State of Illinois

Employee Health Care Plan Summary Plan Description

Plan Number 160001
State of Illinois Local Government Health Plan Members

July 1, 2016
OPEN ACCESS III SPD

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INTRODUCTION

You have chosen to be covered under the State of Illinois Health Benefits Plan. The State of Illinois has a contractual arrangement with HealthLink, Inc. and its subsidiary, HealthLink HMO, Inc., the Claims Administrator, to access two provider contracted networks, to provide Medical Management services and to provide claims administration.

HealthLink does not require selection of a primary care physician. Referrals are not required prior to obtaining services from specialty physicians. You do not have to choose to be in Tier I (HMO) or Tier II (PPO). You are free to seek services from physicians, facilities or other health care providers at any time. Your benefits for each service are determined by whether the service provider falls within your Tier I (HMO), Tier II (PPO) or Tier III (out-of-network) level. You will realize your highest level of benefits when seeking services from a Tier I (HMO) service provider. Please be advised when utilizing a Tier III (out-of-network) provider, charges will be subject to usual and customary (U&C) amounts**. See description for usual and customary (U&C) calculations under *Definitions*.**

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

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

The Medical Management department can be reached toll-free at 1-877-284-0102 with inquiries regarding pre-certification authorization. High-tech imaging pre-certifications are performed by AIM Specialty Health (AIM). Providers can contact AIM at 1-866-745-3266. A complete list of services requiring pre-certification authorization and who performs each type of review is located at *www.healthlink.com*. To access the list, select the “Providers” tab and then “Utilization Management”. For inquiries about Behavioral Health services, please telephone 877-284-0102 and select Option 3 for Behavioral Health. Services requiring pre-certification authorization include:

- All Inpatient Admissions
- Partial Hospitalizations and Intensive Outpatient for Behavioral Health Services (mental and substance abuse)
- Hi-Tech Imaging Including Radiology and Echocardiography Exams (through AIM)
- Selected Outpatient/Ambulatory Services (Ambulatory)
- Selected Ancillary Services
- Selected Durable Medical Equipment
- Specialty Infusion Drugs (see list on the HealthLink website)

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

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

- If you receive care from a provider in the HealthLink PPO contracted provider network, you will pay a deductible and a percentage of the covered expenses for many types of care (Tier II benefits or PPO benefits).
- You may also receive care from an out-of-network provider, but you will pay a higher deductible and a greater share of the covered expenses (Tier III benefits or out-of-network benefits). You will be responsible for anything over usual and customary (U&C) 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 HealthLink Open Access III identification (ID) cards which will identify you as a HealthLink Open Access enrollee, eligible to receive services in accordance with this plan.

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

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

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

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

Section I – Eligibility – Enrollment – Effective Date

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

Section II – Benefits – General

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

   There is no deductible for Tier I (HMO) services. The plan pays 100% of the allowable covered expenses. Refer to the Summary of Benefits (page 13) for more information.

   The co-pay is the fixed dollar amount you pay for Tier I (HMO) physician office visits, emergency room use and certain other services. Refer to page 13 for more information.

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

   For Tier II (PPO) contracted providers, the plan's coinsurance rate is applied to the contracted charge between HealthLink and the contracted provider. For Tier III (out-of-network) providers, the plan's coinsurance rate is applied to the usual and customary (U&C) charges. The out-of-network provider is any provider or facility that does not have a contractual agreement with HealthLink. If your out-of-network provider charges more than the usual and customary (U&C) amount, you must pay the excess amount in addition to your deductible and a percentage of the covered expenses.

C. **Co-pay** – Your co-pay is the fixed amount you pay for Tier I (HMO) and some Tier II (PPO) physician office visits, physician specialist office visits, emergency room and certain other services. Most providers expect to collect the co-pay at the time the services are provided. Co-pays are listed in the *Summary of Benefits*.

D. Deductible – The deductible is the amount you must pay each plan year in covered expenses before the plan begins to pay benefits. **Deductibles apply separately to the covered expenses incurred by each person during one plan year.** Effective July 1, 2014, Tier II (PPO) has a separate deductible from Tier III (out-of-network) deductible and they do not cross-accumulate. Deductibles are listed in the *Summary of Benefits*.

E. Annual Out-of-Pocket Maximum – For care provided by a HealthLink Tier I (HMO) and Tier II (PPO) contracted provider, you may have to pay a co-payment and/or percentage of the covered expenses, called coinsurance, after the deductible. The out-of-pocket maximum limits the amount you could pay for covered medical expenses incurred during one plan year. Once your co-payment and coinsurance share of covered medical expenses for one person reaches the individual out-of-pocket maximum in one plan year, including the deductible, the plan will pay 100% of covered expenses incurred by that person for the remainder of the 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 coinsurance amounts paid for all family members per plan year. After the family out-of-pocket maximum is met, the plan will pay 100% of covered expenses incurred by any family member for the rest of the plan year for Tier I (HMO) and Tier II (PPO) which cross-accumulate.

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

1. Any amounts above plan maximums;
2. Any amounts above usual and customary (U&C) charges (out-of-network only); **See description for usual and customary (U&C) calculations found in *Definitions*.**
3. Medical expenses not covered by the plan;
4. Penalty for non-pre-certification for out-of-network providers;

The *Summary of Benefits* shows annual out-of-pocket maximums for Tier I (HMO) and Tier II (PPO) benefits.

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

Note: Failure to obtain pre-certification from HealthLink for out-of-network providers will result in a reduction in benefits of $500 per hospital confinement or course of treatment or therapy. (Services would still need to be medically necessary and appropriate for payment.)

1. Regardless of the provider chosen, the plan requires advance notice and pre-certification authorization of all planned inpatient hospital admissions, high-tech imaging and some additional outpatient services. If a contracted physician is supervising care for you or your

covered dependent, in most instances he or she will call, on your behalf, our Medical Management department or AIM to request pre-certification. It is your responsibility to make sure that out-of-network providers follow this procedure; however, if you utilize a HealthLink contracted network provider, it would be his or her responsibility to make sure any certifications are handled by his or her office prior to the care being rendered. Remember, if you do not pre-certify care received from out-of-network providers, benefits may not apply to the charges.

2. The Medical Management program includes:
   a. Pre-certification of the medical necessity of non-emergency hospital admission before needed services are rendered;
   b. Partial hospitalization and intensive outpatient services
   c. Retrospective review of the medical necessity of the listed services provided on an emergency basis;
   d. Concurrent hospital stay review for medical necessity;
   e. Pre-certification of the medical necessity for certain outpatient/ambulatory services and selected ancillary services; and
   f. Clinical appropriateness review of listed high-tech imaging services (radiology and cardiology).
   g. A certification decision made within two business days of receipt of the medical necessity information.

