plan participant* 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.
27. **Gene Therapy.** Except as stated herein. See adoptive cell therapy coverage in the Covered Medical Charges section.

28. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any 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. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. For treatment in Veterans Affairs facilities, the law generally requires the *Plan* to provide benefits for a *plan participant* who does not have a service-connected disability.
29. **Growth Hormones.** Growth hormones for children with short stature based upon heredity and not caused by a diagnosed condition.
30. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*.
31. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
32. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
33. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
34. **Illegal Acts.** 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. 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).
35. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
36. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
37. **Infertility Treatment. Infertility treatment exclusions that include, but are not limited to:**
    a. medical or non-medical costs of anyone not covered under the *Plan*; excluding approved donor
    b. costs for services rendered to a *surrogate*; however, costs for procedures to obtain eggs, sperm, or embryos from a *plan participant* shall be covered if the *participant* chooses to use a *surrogate* and the *participant* has not exhausted benefits for completed oocytes retrievals
    c. costs *incurred* for reversing a voluntary tubal ligation or vasectomy. In the event a voluntary sterilization is successfully reversed, *infertility* benefits shall be available if the *plan participant's* diagnosis meets the definition of *infertility* and their benefits have not been exhausted.
    d. costs of preserving and storing sperm, eggs, and embryos
    e. experimental treatments or those unproven in nature
    f. costs for procedures which violate the religious and moral teachings or beliefs of the company or covered group
    g. costs of transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling donor, cost of sperm or egg purchased from a donor bank, cryopreservation, and storage of sperm or embryo, fees payable to a donor
    h. travel costs
    i. *infertility* treatments rendered to *dependents* under the age of eighteen (18)
    j. 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.
    k. pre-implantation genetic testing
    l. donor expenses of an anonymous donor requiring *prescription drugs*

m. any charges for *artificial insemination*, *in vitro fertilization* or embryo or fetal implants, or other assisted reproduction techniques, except as outlined in the Covered Medical Charges.

n. 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 a *plan participant*

This shall not preclude payment for covered expenses as outlined in the Covered Medical Charges.

38. **Legal Fees.** For any legal fees *incurred* by *plan participants* in relation to the benefit *Plan* and its administration.
39. **Long Term Care.**
40. **Maternity.** Charges for services provided to a *surrogate* mother or to the biological mother of a child adopted by *plan participant*. Birthing centers are not a covered benefit. This shall not preclude payment for covered donor expenses for covered transplant procedures nor *donor* expenses approved under as outlined in the Covered Medical Charges.
41. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
42. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
43. **Miscellaneous Items.** Air conditioners, air purifiers, arch supports, support stockings, batteries/battery charges, corrective shoes, specialized baby formula, heating pads, heated humidifiers, hot water bottles, personal care items, and any other primarily nonmedical equipment.
44. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.
45. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
46. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
47. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
48. **Non-Compliance.** All additional charges in connection with treatments or medications which were directly caused by, and attributed to, the patient's non-compliance with or discharge from a *hospital* or *skilled nursing facility* against medical advice.
49. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
50. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, services for telephone consultations (except *network* telemedicine services or virtual visits), or expenses for failure to keep a scheduled visit or appointment.
51. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, Antabuse, Minoxidil, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, nutritional therapy, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.
52. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
53. **Not Covered.** Any charges *incurred* by any person not covered under the plan as an *employee* or *dependent*.

54. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*.

55. **Occlusion Guard.**

56. **Obesity.** Screening and counseling for obesity will be covered to the extent required under the *Preventive Care* provision. Other care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*. Refer to the Covered Medical Charges for coverage for Morbid Obesity.

57. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If *you* are covered as a *dependent* under this *Plan* and *you* are self-employed or employed by an *employer* that does not provide health benefits, make sure that *you* have other medical benefits to provide for *your* medical care in the event that *you* are hurt on the job. In most cases workers' compensation insurance will cover *your* costs, but if *you* do not have such coverage, fail to file, or receive a denial for failure to file timely, *you* may end up with no coverage at all.

58. **Orthognathic Surgery/LeFort Procedures.** Except as explicitly stated herein.

59. **Orthotics.** Charges in connection with non-custom molded orthotics or as explicitly stated herein.

60. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease*, and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care or as outlined under the telemedicine benefit.

61. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings, non-*prescription drugs* and medicines, first-aid supplies, seat risers, and non-*hospital* adjustable beds.

62. **Personal Convenience Items.** For purchase or rental of personal convenience items or supplies for common use, including, but not limited to:

    a. blood pressure kits
    b. exercise equipment/cycles
    c. air purifiers
    d. air conditioners
    e. water purifiers
    f. hypo-allergenic pillows, mattresses, or waterbeds
    g. escalators
    h. elevators
    i. saunas, steam rooms, and/or swimming pools
    j. telephone charges
    k. television rental
    l. guest meals
    m. wheelchair/van lifts
    n. non-*hospital* type adjustable beds
    o. special toilet seats, grab bars, ramps, or any other services or items determined by the *plan* to be for personal convenience
    p. 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

63. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar

type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family owned vehicle or a pedestrian.

64. **Prescription Drugs.** Prescription drug charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
65. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.
66. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
67. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
68. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional.
69. **Scarring Surgery.** Surgical treatment of scarring secondary to acne or chicken pox to include, but not to be limited to:
    a. dermabrasion
    b. chemical peels
    c. abrasion
    d. collagen injections
70. **Skilled Nursing Facility/Hospital Room and Board.** For *skilled nursing facility* and/or *hospital* room and board charges for days when the bed has not been occupied by the *plan participant* (holding charges).
71. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the *Preventive Care* provision. Tobacco cessation care and treatment is otherwise excluded under the medical benefits.
72. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
73. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.
74. **Transplants.** Organ transplants consisting of non-human devices or artificial organs such as heart, kidney, or liver. This exclusion does not apply to VADs or LVADs.

    NOTE: If *you* are a transplant candidate for any type of organ transplant, consult *your HealthLink contracted physician* or *HealthLink* Customer Service department.
75. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for *ambulance* charges defined as a *covered charge* or travel required for an approved organ or tissue transplant. The following are excluded charges, even if *incurred* during travel for an approved organ or tissue transplant:
    a. Entertainment items such as: Alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips.
    b. Convenience items such as: toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, babysitter/childcare, cell phones, valet parking, faxing.
    c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils
    d. apartment rental (such as Air B&B type lodging services)
    e. vehicle maintenance
    f. cash advances/lost wages
    g. taxes

h. moving trucks/vehicles

76. **Vacuum Erection Devices.**

77. **Vision Care Exclusions.** Expenses for the following:

    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    b. diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular *surgery* when the lens of the eye has been removed such as with a cataract extraction

    c. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

    d. orthokeratology lenses for reshaping the cornea of the eye to improve vision

78. **War.** Care of any *injury* or *illness incurred* while on active or reserve military duty or any *injury* or i*llness* resulting from war, declared or undeclared, any act of war or any act of terrorism.

SECTION VII—MEDICAL MANAGEMENT PROGRAM

A. Introduction

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 healthcare consumers 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*.

If a contracted *physician* is supervising care for *you* or *your* covered *dependent*, in most instances, he or she will call the *Medical Management Administrator* to request *pre-certification* on *your* behalf. It is your responsibility to make sure that *out-of-network* providers follow this procedure. However, if *you* utilize a *Tier I* (HMO) or *Tier II* (PPO) *HealthLink* contracted provider, it would be his or her responsibility to make sure any *pre-certifications* are handled by his or her office prior to the care being rendered.

The scope of the Health Care Management Program consists of the following components (each of which will be further discussed in this section):

1. *Utilization Review*
2. Concurrent Review and Discharge Planning
3. Case Management
4. Wellness Program

B. Utilization Review

The *utilization review* program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your employer has contracted with a *Medical Management Administrator* in order to assist *you* in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis, of the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical management Administrator* to receive certification of certain health care management services. This call must be made at least seven (7) day in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket limit.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
   a. *surgical* and non-surgical (excluding routine vaginal or cesarean deliveries)
   b. long term acute care facility (LTAC), not custodial care
   c. *inpatient* mental health/substance abuse treatment (includes *residential treatment facility* services)

   The attending *physician* does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery* (excluding office surgeries, pain injections and screening colonoscopies)
3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

   NOTE: There is no benefit coverage for Tier III (*out-of-network)* transplants.
4. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

   This *Plan* does not cover clinical trials related to other diseases or conditions. Refer to the Medical Benefits section of this document for a further description and limitations of this benefit.
5. specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion), over $3,000 per infusion/injection
6. *durable medical equipment* in excess of $3,000 (purchase price only)
7. *hospice care services*

   NOTE: There is no benefit coverage for Tier III (*out-of-network)* hospice care.
8. non-emergent air *ambulance*
9. chemotherapy drugs/infusions and radiation treatments for oncology diseases
10. adoptive cell therapy

In order to maximize Plan reimbursements, please read the following provisions carefully.

C. How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least seven (7) days before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*

5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility*, the patient, patient's family member, *medical care facility*, or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure will reduce reimbursement received from the *Plan*.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this summary plan description.

NOTE: If *your* admission or service is determined to **not** be *medically necessary*, *you* may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

D. Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, *your* benefits will be unaffected. However, if *you* do not follow the *pre-certification* requirements outlined above for *Tier III* (*out-of-network*) services, **you will be subject to a $500 penalty per *hospital* confinement, course of treatment, trip, or therapy for any resulting *claims***. Penalty will be applied to the facility charge, if applicable. Services would still need to be *medically necessary* and appropriate for payment. Amounts assessed under this penalty will not go towards satisfaction of *your out-of-pocket limit*.

E. Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

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 internal guidelines, policies or clinical review criteria that were used to make the determination.

F. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. *The Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

G. Case Management

Case Management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of Case Management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible Case Management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under Case Management may be provided if *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All Case Management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECTION VIII—CLAIMS PROCEDURES AND COMPLAINTS AND APPEALS

A. Introduction

This section contains the *claims* and *appeals* procedures and requirements for the State of Illnois Health Benefits Plan.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

As a *plan 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. 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 1-877-379-5802. Alternatively, *you* can file a written complaint to HealthLink Grievances and Appeals, P.O. Box 7186, Boise, ID 83707.

C. Appeals

There are two (2) separate categories of *appeals*: medical and administrative. The *Claim Administrator* determines the category of *appeal*. The *plan participant* will receive written notification regarding their *appeal* rights and information regarding how to initiate an *appeal*. *You*, *your* provider, or any other person *you* choose may *appeal* on *your* behalf.

Medical *appeals* pertain to benefit determinations involving medical judgment, including *claim* denials determined by the *Claim Administrator* to be based upon lack of *medical necessity*, appropriateness, health care setting, and level of care or effectiveness and denials for services determined by the *Claim Administrator* to be *experimental* or *investigational*.

D. Submitting for Reimbursement

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.

E. Itemized Bills

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, tax ID number, and NPI number

F. Administrative Appeals

Administrative *appeals* pertain to *claim* denials based on plan design and/or contractual interpretations of *Plan* terms that do not involve any use of medical judgment.

G. Expedited External Reviews

Except for expedited external reviews, the internal *appeal* process must be followed through before the *plan participant* may seek external review or other available *appeal* levels.

1. **First Level/Internal Appeals.** First level *appeals* must be initiated with the *Claim Administrator* within one hundred eighty (180) days of the date of receipt of the initial *adverse benefit determinations*. An expedited review may be requested orally or in writing if the *plan participant*, a contracted *HealthLink* provider, or other healthcare provider involved in the *appeal* believes that the denial of coverage of healthcare services could significantly increase risk to health. Non-urgent *appeals* should be submitted to:

   HealthLink Grievances and Appeals
   P.O. Box 7186
   Boise, ID 83707
   1-877-379-5802

   All *appeals* will be reviewed and decided by an individual(s) who was not involved in the initial *claim* decision. Each case will be reviewed and considered on its own merits. If the *appeal* involves a medical judgment, it will be reviewed and considered by a qualified healthcare professional. In some cases, additional information, such as tests results, may be required to determine if additional benefits are available. Once all required information has been received, the *Claim Administrator* shall provide a decision within the applicable time frame: fifteen (15) days for *pre-service claims*; thirty (30) days for *post-service claims*; or seventy-two (72) hours for *urgent care claims*.