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

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

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

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

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

Medical emergency is defined as the sudden, unexpected onset of a health condition with symptoms so severe that a prudent layperson, possessing an average knowledge of health

and medicine, would believe that immediate medical care is required. Examples include, but are not limited to:

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

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

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

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

H. Preventive Care – 100% benefit for recommended preventive services is provided in-network; as defined by federal law, under the Wellness Benefit. The plan will pay 100% of the cost of certain services provided by a HealthLink network physician or other HealthLink provider if the services are preventive services recommended under guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration (the Guidelines). The 100% benefit will include one 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. When provided by a network provider, all preventive services recommended by the Guidelines will be paid by the plan without deductibles, co-pays or coinsurance.

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

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

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

Note: Pre-certification authorization is required for all inpatient, partial hospital admissions and intensive outpatient (IOP) programs (two partial hospitalization sessions equal one day of inpatient care) whether rendered by a contracted or out-of-network provider.

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

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

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

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

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

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

J. **Maternity Care –** Maternity services provided by Tier I (HMO) contracted providers have a co-pay of $50 once per pregnancy plus an inpatient admission co-pay of: Tier I $250; Tier II $300; or Tier III $400. All services provided by Tier II (PPO) contracted providers and out-of-network providers are subject to deductible and coinsurance, as well as Tier II and Tier III inpatient admission co-pays. A single co-pay is applicable for both mother and newborn (well baby care); if the newborn remains after the mother is discharged, a separate co-pay will apply. If a female is pregnant when she becomes a participant in this plan, coverage is effective upon enrollment. Newly enrolled members who are in the third trimester of pregnancy will be allowed continuity of care provided by their current obstetrician. Pre-certification of maternity care is not required. Licensed Midwives will be covered effective July 1, 2016 while working with an MD for home delivery or in the hospital, no coverage for birthing centers.

HealthLink conducts concurrent medical necessity review if the enrollee is hospitalized more than three days for vaginal delivery or more than five 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.

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

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

L. **Chiropractic/Spinal Manipulation** – Coverage for this benefit is $30 co-pay at Tier I, benefits at 90% after the deductible for Tier II, and 80% after the deductible for Tier III. There is a 25-visit limit per plan year regardless of tier levels accessed.

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

Benefit coverage is provided only if the plan participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this plan. **See definition of Infertility.** Covered services for assisted reproductive procedures are outlined below.

Benefits required to be covered include, but are not limited to:

- Testing
- Prescription drugs (dispensed by CVS/caremark)
- Artificial insemination
- In vitro fertilization
- Uterine embryo lavage
- Embryo transfer
- Zygote intrafallopian tube transfer
- Low tubal ovum transfer
- Gamete intrafallopian tube transfer
- Intracytoplasmic sperm injection
- Donor sperm and eggs (medical costs, lab)
- Procedures utilized to retrieve oocytes or sperm, and subsequent procedures used to transfer the oocytes or sperm to the covered recipient
- 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 covered member (no benefit available for anonymous donor relative to prescription drugs)

What are the limits of the coverage for infertility benefits?
Coverage for treatments that include oocyte retrievals is required only if the covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the plan.

Coverage for such treatments is limited to four completed oocyte retrievals per lifetime of the individual, except that two 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 are covered under the law. If a live birth takes place as a result of the fourth completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of six are covered. The maximum number of completed oocyte retrievals that can be covered under the law is six.

One 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.

IntraUterine Insemination (IUI or AI) – means washed sperm is placed into the uterus through a small catheter (no limit).

Intracytoplasmic Sperm Injection (ICSI) – means 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).

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

Zygote Intra Fallopian Transfer (ZIFT) – means 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 as well).

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

Uterine Embryo Lavage (UEL) – means uterus is flushed to recover a preimplantation 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 covered member as one completed oocyte retrieval.

Note: See *Exclusions & Limitations* for additional information about infertility benefits.

N. Autism – Provided for individuals younger than age 21, benefits include coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders. This benefit will be treated the same as any other illness and is subject to the regular medical co-pay, deductible and coinsurance provisions of the plan.

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

O. Forced Providers – Are hospital-based providers that the patient cannot choose. The charges of certain forced providers will be considered at the same benefit level as the hospital facility in which services are rendered if the provider services would fall under the Tier III level of benefits. The forced provider benefit applies only to the following inpatient or outpatient hospital facility charges:

- Inpatient hospital professional fees for radiology, pathology or anesthesiology
- Outpatient hospital professional fees for radiology, pathology or anesthesiology

P. Non-emergent Services outside 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, medically necessity must be established prior to reimbursement unless it is emergency treatment. Payment for the services will most likely be required from the employee at the time the services are rendered.

Members must file a claim with the claim administrator 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 health care obtained outside of the United States and its territories. When Medicare does not pay, the claim administrator becomes the primary payor and standard benefit levels will apply.

Q. Gender dysphoria services – Effective July 1, 2016, the plan will cover eligible charges for sex reassignment surgery (also known as gender reassignment and gender confirmation surgery), which is one treatment option for extreme cases of gender dysphoria, a condition

in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. People with gender dysphoria often report a feeling of being born the wrong sex. 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 individual 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 individual. **This information must be received prior to beginning sex reassignment surgery to ensure maximum benefits.**

Remember to show your HealthLink ID card anytime you receive care. If you lose your ID card or need additional cards, please call HealthLink Customer Service toll-free at 1-800-624-2356 (You can print a temporary ID card from the HealthLink website).

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

SUMMARY OF BENEFITS

The following is a benefit summary of the most frequently utilized benefits. Please refer to pages 14-20, *Covered Medical Expenses*, for a complete description of covered services.

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

HealthLink Open Access III Plan – Local Government Plan

BENEFIT	TIER I 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
Annual Out-of-Pocket Maximum Per Individual Enrollee Per Family	$6,250 (includes eligible charges from Tier I and Tier II combined) $12,700 (includes eligible charges from Tier I and Tier II combined)		Unlimited Unlimited
Annual Plan Deductible *Must be satisfied for all services*	$0	$300 per Enrollee*	$500 per Enrollee*
HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)			
Inpatient	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C or MAC for covered services after $400 copayment per admission**
Pre-Certification Penalty			$500
Inpatient (Behavioral Health Services, Psychiatric)	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C or MAC for covered services after $400 copayment per admission**
Inpatient (Behavioral Health Alcohol/Substance Abuse)	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C or MAC for covered services after $400 copayment per admission**
Emergency Room *Waived if admitted*	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Surgery	100% after $200 copayment per visit	90% of network charges after $200 copayment	80% of U&C or MAC for covered services after $200 copayment**
Diagnostic Lab & X-Ray	100%	90% of network charges	80% of U&C or MAC for covered services**
PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)			
Physician Office Visits	100% after $30 copayment	90% of network charges	80% of U&C or MAC for covered services**
Specialist Office Visits *Includes Behavioral Health providers*	100% after $30 copayment	90% of network charges	80% of U&C or MAC for covered services**
Preventive Services *Including immunizations*	100%	100%	Covered under Tier I and Tier II only
Well Baby Care *(first year of life)*	100%	100%	Covered under Tier I and Tier II only
OTHER SERVICES			
Prescription Drugs	Prescription Drugs (30-day supply) – Covered through the LGHP administered plan, Express Scripts Generic $12 Preferred Brand $24 Nonpreferred Brand $48 Specialty $96		
Durable Medical Equipment	80% of network charges	80% of network charges	80% of U&C or MAC for covered services**
Skilled Nursing Facility *120 days per plan year*	80% with pre-certification	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100% with pre-certification	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	80% of network charges	Covered under Tier I and Tier II only
Physical Therapy and Occupational Therapy *60 visits per plan year*	100% after $30 copayment with pre-certification	90% of network charges	80% of U&C or MAC for covered services**
Speech Therapy *60 visits per plan year*	100% after $30 copayment with pre-certification	90% of network charges	80% of U&C or MAC for covered services**

Note: Annual plan deductibles must be met before plan benefits apply. Benefits are measured on a plan year. Amounts over the plan's allowable charges do not count toward the out-of-pocket maximum.

Section III - Covered Medical Expenses

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

1. Hospital room and board and general nursing services or special charges for intensive care confinement. This benefit requires pre-certification.

2. Other inpatient hospital charges for medical care, services and supplies.

3. Medical care services and supplies for treatment received as an outpatient at a contracted hospital or contracted urgent care facility or the use of a contracted licensed ambulatory surgical center. Some services may require pre-certification.

4. Contracted physician fees for other medical care and services in the office, home or contracted hospital.

5. A cardiac rehabilitation program, when prescribed by a contracted treating physician and provided through a recognized contracted medical facility.

6. Anesthesia charges from a contracted physician or certified registered nurse anesthetist (CRNA). Services provided by a registered nurse first assistant (RNFA) or certified registered nurse first assistant (CRNFA) if medically necessary and appropriate for care.

7. Nursing charges from a registered nurse (RN), licensed practical nurse (LPN) or certified nursing aide, provided he or she is not a close relative. A close relative includes you and your spouse and the following relations to either of you: parents, brothers, sisters or children. (Custodial services, or services that a family or friend can be trained to perform, are not covered.)

8. Professional service charges for medical care and services provided by a contracted radiologist and contracted pathologist.

9. Maternity coverage is for maternity care provided to a female employee, enrolled spouse of a male employee and enrolled dependent daughter. No coverage is provided for a child of an enrolled dependent daughter.

10. Routine services as defined under "Preventive" in your Summary Plan Description. Routine services must be performed by a Tier I (HMO) contracted provider or Tier II (PPO) contracted provider.

11. Human Papillomavirus (HPV) vaccine (female employees/dependents from age 11 to 26; male employees/dependents from age 9 to 26).

12. Routine hearing screening examination services, provided these services are performed by a Tier I (HMO) contracted Provider or Tier II (PPO) contracted Provider.

13. Infertility benefits. **See *Section II* and refer to *Exclusions and Limitations* and *Definitions* for additional information about infertility benefits.**

14. Short-term speech therapy by a contracted qualified speech therapist to restore speech lost due to surgery, injury or illness other than a functional nervous disorder. If speech is lost due to a congenital anomaly, speech therapy is covered only if previous surgery has been performed to correct the anomaly. This benefit requires pre-certification (60 visits per plan year).

15. Short-term restorative physical and occupational therapy by a contracted licensed therapist in a home setting or at a contracted facility primarily providing medical care. This benefit requires pre-certification (60 visits per plan year).

16. Professional ambulance service, when required for local transportation to a contracted hospital or other contracted facility or for transportation to the nearest hospital that is equipped to provide necessary treatment.

17. Diagnostic laboratory and X-ray examinations, including professional fees.

18. Oxygen and the rental of equipment for its administration.

19. Administration of blood or blood components.

20. Radium, radioactive isotopes and X-ray therapy.

21. Dressings, sutures, casts, splints, braces, customized foot orthotics (two per plan year) including shoe inserts that are custom made, trusses and crutches, or other specialized medical supplies ordered by a physician, with the exception of dental braces and corrective shoes. This benefit may require medical necessity review prior to purchase.

22. Initial purchase of artificial limbs, eyes, larynx and other orthotic or prosthetic appliances to replace natural limbs or organs. Replacement of a prosthetic appliance due to growth or a change in the person's medical condition, or wear which cannot be repaired and is still deemed medically necessary. This benefit may require medical necessity review prior to purchase.

23. Surgically implanted penile prostheses when the dysfunction is related to an injury or illness. **Refer to *Exclusions and Limitations* for more information.**

24. Rental fees, up to the purchase price only if it is expected that the rental costs will exceed the purchase price for the initial purchase only, for the following along with all items that can be purchased or rented for service:
    a. Wheelchair
    b. Hospital bed
    c. Kidney dialysis equipment

25. Rental fees, up to the purchase price only if it is expected that the rental costs will exceed the purchase price for the initial purchase only, for the following:
    a. Other durable medical equipment that is determined under the Medical Management program to be medically necessary and appropriate and made and used only for treatment of injury or illness or to replace a body function that was lost or impaired due to an injury, illness or congenital anomaly. Pre-certification is required for this benefit.

26. Convalescent skilled nursing contracted facility charges for semi-private room and board, as well as general nursing and other medical services customarily provided. Pre-certification is required for this benefit (120 days per plan year). Confinement in a convalescent skilled nursing contracted facility must begin within 14 days following a hospital confinement of at least three days. In addition, the confinement must be necessary for skilled nursing or physical restorative services required to recover from the illness or injury that caused the hospital stay.

27. Home health care contracted agency charges for the following:
    a. Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN).
    b. Part-time or intermittent home health aide services consisting primarily of caring for the patient.
    c. Medical supplies, drugs and medicines that would have been covered had the patient remained in the hospital.

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

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

29. The following services for human-to-human organ or tissue transplants, provided the transplant is medically necessary and not experimental. Pre-certification is required for this benefit. Transplant services are only covered when provided by a Tier I (HMO) contracted provider or Tier II (PPO) contracted provider; not covered when provided by an out-of-network provider. Services include:
    a. Procurement of cells, as long as the transplant has been approved and pre-certification has been completed.
    b. Donor expenses, as long as the donor is covered by this plan. (lab services only)

c. Donor expenses, if the recipient is covered by this plan and the donor's health plan will not provide coverage for the donation. (lab services only)
d. Transportation, storage, surgery services and any fees for obtaining an organ from a cadaver or tissue bank.
e. Transportation and lodging benefit – The plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been approved for transplant services from HealthLink. The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement schedule is established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.