2. **Final Benefit Determination — Administrative Appeals Only.** After exhausting the first level/internal appeal available, if the *plan participant* still feels that the *Claims Administrator benefit determination* is not consistent with the published benefit coverage through the *Claim Administrator*, they may *appeal* the *Claim Administrator's* decision to CMS Group Insurance Division. For an *appeal* to be considered by CMS Group Insurance Division, the *plan participant* must *appeal* in writing within sixty (60) days of the date of receipt of the *Claim Administrator's* final internal *adverse benefit determination*. All *appeals* must be accompanied by documentation to support the request for reconsideration. Submit administrative *appeal* documentation to:

   CMS Group Insurance Division
   801 S 7th Street PO Box 19208
   Springfield, IL 62794-9208

   The decision of CMS Group Insurance Division shall be final and binding on all parties.

3. **External Review Process — Medical Appeals Only.** After completion of the internal *appeal* process referenced above, the *plan participant* may request an *external review* of the *Claim Administrator's* final internal benefit determination. A request for an *external review* must be filed in writing within four (4) months of the date of receipt of the *Claim Administrator's* final internal *adverse benefit determination*. The *Claim Administrator* will provide more information regarding how to file a request for *external review*. The *plan participant* will be given the opportunity to submit additional written comments and supporting medical documentation regarding the *claim* to the external reviewer. The external reviewer will provide a final external review decision within forty-five (45) days of thereceipt of the request. If the external reviewer decides in favor of the *plan participant*, the decision shall be final and binding on the *Claim Administrator*.

4. **Expedited External Review — Medical Appeals Only.** For medical *appeals* involving urgent care situations, the *plan participant* may make a written or oral request for expedited *external review* even if the internal *appeals* process has not been exhausted. The external reviewer will review the request to determine whether it qualifies for *expedited review*. If the external reviewer determines that the request qualifies for expedited review, the external reviewer will provide a final *external review* decision within seventy-two (72) hours after the receipt of the request. If the external reviewer decides in favor of the *plan participant*, the decision shall be final and binding on the *Claim Administrator*.

H. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

I. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

J. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for their estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

K. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which they are a *plan participant* in the *Plan*, or following their termination as a *plan participant*, in any manner, have any right to assign their right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan*, or to any other causes of action which they may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

L. Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (non-U.S. provider) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a non-U.S. provider.
2. The *plan participant* is responsible for making all payments to non-U.S. providers and submitting receipts to the *Plan* for reimbursement.
3. Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date.
4. The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. *Claims* for benefits must be submitted to the *Plan* in English.

M. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such, this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement And Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of their covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a provider due to a *claim* being made in error, a *claim* being fraudulent on the part of the provider, and/or a *claim* that is the result of the provider's misstatement, said provider shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount.

SECTION IX—COORDINATION OF BENEFITS (COB)

A. Overview

Often, if both partners work, members of a family may be covered under more than one (1) plan. The *Plan* has adopted coordination of benefit rules to avoid duplication of coverage, which is two (2) plans paying benefits for the same allowable expenses. When a *plan participant* is covered by more than one (1) plan, these rules determine the order in which the *Plan* pays benefits:

1. The amount of benefits payable under this *Plan* will take into account any coverage a participant has under another plan. For purposes of COB, the term "plan" is defined as any plan that provides medical coverage, including the following:
    a. Any group or individual insurance plan including Health Maintenance Organizations (HMOs)
    b. Any governmental plan, except the Illinois Medical Assistance Program (Medicaid)
    c. 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.
    d. As required by law.
    e. The *Plan* does not coordinate benefits with private individual insurance plans, elementary, high school, and college *accident* insurance and Medicaid.

    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 (1) of the plans defined above.
2. Amount paid when benefits are coordinated including *Medicare — plan participants* must report any other coverage for reimbursement of their 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 COB 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:
    a. 100% of the total allowable expenses, or
    b. The amount of benefits it would have paid had it been the primary plan.

B. 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 allowed amount*
2. The plan that covers the *plan participant* as an active *employee* is primary over the plan that covers the *plan participant* as a *dependent*:
    a. The plan that covers the *plan participan*t as an active *employee* (not as a laid-off *employee* or retiree) is primary over the plan that covers the participant as a laid-off *employee* or retiree.
    b. If the *plan participant* is covered as an active *employee* under more than one (1) 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.

NOTE: 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 (2) plans, the gender rule applies.

4. *Dependent* children of separated or divorced parents:

   If a child is covered by more than one (1) 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 (1) parent is responsible for the healthcare 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. The birthday rule applies to *dependent* children of parents with joint custody.

C. Claims Determination Period

Benefits will be coordinated on a *plan year* basis. This is called the claims determination period.

D. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or *notice* to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

E. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

F. Right of Recovery

Whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or their *dependents*. Please see the Recovery of Payments subsection for more details.

G. Medicare

Medicare is a federal health insurance program for individuals aged sixty-five (65) and older, under age sixty-five (65) with certain disabilities, and *plan participants* of any age with End-Stage Renal Disease (ESRD).

The Social Security Administration (SSA) determines *Medicare* eligibility upon application and enrolls eligible *plan participants* into the *Medicare* program. *Medicare* is administered by the Centers for *Medicare* and Medicaid Services (also known as the federal CMS). *Medicare* has the following parts:

1. Part A
2. Part B
3. Part C (also known as *Medicare* Advantage)
4. Part D

NOTE: The State Employees Group Insurance Program does not require *plan participants* to choose a *Medicare* Part C plan (over the original *Medicare* Part A and B option) or to enroll in a *Medicare* Part D prescription plan.)

1. **Medicare Due to Age: Participants aged sixty-five (65) and older.** The State of Illinois Group Insurance Program requires all *plan participants* to contact the SSA and apply for *Medicare* benefits three (3) months prior to turning age sixty-five (65).

    a. **Part A.** Eligibility for premium-free *Medicare* Part A occurs when an individual is age sixty-five (65) or older and has earned at least forty (40) work credits while paying into *Medicare* through Social Security. An individual who is not eligible for premium-free *Medicare* Part A benefits based on his/her own work credits may qualify for premium-free *Medicare* Part A benefits based on the work history of a current, former, or deceased spouse. All *plan participants* that are determined to be ineligible for premium-free *Medicare* Part A based on their own work history are required to apply for premium-free *Medicare* Part A on the basis of a spouse (when applicable). If the SSA determines that a participant is eligible for premium-free *Medicare* Part A, the State of Illinois Group Insurance Program requires the participant to accept the *Medicare* Part A coverage and submit a copy of the *Medicare* identification card to the *Medicare* Coordination of Benefits (COB) Unit upon receipt. If the SSA determines that a *plan participant* is not eligible for *Medicare* Part A benefits at a premium-free rate, the State does require the *plan participant* to provide a written statement from the SSA advising of his/her *Medicare* Part A ineligibility. The *plan participant* is required to submit a copy of the SSA statement to the *Medicare* COB unit.