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

30. Expenses for a medically necessary mastectomy, including reconstruction of the affected breast(s). Covered expenses also include surgery and reconstruction of an unaffected breast to produce a symmetrical appearance. Coverage is also provided for any physical complications in all stages of the mastectomy (including lymphedemas), and for prosthetics. 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 patient after discharge. Limitation of two mastectomy bras per plan year due to a mastectomy. Pre-certification is required for this benefit.

31. Diabetes self-management training means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process. This coverage is for contracted physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of an enrollee with gestational, type I or type II diabetes.

32. Treatment of varicose veins including but not limited to vein stripping, radiofrequency or laser ablation and sclerotherapy if deemed medically necessary.

33. Custom made shoes (diabetic shoes); no more than one pair every five plan years. **Individual must have been diagnosed with diabetes for coverage to apply**.

34. Contraceptive expenses include the following:
    a. Oral
    b. Diaphragm, Lea's Shield, Cervical Cap
    c. Patch: Ortho Evra
    d. Depo-Provera injection
    e. Implant: Norplant and Etonogestrel IUD

35. Compression hose are covered as non-surgical treatment of varicose veins. A diagnosis of varicose veins is required for this benefit, and this is limited to two pair per plan year. In addition, compression hose are covered after a surgical procedure and no longer than six months after the procedure with a limit of two per covered period.

36. Jobst or Gradient stockings are covered with a diagnosis of lymphedema.

37. Cochlear implants will be covered under the regular medical plan when deemed medically necessary.

38. Nutritional Counseling/Dietitian will include nutritional evaluation and counseling as medically necessary for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when prescribed by a physician and provided by a licensed health care professional (e.g., a registered/clinical dietitian). A letter of medical necessity from the prescribing physician is required. Coverage shall be limited to one nutritional counseling session per primary medical condition per lifetime not to exceed 10 classes per session. Conditions for which nutritional evaluation and counseling may be considered medically necessary include, but are not limited to the following:

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

Specifically excluded is nutritional counseling solely for the management of the following conditions:
a. Attention-Deficit/Hyperactivity Disorder
b. Chronic Fatigue Syndrome
c. Idiopathic Environmental Intolerance (casual connection between environmental chemicals, foods and/or drugs)

39. Anesthesia coverage for dental services when the medical condition is significant enough to impact the need to provide anesthesia services, and when other alternative type of anesthesia, sedation or analgesia are not appropriate and the following requirements exist:
a. The individual is a child age six or younger.
b. The individual is disabled.

40. If a member is confined in a hospital and coverage is terminated, benefits will continue until discharge from that facility.

41. Clinical trials are not covered; however, routine patient care provided in connection with a covered person's participation in approved Phase I, Phase II and Phase III clinical trials for eligible expenses is covered in the same manner as when such expenses are incurred for non-investigational purposes, provided that the covered person has been diagnosed with a life-threatening disease and the clinical trial is designed with therapeutic intent to improve participants' health outcomes (not simply to test toxicity or disease pathophysiology).
Covered routine patient care includes:
a. Items or services that are typically provided in the absence of a clinical trial (e.g., medically necessary conventional care, including but not limited to office visits, consultations, diagnostic tests, hospital charges, non-experimental drugs);

b. Items or services required for the provision of the investigational item or service (such as administration of a non-covered chemotherapy drug);
c. Items and services required for the clinically appropriate monitoring of the effects of the treatment, or the prevention of complications, but not services provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient;
d. Items and services which are medically necessary for the diagnosis or treatment of complications arising from the provision of the investigational treatment.

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

42. Total Parenteral Nutrition (TPN) for pre- or post-surgical patients, or when determined to be medically necessary in order to safeguard the covered person's life. A statement of medical necessity from the attending physician must be submitted prior to receiving services in cases that are other than pre- or post-surgical related.

43. Genetic Testing which includes diagnostic testing and counseling when medically appropriate, including but not limited to: Diagnostic testing where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder; diagnostic testing when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease; predictive testing if the covered person's family history establishes the patient is at risk for a genetic disease, but only if there are accepted treatment alternatives for that condition; prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother or father has a family history that established that parent is at risk for having a hereditary genetic disorder or if multiple miscarriages have occurred.

44. Vasectomy and tubal ligations are considered a covered benefit; however, reversals are not.

45. Flu Mist is a covered expense.

46. Family counseling and group counseling when performed by a covered provider; does not include coverage for marital counseling.

47. Telemedicine will be covered when utilizing the HealthLink product.

48. If the Sleep Apnea Dental device is prescribed by a medical provider (codes E0485 or E0486 only) it must meet medical necessity guidelines including custom filling and may not be sold over the counter. If a network provider is not found, the device will be handled as Tier 1; otherwise the network status of the provider will be utilized for processing after the criteria have been met.

49. Manual breast pumps will be covered under the Plan.

50. Durable medical equipment supplies will be processed and paid based upon the summary of benefits under Durable Medical equipment.

51. Residential treatment centers when deemed medically necessary and network providers are utilized.

52. Gender dysphoria relative to gender reassignment surgery (also known as gender confirmation surgery and/or sex reassignment surgery) may be covered effective July 1, 2016 when certain criteria has been met as outlined in *Section II* under *Q*.

Section IV – Exclusions and Limitations

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

1. Services and supplies which are not medically necessary; nor for charges for which the covered person is not legally liable, or any expenses which exceed the usual and customary (U&C) charges for the geographic area in which the expenses were incurred.

2. Any charges that are considered over usual and customary (U&C) for out-of-network providers. **Further explanation of what usual and customary (U&C) is will be found in *Definitions*.**

3. Any charges that are considered over usual and customary (U&C) for out-of-network providers when Medicare reimbursement schedule (MAC) is utilized for services, beginning January 1, 2014. **See *Definitions* for additional explanation.**

4. Any expenses for any condition or disability, which is due to injury or illness arising out of or in the course of any occupation or employment for wage or profit and which would entitle the covered person to any benefit under a Workers' Compensation act, law or similar legislation, including those situations whereby the covered person lawfully chose not to be covered or waived or failed to assert his/her rights under a Workers' Compensation law, act or similar legislation.

5. Any expenses for any conditions or services that are reimbursed by a third party.

6. Any service, procedure or supply not specifically identified as being covered under the plan.

7. Care of any injury or illness incurred while on active or reserve military duty. Care of any injury or illness resulting from war, declared or undeclared, any act of war or any act of terrorism.

8. Convalescent care, custodial care, sanatoria care, care in residential and non-residential treatment centers and nursing homes.

9. Any expenses for cosmetic surgery. Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and

related expenses are allowed only when such surgery is required as the result of accidental injury, or congenital deformities evident in infancy and/or may become evident as the individual grows and develops, or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.

10. Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, return to work services, work hardening programs, driving safety and services, training, educational therapy or non-medical ancillary services for learning disabilities, developmental delays or mental retardation except when deemed medically necessary under autism coverage.

11. Marital counseling

12. 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, wigs and their care, and any other primarily non-medical equipment.

13. Any services provided by immediate family members or household members.

14. Travel, whether or not recommended or prescribed by a physician.

15. Hypnotism, hypnotic anesthesia, acupuncture, acupressure, electric stimulation and massage therapy.

16. Eyeglasses and contact lenses or the examination for prescription and fitting.
    Exception: Coverage will be provided for eye examination, including refractions, when received as a result of a covered medical illness or accidental injury that occurred while covered under the plan and within one year of the accident.

17. Dental injuries that occur as a result of chewing are not covered. Coverage will apply as a result of accidental injury to sound natural teeth if accident occurred while covered under the plan and within one year of the accident. **Dental implants are excluded as a covered expense regardless if the request is due to an accidental injury to the sound natural teeth. (Services deemed covered for accidental injury to sound natural teeth do not require the dental EOB before services are calculated for payment.)**

18. Dental services including treatment for impacted teeth, dental implants or orthodontia related services are not covered. Removal of cysts and/or lesions located in the mouth that would be considered as medical must be denied by the dental carrier before being considered for coverage under the medical plan. (Any additional expenses performed or prescribed by a dentist will be considered not covered under your medical plan including but not limited to Sleep Apnea Dental device, MAS devices, Mandibular Advancement Splint, Mandibular Repositioning appliances (MRA).) If the Sleep Apnea Dental device is prescribed by a medical provider (codes E0485 or E0486 only), it must meet medical necessity guidelines including custom fitting and may not be sold 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.

19. Expenses incurred for procedures intended primarily to treat morbid obesity, including but not limited to gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw and services of a similar nature, Mason Shunt, banding gastroplasty or intestinal bypass, unless such procedures are medically necessary.

20. Expenses for weight loss programs and clinics regardless of associated medical or psychological conditions. Includes counseling, educational materials, diagnostic testing or monitoring, food, special formulas, food or vitamin supplements, special diets, or supplies associated with weight loss programs.

21. Infertility treatment exclusions that include, but are not limited to: **See additional information under *Section II* and *Section XIII*.**
    a. Medical or non-medical costs of anyone not covered under the plan.
    b. Costs for services rendered to a surrogate; however, costs for procedures to obtain eggs, sperm or embryos from a covered individual shall be covered if the individual chooses to use a surrogate and the individual 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 covered individual'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. Costs for an egg or sperm donor which is not medically necessary.
    f. Experimental treatments or those unproven in nature.
    g. Costs for procedures which violate the religious and moral teachings or beliefs of the company or covered group.
    h. 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.
    i. Travel costs.
    j. Infertility treatments rendered to dependents under the age of 18.
    k. 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.
    l. Pre-implantation genetic testing.
    m. Donor expenses of an anonymous donor requiring prescription drugs. **See additional information under *Definitions*.**

22. Orthognathic surgery for correction of deformities of the jaw, unless to correct birth defects of eligible plan participants since birth and/or may become evident as the individual grows and develops, or which occurred through accidental injury while covered under this plan.

23. Services or supplies relating to the diagnosis, treatment and/or appliance for temporomandibular joint disorders or syndromes (TMJ), or myofunctional disorders or other orthodontic therapy.

24. Organ transplants consisting of nonhuman devices or artificial organs such as heart, kidney or liver.

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

25. Surgical procedures performed on the cornea of the eye to improve vision by changing the refraction. (Including but not limited to Refractive Keratoplasty, Radial Keratotomy including lasik or lasek procedures, and surgery to correct astigmatism after cataract or corneal transplant procedures).

26. Experimental, obsolete or investigative procedures, services, or supplies. Alternative medicine that does not meet generally accepted medical standards.

27. Any charges related to reversal of a prior sterilization; or elective abortion.

28. Blood donor expenses.

29. Lenses (eye glasses or contacts) except initial pair following cataract surgery. (Initial pair of glasses includes basic glasses only and excludes tinting, transition lens and safety lens; should vision correcting IOLs (intraocular lenses) be utilized they would need to meet medical necessity criteria prior to the implantation to determine if covered.)

30. Any services or supplies for which you have no legal obligation to pay.

31. Charges for failure to keep an appointment and any late payment charges.

32. Examinations for or in connection with insurance, traveling abroad or employment including immunizations required for insurance, traveling abroad or employment.

33. For non-medical expenses such as preparing medical reports, itemized bills or charges for mailing.

34. Items for comfort or convenience, stethoscopes, blood pressure cuffs, warning devices and other types of apparatus used for diagnosis or monitoring.

35. Surgical treatment of scarring secondary to acne or chicken pox to include, but not to be limited to, dermabrasion, chemical peels, abrasion and collagen injections.

36. Inpatient services (other than diagnostic X-ray, laboratory and clinical tests) by all providers in connection with an admission if the enrollee was admitted primarily for diagnostic reasons and if such services could have been provided adequately on an outpatient basis without endangering the enrollee's health.

37. Inpatient services provided by all providers if the enrollee was admitted primarily for physical therapy or occupational therapy and if such services could have been provided adequately on an outpatient basis without endangering the enrollee's health.

38. Speech and hearing therapy screening examinations for services received under any program offered by any governmental body or division thereof.

39. Services provided by a registered nurse first assistant (RNFA) or certified registered nurse first assistant (CRNFA) except when deemed medically necessary and appropriate for care.

40. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with diagnosis of diabetes. In addition, if these services are deemed medically necessary for non-professional performance if the service would be hazardous for the member because of an underlying condition or disease; or routine foot care if performed as a necessary and integral part of an otherwise covered service (i.e., treatment of warts, or debriding of a nail to expose a subungual ulcer; or debridement of mycotic nails if undertaken when the mycosis dystrophy of the toenail is causing secondary infection and/or pain, which results or would result in marked limitation of ambulation and required the professional skills of a physician.

41. Foot orthotics not custom-molded or fitted to the foot.

42. For purchase or rental of personal convenience or comfort items or supplies for common use, including but not limited to: blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools, in addition to telephone charges, television rental, guest meals, wheelchair/van lifts, non-hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps, or any other services or items determined by the plan to be for personal convenience. Ceiling lifts and overhead lifts (portable and semi-portable that attach to a ceiling track system) would be non-covered if prescribed to address accessibility limitations of the home.

43. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).

44. For private room charges in excess of the established semi-private room and board charges regardless of any medical necessity such as isolation.

45. Occlusion guard

46. Replacement for C-PAP machine when traveling out of the country.

47. Repair services on durable medical equipment.

48. For replacements due to negligence or loss of an item.

49. Scooters, Tedhose or paraffin bath are not covered.

50. Any condition, disability or expense resulting from or sustained while engaged in an illegal occupation or commission of or attempted commission of an assault or a felonious act; provided that these exclusions will not apply if the injury resulted from an act of domestic violence or a medical condition (including both physical and/or mental health conditions).

51. Any condition, disability or expense resulting from an injury caused by participating in an insurrection or riot or participation in the commission of an assault or felony.

52. Any charges for care or treatment provided or furnished by the United States government or the government of any country, except to the extent that United States federal law requires the plan to provide benefits for such care or treatment. (For treatment in VA facilities, the law generally requires the plan to provide benefits for a covered individual who does not have a service-connected disability.)

53. Vacuum erection devices are not covered.

54. Any charges for treatment, services or supplies related to the pregnancy (including complications of pregnancy) or maternity care of dependent children.

55. Any charges for services received or supplies purchased outside of the United States, unless the covered person is a resident of the United States, and the charges are incurred while traveling on business or for pleasure and meet the guidelines under the plan as being covered and meeting medical necessity guidelines.

56. Any charges for artificial insemination, in vitro fertilization or embryo or fetal implants, or other assisted reproduction techniques, except as provided under “Infertility”.

57. Any charges incurred by any person not covered under the plan as an employee or dependent, including, but not limited to, charges for services provided to a surrogate mother or to the biological mother of a child adopted by an employee. This shall not preclude payment for covered donor expenses for covered transplant procedures as outlined under “donor expenses”.

58. For rest, convalescence, custodial care, or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.

59. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.

60. 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.

61. For treatment and services rendered in a setting other than direct patient-provider contact except as outlined under the Telemedicine benefit.

62. For any legal fees incurred by members in relation to the benefit plan and its administration.

63. For services rendered by a doctor of Naprapath, MBBS (bachelor of medicine/bachelor of surgery), CBBT (certified cognitive behavioral therapist), CNOR, LMT, ATC (certified athletic trainer), DMN (doctor of ministry), CN (doctor of neuropathy) or certified weight trainer.

64. For facility fees billed by day programs under the plan. (Physical therapy or medical care will need to be billed separately. If not, no coverage will be allowed. This would include services from a covered Skilled Nursing Facility or custodial care unit on an outpatient basis only; inpatient services would still be denied if utilizing a non-contracted provider.)

65. For costs incurred in the search or profiling of a transplant donor.

66. Residential treatment centers regardless of diagnosis or condition when an out-of-network provider is utilized.

67. Any costs or services for holistic medicine.

68. Hearing aids are not covered.

69. Any services for sex transformations unless you are approved through "reassignment"; this must be documented and information provided to the health plan as outlined in *Section II* under *Q*.

70. For growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed condition).

Section V – Continuation of Coverage

Upon termination from this plan, you and your enrolled dependents may be eligible for continuing coverage. Please see your insurance representative or contact the Illinois Department of Central Management Services for more information.

Section VI – Qualified Medical Child Support Orders (QMCSO)

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

A. If this plan receives a QMCSO for one or more of your children, your insurance representative will notify you and each child affected by the order.

B. If you receive the QMCSO as part of your divorce decree or as a result of a paternity suit, contact the insurance representative immediately after receipt of your decree.

C. Contact your insurance representative or HealthLink Customer Service for additional information.

Section VII – Coordination of Benefits (COB)

Overview

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

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

B. The term "allowable expense" means any medically necessary covered service for which part of the cost is eligible for payment by this plan or one of the plans defined above.

C. Amount paid when benefits are coordinated including Medicare – you must report any other coverage for reimbursement of your allowable expenses. The primary plan, which pays first, will pay the benefits that would be payable under the terms of the plan in the absence of a coordination of benefits provision. The secondary plan will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:
   - 100% of the total allowable expenses, or
   - The amount of benefits it would have paid had it been the primary plan.

D. Which Plan Pays First – The plan follows the National Association of Insurance Commissioners (NAIC) model regulations. These regulations dictate the order of benefits determination. The rules are applied in sequence. If the first rule does not apply, the sequence is followed until the appropriate rule that applies is found. The order is as follows:
   1. If other plan is primary, benefits under the plan will be determined in the following manner:
      a. The plan will first determine what would have been paid in the absence of any other coverage.
      b. If a balance due remains after the primary carrier has paid, the plan will pay that balance *up to* the maximum amount allowed.
   2. The plan that covers the plan participant as an active employee is primary over the plan that covers the plan participant as a dependent:
      a. The plan that covers the plan participant as an active employee (not as a laid-off employee or retiree) is primary over the plan that covers the plan participant as a laid-off employee or retiree.
      b. If the plan participant is covered as an active employee under more than one plan, and none of the above rules apply, then the plan that has been in effect the longest is

primary, back to the original effective date under the employer group, whether or not the insurance company has changed over the course of coverage.

3. Dependent children of parents not separated or divorced:
   a. Birthday Rule – the plan covering the parent whose birthday falls earlier in the calendar year is the primary plan.
   b. If both parents have the same birthday, the plan that has provided coverage longer is the primary plan.
   Birthday refers only to the month and day in a calendar year, not the year in which the person was born.

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

4. Dependent children of separated or divorced parents:
   If a child is covered by more than one group plan and the parents are separated or divorced, the plans must pay in the following order:
   a. The plan of the parent with custody of the child.
   b. The plan of the spouse of the parent with custody of the child.
   c. The plan of the parent not having custody of the child.

   NOTE: If the terms of a court order state that one parent is responsible for the health care expenses of the child, and the health plan has been advised of this responsibility, that plan is primary over the plan of the other parent.

5. Dependent children of parents with joint custody:
   a. The birthday rule applies to dependent children of parents with joint custody.

E. Medicare – Medicare is a federal health insurance program for individuals age 65 and older, under age 65 with certain disabilities, and individuals 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: Part A, Part B, Part C (also known as Medicare Advantage) and Part D. (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 – Plan Participants age 65 and older* – The State of Illinois Group Insurance Program requires all plan participants to contact the SSA and apply for Medicare benefits three months prior to turning age 65.

   Medicare Part A – Eligibility for premium-free Medicare Part A occurs when an individual is age 65 or older and has earned at least 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 plan participant is eligible for premium-free Medicare Part A, the State of Illinois Group Insurance Program requires the plan 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.