    b. **Medicare Part B.** Most *plan participants* are eligible for *Medicare* Part B upon turning age sixty-five (65). The State of Illinois Group Insurance Program does not require *plan participants* to enroll in *Medicare* Part B if they are still actively working. The SSA allows *plan participants* to delay enrollment in *Medicare* Part B (without penalty) until the *plan participant* either retires or loses current/*active employment* status (usually due to a *disability*-related leave of absence). At that time, the State requires the *plan participant* to enroll in *Medicare* Part B. *Plan participants* must contact the SSA in order to enroll in *Medicare* Part B benefits. *Plan participants* who are actively working and receiving *Medicare* due to End-Stage Renal Disease should refer to the below for information on the *Medicare* requirements.

    c. **Coordination of Benefits.** The State of Illinois Group Insurance Program is the primary payor for health insurance *claims* for actively working *employees* enrolled in *Medicare* due to age.

H. Medicare Due to Disability

1. ***Plan* participants aged sixty-four (64) and under.** *Plan participants* are automatically eligible for *Medicare* (Parts A and B) disability insurance after receiving Social Security disability payments for a period of twenty-four (24) months.

    a. **Medicare Part A.** *Plan participants* who become eligible for *Medicare* disability benefits are required to accept the *Medicare* Part A coverage and submit a copy of the *Medicare* identification card to the *Medicare* COB unit upon receipt.

b. **Medicare Part B.** Actively working *plan participants* who become eligible for *Medicare* disability benefits are not required to accept the *Medicare* Part B coverage. The SSA allows *plan participants* to delay enrollment into *Medicare* Part B until retirement or the loss of current/*active employment* status occurs. At that time, the State requires the *plan participant* to enroll in *Medicare* Part B.

c. **Participants who are no longer working (without current/active employment status due to retirement or a disability related leave of absence) are required to enroll in Medicare Part B.** The *Medicare* Part B requirement remains in effect as long as the *employee* is without current/*active employment* status and does not permanently return to work.

d. **Coordination of Benefits.** The State of Illinois Group Insurance Program is the primary payor for health insurance *claims* for actively working *employees* enrolled in *Medicare* due to *disability*.

Plan participants who are eligible for *Medicare* due to a *disability* must contact the State of Illinois *Medicare* Coordination of Benefits (COB) Unit at 1-800-4421300 in order to determine which insurance is the primary payor.

2. **Medicare Part A & B Reduction.** When *Medicare* is determined to be the primary payor of health care insurance benefits, the State of Illinois Group Insurance Program requires the *plan participant* to enroll in *Medicare* Part A and B.

   a. Failure to enroll or remain enrolled in Medicare Part A & B, when Medicare is determined to be the primary payor, results in a reduction of eligible benefit payments under the State Plan. This means that the State *Plan* will only pay up to 20% of the total *in-network* eligible amount for services rendered by *in-network providers*. For services rendered by *Tier III* (*out-of-network*) providers, the *claim* payment will be no more than 20% of the total eligible *billed amount*.

   b. The reduction of benefits provision will apply until Medicare Part A & B is in effect. The *plan participant* is responsible to pay the remaining *claim* balance. The State *Plan* has the right to recover any overpaid *claim* amounts.

3. **Medicare Due to End-Stage Renal Disease (ESRD).** All State of Illinois Group Insurance Program *plan participants* who are receiving regular dialysis treatments, or who have had a kidney transplant on the basis of ESRD, are required to apply for *Medicare* benefits.

   a. **Plan Participants must contact the State of Illinois Medicare Coordination of Benefits (COB) Unit at 1-800-442-1300.** The State of Illinois *Medicare* COB Unit calculates the thirty (30)-month coordination period in order for *plan participants* to sign up for *Medicare* benefits on time to avoid additional *out-of-pocket* expenditures.

   b. **Medicare Part A.** *Plan participants* who become eligible for *Medicare* benefits on the basis of ESRD are required to accept the *Medicare* Part A coverage and submit a copy of the *Medicare* identification card to the *Medicare* COB Unit upon receipt.

   c. **Medicare Part B.** The State of Illinois Group Insurance Program allows actively working *plan participants* who are eligible for *Medicare* on the basis of ESRD to delay enrollment in *Medicare* Part B until the end of the ESRD coordination period. *Medicare* Part B is required at the end of the ESRD coordination period.

   d. **Coordination of Benefits.** The insurance *Plan* that is determined to be the primary payor at the start of the coordination period remains the primary payor for thirty (30) months, as long as *Medicare* and the State plan both remain in effect.

   e. **Medicare Part B reduction.** *Plan participants* who become eligible for *Medicare* benefits on the basis of ESRD are required to accept the *Medicare* Part B coverage when *Medicare* is determined to be the primary payor.

   f. **Failure to enroll or remain enrolled in Medicare Part B, when Medicare is determined to be the primary payor, results in a reduction of eligible benefit payments under the State Plan.** This means that the State *Plan* will only pay up to 20% of the total *in-network* eligible amount for services rendered by *in-network* providers. For services rendered by *Tier III* (*out-of-network*) providers, the *claim* payment will be no more than 20% of the total eligible *billed amount*.

g. **The reduction of benefits provision will apply until Medicare Part B is in effect. The plan participant is responsible to pay the remaining claim balance.** The State *Plan* has the right to recover any overpaid *claim* amounts.

4. **Services and Supplies Not Covered by Medicare.** Services and supplies that are not covered by *Medicare* will be paid in the same manner (i.e., same benefit levels and *deductibles*) as if the *plan participant* did not have *Medicare*, provided the services and supplies meet *medical necessity* and benefit criteria and would normally be eligible under the *Plan* coverage.

5. **Private Contracts with Providers who Opt out of Medicare.** Some healthcare primary payor, has medical services rendered by a provider who has opted out of the *Medicare* program, a private contract is usually signed explaining that the *plan participant* is responsible for the cost of the medical services rendered. Neither provider nor *plan participant* is allowed to bill *Medicare*. Therefore, *Medicare* will not pay for the service, even if it would normally qualify as being *Medicare*-eligible or provide a *Medicare* summary.