Medicare Part B – Most plan participants are eligible for Medicare Part B upon turning age 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 section titled "Medicare Due to End-Stage Renal Disease (ESRD)' for information on the Medicare requirements.

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.

2. *Medicare Due to Disability – Plan participants age 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 24 months.

   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.

   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.

   Plan 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.

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 800-442-1300 in order to determine which insurance is the primary payor.

Medicare Part 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 B.

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 out-of-network providers, the claim payment will be no more than 20% of the total eligible billed amount. 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.

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.

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

   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.

   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.

   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 30 months (as long as Medicare and the State plan both remain in effect).

   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.

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 out-of-network providers, the claim payment will be no more than 20% of the total eligible billed amount. 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.

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

Section VIII – Claim Procedures

A. As a participant in the HealthLink Open Access III Plan, you will rarely have to file a claim. Typically, the HealthLink contracted providers will file claims on your behalf directly with HealthLink.

B. You may need to submit a claim for reimbursement for such items as ambulance services, durable medical equipment, private duty nursing, emergency care outside the HealthLink service area or whenever you are required by the provider to pay at the time the services are rendered. Always get an itemized copy of any bill that you pay. You may obtain claim forms from HealthLink, Inc. In order to receive reimbursement, the following information is required:
   1. Patient's name, address and ID number
   2. Date of service
   3. Procedure and diagnosis codes
   4. Billed amount for each procedure code performed
   5. Provider name, address and tax ID number

C. Time Limits for Filing – HealthLink HMO, Inc., the Claims Administrator, must receive proof of a claim for covered services no later than one year from the date of service.

Section IX – Complaints and Appeals

Complaints

If you have a complaint about any medical or administrative matter related to services provided in connection with this plan that is not resolved by your HealthLink provider, please call HealthLink Customer Service at 1-800-624-2356. Alternatively, you can file a written complaint to HealthLink Grievances and Appeals, PO Box 411424, St Louis MO 63141-1474.

Appeals

There are two separate categories of appeals: medical and administrative. The claim administrator determines the category of appeal. The member 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.
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.

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

A. **First Level/Internal Appeals** – First level appeals must be initiated with the claim administrator within 180 days of the date of receipt of the initial adverse benefit determinations. An expedited review may be requested orally or in writing if you, your contracted HealthLink provider or other health care provider involved in the appeal believes that the denial of coverage of health care services could significantly increase risk to your health. Non-urgent appeals should be submitted to:

    HealthLink Grievances and Appeals
    PO Box 411424
    St. Louis, MO 63141-1424

    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 health care 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: 15 days for pre-service claims; 30 days for post-service claims; or 72 hours for urgent care claims.

B. **Final Benefit Determination – Administrative Appeals Only –** After exhausting the first level/internal appeal available, if the member 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 member must appeal in writing within 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.

C. **External Review Process – Medical Appeals Only** – After completion of the internal appeal process referenced above, the member 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 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 member 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 45 days of the receipt of the request. If the external reviewer decides in favor of the member, the decision shall be final and binding on the claim administrator.

D. **Expedited External Review – Medical Appeals Only** – For medical appeals involving urgent care situations, the member 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 72 hours after the receipt of the request. If the external reviewer decides in favor of the member, the decision shall be final and binding on the claim administrator.

Section X – Subrogation/Third Party Liability

Liability Overview

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

However, the plan will provide benefits otherwise payable under the plan, to or on behalf of its covered persons, but only on the following terms and conditions:

A. In the event of any payment under the plan, the plan shall be subrogated to all of the covered person's rights of recovery against any person or entity. The covered person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The covered person shall do nothing after loss to prejudice such rights. The covered person shall cooperate with the plan and/or any representatives of the plan in completing such documents and in providing such information relating to any accident as the plan by its representatives may deem necessary to fully investigate the incident. The plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the covered person.

B. The plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the covered person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the plan.

C. The plan, by payment of any proceeds to a covered person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the covered person or a representative. The covered person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the plan secure said lien.

D. The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the covered person as a result of the injuries sustained, including but not limited to the following:
   1. Payments made directly by a third party tort-feasor or any insurance company on behalf of a third party tort-feasor or any other payments on behalf of a third party tort-feasor.
   2. Any payments, settlements, judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a covered person or other person.
   3. Any other payments from any source designed or intended to compensate a covered person for injuries sustained as the result of negligence or alleged negligence of a third party.
   4. Any Workers' Compensation award or settlement.

E. The parents of any minor covered person understand and agree that the State's plan does not pay for expenses incurred for injuries received as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor covered person are conditional upon the plan's express right of reimbursement. No adult covered person hereunder may assign any rights that such person may have to recover medical expenses from any tort-feasor or other person or entity to any minor child or children of the adult covered person without the express prior written consent of the plan. In the event any minor covered person is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the plan of the existence of any claim on behalf of the minor child against the third party tort-feasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any claim against the third party tort-feasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tort-feasor or other person or entity to the plan, or at their election, to prosecute a claim from medical expenses on behalf of the plan. The adult covered persons/parents further agree that in the event they elect to prosecute a claim for medical expenses that any recovery shall not be diminished under any theory of common fund and that the provisions of this section shall specifically apply hereto. In default of any obligation hereunder by the adult covered persons/parents, the plan is entitled to recover the conditional benefits advanced plus costs, (including reasonable attorney's fees), from the adult covered persons/parents.

F. No covered person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the plan.

G. The plan's right of recovery shall be a prior lien against any proceeds recovered by a covered person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

H. No covered person under the plan shall incur any expenses on behalf of the plan in pursuit of the plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."

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

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

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

Section XI – Termination of Coverage

A. **Termination of Employee and Dependent Coverage –** An employee's and/or dependent's coverage will cease as of the date and for the reasons specified in the State of Illinois Benefits Handbook.

B. **Benefits Upon Plan Termination –** If this plan terminates and there is no successor plan, all remaining assets shall be used to provide plan benefits and to pay administrative costs incurred as a result of such termination.

Section XII – Miscellaneous Provisions

A. **Binding Effect –** The plan, and all actions and decisions hereunder, shall be binding upon the heirs, executors, administrators, successors and assignees of any and all parties hereto including all participants, dependents and beneficiaries, present and future.

B. **Governing Law –** The validity of the plan or any of its provisions shall be determined under, and construed according to the laws of the State of Illinois.

C. **Non-Alienation –** No benefit or interest available hereunder will be subject to assignment, alienation, transfer, attachment, execution, garnishment, sequestration or other legal, equitable or other process, either voluntarily or involuntarily, by operation of law or otherwise except as may be expressly permitted herein. The preceding sentence shall also apply to the creation, assignment or recognition of a right to any benefit payable with respect to a participant pursuant to a Qualified Medical Child Support Order.