NOTE: If the service(s) would have normally been covered by *Medicare*, the *plan* will only pay up to 20% of the *in-network* eligible charges; the *plan participant* will be responsible for the remaining balance of the *claim*.

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

SECTION X—SUBROGATION/THIRD PARTY LIABILITY

A. 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 *plan participants*, but only on the following terms and conditions:

1. In the event of any payment under the *Plan*, the *Plan* shall be subrogated to all of the *plan participants* rights of recovery against any person or entity. The *plan participant* shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The *plan participant* shall do nothing after loss to prejudice such rights. The *plan participant* 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 *plan participant*.
2. 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 *plan participant*. 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*.
3. 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 *plan participant* or a representative. The *plan participant* 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.
4. The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the participant as a result of the injuries sustained, including but not limited to the following:
    a. 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.
    b. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a *plan participant*, or other person.
    c. any other payments from any source designed or intended to compensate a participant for injuries sustained as the result of negligence or alleged negligence of a third party.
    d. any workers' compensation award or settlement
5. The parents of any minor *plan participant* 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.
    a. Any benefits paid on behalf of a minor *plan participant* are conditional upon the *plan's* express right of reimbursement
    b. No adult *plan participant* 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 participant without the express prior written consent of the *Plan*.
    c. In the event any minor *plan participant* is injured as a result of the acts or omissions of any third party, the adult *plan participant*/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.
    d. Further, the adult *plan participant*/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*.
    e. The adult *plan participant*/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.

f. In default of any obligation hereunder by the adult *plan participants*/parents, the *Plan* is entitled to recover the conditional benefits advanced plus costs, including reasonable attorney's fees, from the adult *plan participant*/parents.

No *plan participant* shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the *Plan*.

The *Plan's* right of recovery shall be a prior lien against any proceeds recovered by a *plan participant*, 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.

No *plan participant* 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."

The *Plan* shall recover the full amount of benefits paid hereunder without regard to any *claim* of fault on the part of any *plan participant*, whether under comparative negligence or otherwise.

The benefits under this *Plan* are secondary to any coverage under no-fault, medical payments, or similar insurance.

This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.

SECTION XI—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Upon termination from this *Plan*, *plan participants* may be eligible for continuing coverage. Please contact *your* Group Insurance Representative (GIR) or contact the Illinois Department of Central Management Services for more information.

SECTION XII—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

B. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or *institution* receiving the overpayment will be required to return the incorrect amount of money. In the case of a *plan participant*, the amount of overpayment may be deducted from future benefits payable.

SECTION XIII—STATE LAW RIGHTS

A. Enforce Your Rights

Plan participants may be entitled to certain rights and protections pursuant to Illinois insurance regulations and/or insurance laws.

B. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, they should contact the *Plan Administrator*. If the *plan participant* has any questions about this statement or their rights under the law, including *COBRA* or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

SECTION XIV—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state *children's health insurance program (CHIP)* under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or *CHIP* coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or *CHIP* plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

Coverage will become effective as of the date the request for enrollment is received by the *employer*.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA Title I applies to group health plans sponsored by local government *employers*. Title I generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. Title I provides a clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders/substance abuse* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *out-of-network* exclusion, or treatment limitation on *mental disorders/substance abuse* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., *your physician*, nurse midwife or *physician* assistant), discharges the mother or newborn after consultation with the mother.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical

condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon re-employment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator*. The *employee* may also have continuation rights under USERRA. In general, the *employee* must meet the same requirements for electing USERRA coverage as are required under *COBRA* continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect USERRA continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect USERRA health plan continuation.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that *you* be informed of *your* rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

SECTION XV—NOTICE OF PRIVACY PRACTICE

For *plan* participants enrolled in an Open Access Plan (OAP), the Quality Care Health Plan (QCHP), and the Quality Care Dental Plan (QCDP)

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.

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act. These plans include Open Access *Plans*, the Quality Care Health Plan, and the Quality Care Dental Plan. The term "we" in this Notice means the Bureau and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of *your* Protected Health Information (PHI), and to provide *you* with this Notice of our legal duties and privacy practices concerning *your* PHI. We are also required by law to notify affected individuals following any breach of unsecured PHI. We are required to obtain *your* written authorization for most uses or disclosures of psychotherapy notes and disclosures that constitute the sale of 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.

The Bureau contracts with Business Associates to provide services including *claim* processing, *utilization review*, *behavioral health services* and *prescription drug* benefits. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on the Bureau's behalf in performing their respective functions. When we seek help from individuals or entities in 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. Aetna is the Medical Plan Administrator for QCHP. *HealthLink* and Aetna are Medical *Plan Administrators* for the OAPs. CVS Caremark is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator for QCHP. Delta Dental is the Dental Plan Administrator. If *you* have insured health coverage, such as an HMO, *you* will receive a notice from the HMO regarding its privacy practices.

A. How We May Use or Disclose Your PHI

1. **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*.
2. **Payment.** We use and disclose PHI to process *claims* and make payment for covered services *you* receive under *your* benefit plan, except for genetic information that is PHI. For example, *your* provider may submit a *claim* for payment. The *claim* includes information that identifies *you*, *your* diagnosis, and *your* treatment.
3. **Health Care Operations.** We use or disclose PHI for health care operations; except for *genetic information* that is PHI. For example, we may use *your* PHI for customer service activities and to conduct quality assessment and improvement activities.
4. **Appointment Reminders.** Through a Business Associate, we may use or disclose PHI to remind *you* of an upcoming appointment.
5. **Legal Requirements**. We may use and disclose PHI **as required or authorized by law. We are also prohibited from use or disclosure of certain information.** For example:
    a. **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 child abuse or neglect.
    b. **Abuse, Neglect, or Domestic Violence.** We may use and disclose PHI to report suspected cases of abuse, neglect, or domestic violence to a government authority.
    c. **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.

d. **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.

e. **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 limited PHI to identify or locate a suspect, fugitive, witness, or missing person; to provide information relating to a crime victim; to report a death; or to report criminal activity at our offices.

f. **Avert a Serious Threat to Health or Safety.** We may use or disclose PHI to prevent or lessen a threat to the health or safety of *you*, another person, or the public.

g. **Work-Related Injuries.** We may use or disclose PHI to workers' compensation or similar programs in order for *you* to obtain benefits for work-related *injuries* or *illness*.

h. **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. We may disclose PHI to funeral directors as necessary to carry out their duties.

i. **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.

j. **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.

k. **Armed Forces.** We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission.

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

m. **Correctional Institutions and Custodial Situations.** We may use or disclose PHI to correctional institutions or law enforcement custodians for the provision of health care to individuals at the correctional institution, for the health and safety of individuals at the correctional institution and those who are responsible for transporting inmates, and for the administration and maintenance of safety, security, and order at the correctional institution.

n. **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.

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

7. **Underwriting.** We are prohibited from using or disclosing PHI that is *genetic information* about an individual for underwriting purposes.

B. Plan Sponsors

Your employer is not permitted to use PHI for any 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.

C. 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, *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.

D. 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 to the appropriate *Plan Administrator*. These *Plan Administrators* are as follows:

<table>
<tr><td colspan="2">For HealthLink OAP:
HealthLink
P.O. Box 7186
Boise, ID 83707
1-877-379-5802</td></tr>
<tr><td>For Dental Plan Benefits:
Delta Dental of Illinois
P.O. Box 5402
Leslie, IL 60532
1-800-323-1743</td><td>For Pharmacy Benefits:
CVS/Caremark
P.O Box 52136
Phoenix, AZ 85072
1-877-232-8128</td></tr>
</table>

E. 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 unless the request is for a restriction on a disclosure, not otherwise required by law, to another health plan for the purpose of carrying out payment or health care operations and *you* or another individual on *your* behalf paid for the item or service in full.

F. 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.

G. 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 letting *you* know why 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. *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.

H. 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.

I. 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 (1) accounting in a twelve (12) month period.

J. 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, we will post the revised Notice on our website at http://www.benefitschoice.il.gov. *You* will also receive information about the change and how to obtain a revised notice in our next annual mailing following the change.

K. Complaints

If *you* feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective *Plan Administrator*. If the Privacy Officer does not handle *your* complaint or request adequately, please contact the Central Management Services, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 1-217-782-9669. 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.

SECTION XVI—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury (Accidental Injuries)

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

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.

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulance

A vehicle designed and operated to provide medical services and authorized to operate as required by law.

Ambulatory Surgical Center

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.

Anonymous Infertility Donor

Charges will be considered if the services meet the requirements as outlined in the *Plan*.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and *appeals* procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, or the Department of Defense or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines (1) to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Artificial Insemination

The introduction of sperm into a woman's vagina or uterus by non-coital methods, for the purpose of conception.

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan*

participant authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Assisted Reproductive Technologies (ART)

Treatments and/or procedures which the human oocytes and/or sperm are retrieved and the human oocytes and /or embryos are manipulated in laboratory. ART shall include *prescription drug* therapy, dispensed by CVS/Caremark, during the cycle where oocyte retrieval is performed.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on *your* behalf, *you* are giving them permission to see *your* Protected Health Information (PHI) and act on all matters related to your *claim* and/or *appeal*. If *you* choose to authorize a person to act on *your* behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Autism Spectrum Disorder

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

One (1) 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 psychologist with expertise in diagnosing *autism spectrum disorders*.

Autism Spectrum Disorders Treatment

Shall include the following care prescribed, provided, or ordered for a *plan participant* diagnosed with an *autism spectrum disorder* by:

1. A *physician* licensed to practice medicine in all its branches
2. A certified, registered, or licensed healthcare 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, treatment can include:

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, 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:
    a. self care and feeding
    b. pragmatic, receptive, and expressive language
    c. cognitive functioning
    d. applied behavior analysis

e. intervention and modifications

f. motor planning

g. sensory processing

Behavioral Health

Mental health, psychiatric and addictions treatment, including services provided by social workers, counselors, psychiatrists, neurologists, and *physicians*.

Behavioral Health Provider

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.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*.

Claims Administrator

See *Third Party Administrator*.

Clean Claim

A *claim* that can be processed in accordance with the terms of this summary plan description without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for usual and/or customariness and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the participant has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by *you* to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill *you* directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the pre-certification list nor an exclusion of the *Plan*.

Covered Charges

Means either:

1. The *actual* charge for a covered service
2. 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 *maximum allowed amount* charges for that service if the provider is a *Tier III* (*out-of-network*) provider, or amounts over the Medicare reimbursement.

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. *Plan participants* are responsible for charges that are not covered expenses, including charges for services that are not covered services. *Plan participants* are also responsible for covered expenses not paid by the *Plan* by reason of *co-payments*, *deductibles*, *co-insurance* amounts, and *out-of-pocket expense* maximum for covered services.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

Care that mainly provides room and board (meals). This care is for physically or mentally *disabled plan participants* 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 reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

A member of the family of the *plan participant* as defined by the Act.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disabled or Disability

The inability to perform the material and substantial duties of the *employee's* occupation subject to a *physician'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 twelve (12) months.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Donor Sperm, Eggs, and Embryos

In Vitro Fertilization (IVF) may be performed with a couple's own eggs and sperm or with *donor* eggs, sperm, or both. A couple may choose to use a *donor* if there is a problem with their own sperm or eggs, or if they have a genetic disease that could be passed on to a child. *Donors* may be known or anonymous. In most cases, *donor* sperm is obtained from a sperm bank. Both sperm and egg d*onors* undergo extensive medical and genetic screening, as well as testing for infectious diseases. Sexually transmitted disease screening and testing for both sperm and egg donation are highly regulated by the FDA.

Donor sperm is frozen and quarantined for six (6) months, the *donor* is re-tested for infectious diseases including the AIDS virus, and sperm are only released for use if all tests are negative. *Donor* sperm may be used for insemination or in an ART cycle. Unlike intrauterine insemination (IUI) cycles, the use of frozen sperm in IVF cycles does not lower the chance of *pregnancy*.

Donor eggs are an option for women with a uterus who are unlikely or unable to conceive with their own eggs. Egg *donors* undergo much the same medical and genetic screening as sperm *donors*. Until recently, it has not been possible to freeze and quarantine eggs like sperm. Recent advances in oocyte freezing, though, have made

this a possibility, and there are a few companies and clinics that are using such an approach. The egg *donor* may be chosen by the infertile couple or the *ART* program. Egg *donors* assume more risk and inconvenience than sperm *donors*. In the United States, egg *donors* selected by *ART* programs generally receive monetary compensation for their participation. Egg donation is more complex than sperm donation and is done as part of an *IVF* procedure. The egg *donor* must undergo ovarian stimulation and egg retrieval. During this time, the recipient (the woman who will receive the eggs after they are fertilized) receives hormonal medications to prepare her uterus for implantation. After the retrieval, the *donor's* eggs are fertilized by sperm from the recipient's partner and transferred to the recipient's uterus. The recipient will not be genetically related to the child, but she is a biologic parent in the sense that she will carry the *pregnancy* and give birth. Egg donation is expensive because *donor* selection, screening, and treatment add additional costs to the *IVF* procedure. However, the relatively high live birth rate for egg donation, over 50% nationally, provides many couples with their best chance for success. Overall, *donor* eggs are used in nearly 10% of all ART cycles in the United States.

In some cases, when both the man and woman are infertile, both *donor* sperm and eggs have been used. *Donor* embryos may also be used in these cases. Some *IVF* programs allow couples to donate their unused frozen embryos to other infertile couples. Appropriate screening of the individuals whose genetic *embryos* are used should adhere to federal and state guidelines. The use of *donor* sperm, eggs, or embryos is a complicated issue that has lifelong implications. Talking with a trained counselor who understands *donor* issues can be very helpful in the decision-making process. Many programs have a mental health professional on staff or the *physician* may recommend one (1). If a couple knows the *donor*, their *physician* may suggest that both the couple and the *donor* speak with a counselor and an attorney. Some states require and most *IVF* centers recommend an attorney to file paperwork for the couple with the court when *donor gametes* or *embryos* are used.

Donor (infertility only)

An oocyte *donor* or sperm *donor*.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Educational in Nature

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.

Embryo

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

Embryo Transfer

The placement of the pre-embryo into the uterus or, in the case of *zygote intrafallopian tube transfer*, into the fallopian tube.

Emergency

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.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

An eligible *employee*, *retiree*, or annuitant under the Act who has enrolled in the *Plan* for the *Open Access III Program*.

Employer

State of Illinois

Enrollment Date

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Cart Act of 2010* (*PPACA*), including the categories listed in the state of Illinois benchmark plan.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

   'Reliable evidence' shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the FMLA.

Formulary

A list of prescription medications compiled by the third party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Gamete

A reproductive cell. In a man, the gametes are sperm; in a woman, they are eggs or ova.

Gamete Intrafallopian Tube Transfer or GIFT

The direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

Gender Dysphoria

A condition in which a person feels clinically significant distress because of a marked incongruence with that person's expressed/experienced gender and assigned gender.

Genetic Information

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 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.

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Healthlink

Refers to *HealthLink HMO* and *HealthLink PPO*.

Healthlink HMO or Healthlink HMO, Inc.

The *Claims Administrator* and the *HMO network* administrator for *plan participants* who enroll in the *Open Access Program*.

Healthlink PPO or Healthlink, Inc.

The PPO network administrator and Medical Management program for *plan participants* who enroll in the *Open Access Program*.

Home Health Care Agency

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.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

HealthLink participating contracted *hospital* means a *hospital* that has a *HealthLink HMO* or *PPO* participating *hospital* contract with *HealthLink*. Non-participating *hospital* means a *hospital* that does not have a *HealthLink HMO* or *PPO* participating *hospital* contract with *HealthLink*. Is also provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term *hospital* does not include a provider, or that part of a provider, used mainly for:

1. residential or non-*residential treatment facilities*
2. health resorts

3. nursing homes
4. christian science sanatoria
5. institutions for exceptional children
6. *skilled nursing facilities*
7. places that are primarily for the care of convalescents clinics
8. *physician* or practitioner offices
9. private homes
10. *ambulatory surgical centers*

Refer to the defined terms for *Residential Treatment Facility* and *Substance Abuse/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

A bodily disorder, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Immediate Family

Someone's spouse, parents and grandparents, children and grandchildren, brothers and sisters, mother-in-law and father-in-law, brother(s)-in-law and sister(s)-in-law, daughter(s)-in-law and son(s)-in-law. Adopted, half, and step members are also included in *immediate family*.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Infertility means a disease, condition, or status characterized by:

1. a failure to establish a pregnancy or to carry a pregnancy to live birth after twelve (12) months of regular, *unprotected sexual intercourse* if the woman is thirty-five (35) years of age or younger, or after six (6) months of regular, *unprotected sexual intercourse* if the woman is over thirty-five (35) years of age; conceiving but having a miscarriage does not restart the twelve (12) month or six (6) month term for determining infertility
2. a *p*erson's inability to reproduce either as a single individual or with a partner without medical intervention; or
3. a licensed *physician's* findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance abuse treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Intensive Outpatient Treatment

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 three (3) treatment hours per day at least three (3) times per week. *Intensive outpatient* programs may offer group, DBT, individual, and family services.

Investigational

See *Experimental/Investigational*.

In Vitro Fertilization or IVF

A process in which an egg and sperm are combined in a laboratory dish were fertilization occurs. The fertilized and dividing egg is transferred into the woman's uterus.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Low Tubal Ovum Transfer

The procedure in which oocytes are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The maximum amount a *Plan* will pay for a covered health care service. The *maximum allowed amount* is based on Medicare rates by locality for *out-of-network* rate fee calculation, otherwise referred to as *maximum allowed amount* (MAA) rates. Medicare rates are utilized because Medicare's methodology is adjusted by physical location (locality), reviewed, and routinely updated with changes in coding and is nationally

recognized by most, if not all, providers. *Physician* and ancillary *claims* are priced at 125% of current Medicare fee schedule by locality. Facility *claims* are priced at 150% of current Medicare, by locality, based on APC and DRG reimbursement. Pricing changes generated by Medicare are implemented with each Medicare pricing change throughout the year. Fair Health or National Care Network values will be used to fill gaps in fees not provided by Medicare. Any code that cannot be priced by Fair Health or National Care Network will be priced at 40% of *billed charges*.

The maximum allowed amount for emergency care from an *out-of-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *plan year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Abuse

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health or Substance Abuse Hold

An involuntary detainment, by an officer of the court, in an *in-patient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely *disabled* due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance abuse* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance abuse* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance abuse* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance abuse* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Morbid Obesity

A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight.

Multiple Surgery Guidelines

When two (2) 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.

Network/Provider Network

The contracted *hospitals*, contracted *physicians*, and other contracted healthcare providers in the *HealthLink* contracted *HMO* or *PPO network* who are participating on the date a particular service or supply is rendered or received.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Non-Participating Provider Reimbursement Method

Services provided by *physicians*, *hospitals*, and other healthcare professionals, called *non-participating providers*, who have not contracted with *HealthLink* to treat *participants* of the *Plan*. The amounts that will be allowed for such services, called *non-participating provider* reimbursement amounts, are based on the *maximum allowed amount*. These amounts may be subject to *deductible*s, *co-payments*, and *co-insurance*. Because there is no provider contract or participating agreement, a *non-participating provider* has not agreed to a reimbursement rate for services provided to *plan participants*. Therefore, absent a regulation or law, the *non-participating provider* can bill the *plan participant* for the difference between the amounts they charge and the *non-participating provider* reimbursement amount. *Plan participants* are responsible for paying *non-participating providers* this difference. Depending on the service, this difference can be substantial.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Oocyte

The female egg or ovum, formed in an ovary.

Oocyte Donor

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

Oocyte Retrieval

The procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. Also called ova aspiration.

Open Access Plan or Open Access Program

The group health benefit *Plan*, and related documents and materials describing the benefits available thereunder, sponsored by the State of Illinois under which *plan participants* are provided various incentives to use *Tier I* (HMO) contracted providers and *Tier II* (PPO) contracted providers in accordance with the following:

1. The benefit tier with the greatest benefits applies when *plan participants* utilize contracted providers who are designated by *HealthLink HMO* as *Tier I* (HMO) contracted providers.
2. The benefit tier that does not contain the least benefits applies when *plan participants* utilize contracted providers who are designated by *HealthLink PPO* as *Tier II* (PPO) contracted providers.
3. The benefit tier that contains the least benefits applies when *plan participants* utilize providers who are not Tier I (HMO) contracted providers or *Tier II* (PPO) contracted providers, also called *Tier III* (*out-of-network*) providers.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage

5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network/Tier III Provider

A *physician*, *hospital*, or other healthcare 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 *maximum allowed amount* guidelines.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *plan year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

Partial Hospitalization Program

An intensive structured setting providing six (6) or more hours of treatment or programming per day or evening, in a program that is available five (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.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

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

State of Illnois Local Government Option, which is a benefits *Plan* for certain *employees* of State of Illinois and is described in this document. State of Illnois Local Government Health Option is a distinct entity, separate from the legal entity that is *your employer*.

Plan Administrator

State of Illinois, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

An eligible *employee*, *retiree*, or annuitant under the Act who has enrolled in the *Plan* for the *Open Access III Program*.

Plan Sponsor

State of Illinois

Plan Year

The twelve (12) month period beginning on the effective date of the *Plan*. All *deductibles* and benefit maximums accumulate during the *plan year*.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

PPO Provider, Healthlink PPO Contracted Network Provider, PPO Contracted Network Provider, Tier II (PPO) Contracted Provider, or Tier II Contracted Provider

A contracted *physician*, *hospital*, or other healthcare provider participating in the *HealthLink PPO provider network* as designated by *HealthLink* from time to time.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified/Utilization Review

An evaluation conducted by a *utilization review* team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

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.

Pregnancy

Childbirth and conditions associated with *pregnancy*, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the Health Care Management Program).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. For more information, *you* may contact the *Plan Administrator/employer*.

Primary Care Physician (PCP)

Family practitioners, nurse practitioners (N.P.), general practitioners, internists, OBGYNs, physician's assistants (P.A.), and pediatricians.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric *hospital*.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric *hospital* does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Reasonable

In the *Plan Administrator's* discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Reconstructive Breast Surgery Coverage

Benefits under the *Plan* will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The *Plan* will provide to the *plan participant*, who is receiving *Plan* benefits in connection with mastectomy coverage for:

1. all stages of reconstruction of the breast on which the mastectomy has been performed
2. *surgery* and reconstruction of the other breast to produce symmetrical appearance
3. Prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending *physician* and the *plan participant*.

The coverage will be subject to the terms of the *Plan* established for other coverage under the *Plan*, including the annual *deductible* and *co-insurance* provisions if applicable.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting

4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective *utilization review* plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

Sleep Apnea Device

A device prescribed by a medical provider for *plan participants* that are unable to utilize a c-pap machine. This device is not for snoring. Only certain devices may be considered for benefits. *Medical necessity* will be reviewed.

Sound Natural Tooth/Teeth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Spinal Manipulation

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Stabilize

With respect to a medical *emergency*, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the *plan participant* from a facility.

Substance Abuse/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance abuse* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by the Joint Commission on Accreditation of Hospitals or CARF
3. licensed, certified, or approved as an alcohol or *substance abuse* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance abuse* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance abuse*

Substance Abuse/Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

    This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.

11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Surrogate

A woman who carries a *pregnancy* for a woman who has *infertility* coverage.

Temporomandibular Joint (TMJ)

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.

Third Party Administrator

Healthlink, Inc. has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and

medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Unprotected Sexual Intercourse

Should include appropriate measure to ensure the health and safety of sexual partners and means sexual union between a male and a female, without the use of any process, device, or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical, or barrier contraceptives, natural abstinence, or voluntary permanent *surgical procedures*.

Uterine Embryo Lavage

A procedure by which the uterus is flushed to recover a preimplantation embryo.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.

You, Your, or Yours

Generally refers to a *plan participant* unless the context requires otherwise and, then in such instances, the term is generally only referring to the *employee*.

Zygote

A fertilized egg before cell division begins.

Zygote Intrafallopian Tube Transfer or ZIFT

A procedure by which an egg is fertilized in vitro, and the *zygote* is transferred to the fallopian tube at the pronuclear stage before cell division takes place. The eggs are harvested and fertilized on one (1) day and the embryo is transferred at a later time.

SECTION XVII—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

State of Illinois, hereby adopts the provisions of this State of Illnois Local Government Health Option (*Plan*), and its duly authorized officer has executed this summary plan description effective the first day of July 2023.

By: _____ Date: _____

Title: _____

If *you* have questions about *your Plan* benefits, please contact the *Third Party Administrator* at 1-877-379-5802.

P.O. Box 7186
Boise ID 83707