D. **Records –** The member shall furnish HealthLink HMO, Inc. with all information and proof that HealthLink HMO, Inc. may reasonably require with regard to any matters pertaining to this plan.

E. **Authorization for Release –** By accepting coverage under the plan, each participant (member), including dependents, whether or not such dependents have signed the medical release, authorizes and directs any person or institution that has provided services to the member, to furnish the plan, plan administrator, HealthLink and all persons providing services in connection with the plan at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to the member. This authorization constitutes a waiver of any provision of law for such rights. HealthLink shall not be deemed or construed as an employer or the plan sponsor for any purpose with respect to the administration or provision of benefits under the employer's benefit plan. HealthLink shall not be responsible for fulfilling any duties or obligations of the plan sponsor with respect to the plan sponsor's benefit plan.

F. **Reimbursement to HealthLink HMO, Inc., the Claims Administrator, on Behalf of the Plan Sponsor –** The subscriber agrees to refund to HealthLink HMO, Inc., the Claims Administrator, any benefit payment HealthLink HMO, Inc., the Claims Administrator, made to the subscriber or on the subscriber's behalf for a claim paid or payable under any Workers' Compensation or employer's liability law.

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

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

G. **Conformity with State Laws and Benefits Handbook –** Laws of the state in which the plan was issued, or issued for delivery, may conflict with some of its provisions. If so, then those provisions are automatically changed to conform to at least the minimum requirements of such laws. In the event of a conflict between this Summary Plan Description and a specific provision in the State of Illinois Benefits Handbook that is applicable to the Open Access III Plan, the terms of the State of Illinois Benefits Handbook will be followed.

H. **Commission or Omission –** No HealthLink contracted provider will be liable for any act of commission or omission by HealthLink. HealthLink will not be liable for any act of commission or omission by any contracted provider or provider's agent or employee, or the plan sponsor or the plan sponsor's agent or employee.

I. **Incentive and Calculation of Amounts –** Some of the plan's contractors (e.g., HealthLink HMO, HealthLink PPO and others) have contracts with providers and administrators that allow for discounts, allowances, fees, incentives, adjustments and settlements to be paid to, or retained by, such contractors. These amounts are for the sole benefit of such contractors, who will retain any payments resulting therefrom, or may distribute or share these amounts with providers, administrators or others. Claims submitted will have co-pays, deductibles

and other amounts, which are the enrollee's responsibility, calculated without regard to such allowances, fees, incentives, adjustments, settlements, and, in some cases, discounts. In addition, some contracted providers may also participate in incentive and other programs; under which such contracted providers, administrators and contractors may be entitled to additional payments for effectively managing care and satisfaction of enrollees or contracted providers.

Section XIII — Definitions

- **Accidental Injury** means accidental bodily injury sustained by you, which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. Damage to natural teeth or dental prostheses, which occur during the act of chewing, is not considered an accidental injury.

- **Act** shall mean the State Employees Group Insurance Act of 1971 (5 ILCS 375/1 et seq.) as now or hereafter amended and such rules and regulations as shall be promulgated thereunder.

- **Admission** begins when you become a registered hospital bed patient and continues until you are discharged.

- **Alcoholism and Substance Abuse** means the uncontrollable or excessive abuse of addictive substances and the resultant physiological dependency that develops with continued use, requiring care as determined by a contracted physician or contracted psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

- **Ambulance** means a vehicle designed and operated to provide medical services and authorized to operate as required by law.

- **Ambulatory Surgical Center** means a contracted facility licensed by the State as an Ambulatory Surgical Center. It must be equipped and operated mainly to perform surgeries that allow patients to leave the facility the same day their surgery is performed. It cannot be equipped for overnight care of patients.

- **Anonymous Infertility Donor** charges will be considered if the services meet the requirements as outlined in the plan; however no prescription medicines will be covered unless the donor agrees to provide their name, social security number, date of birth, complete address, gender, prescriptions being requested along with health provider. **See additional definition under "Oocyte Donor".**

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

- **Assisted Reproductive Technologies or ART** means 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.

- **Autism Spectrum Disorders** means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

- **Autism Spectrum Disorders Diagnosis** means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by a) a physician licensed to practice medicine in all its branches or b) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

- **Autism Spectrum Disorders Treatment** shall include the following care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder by a) a physician licensed to practice medicine in all its branches or b) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches: (1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist. (2) Psychological care, meaning direct or consultative services provided by a licensed psychologist. (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection, (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modifications, (v) motor planning, and (vi) sensory processing.

- **Behavioral Health** means the uncontrollable or excessive abuse of addictive substances and the resultant physiological dependency that develops with continued use, requiring care as determined by a physician or psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines. Also includes a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, even if organic origin is believed contributory.

- **Behavioral Health Provider** means an individual professional or group of professional providers for mental health/substance abuse treatment or institutions which are licensed to provide such covered services under applicable state law.

- **Coinsurance** is a percentage of the covered expenses you are responsible for after the deductible is met.

- **Co-pay or co-payment** means the fixed dollar amount you must pay to a contracted provider at the time the service is rendered.

- **Covered expenses** means either (a) the actual charge for a covered service, or (b) the amount that the plan determines is the appropriate charge for a covered service, which, in many cases, will be the contracted rate with a Tier I (HMO) contracted provider or a Tier II (PPO) contracted provider for that service, or the usual and customary (U&C) charges for that service if the provider is an out-of-network provider, or amounts over the Medicare reimbursement schedule (MAC) for services rendered January 1, 2014 and after. The plan has the sole discretion to determine the covered expense and to select the methodologies for making these determinations. Charges above the covered expense are not covered for benefits. Enrollees are responsible for charges that are not covered expenses, including charges for services that are not covered services. Enrollees are also responsible for covered expenses not paid by the plan by reason of co-pays, deductibles, coinsurance amounts, and out-of-pocket expense maximum for covered services.

- **Custodial Care** means care that mainly provides room and board (meals). This care is for physically or mentally disabled persons who are not receiving care specifically to reduce the disability to the extent that the person can live outside a hospital or nursing home. Care is considered custodial, no matter where the person lives, if it is non-skilled nursing care; training in personal hygiene; other forms of self-care; supervisory care by a contracted physician or practitioner; or medical services which are given merely as care to maintain present health and which cannot be expected to improve a medical condition. The fact that the covered person is concurrently receiving medical services that are merely maintenance care and cannot reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.

- **Deductible** is the amount that you must pay each plan year in covered expenses before the plan begins to pay benefits.

- **Dependent** means a member of the family of the subscriber as defined by the Act.

- **Disability or Disabled** means the inability to perform the material and substantial duties of the employee's occupation subject to a doctor's initial verification and periodic re-certifications as required by the employer. Dependent disability or disabled means an individual who has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and is expected to last or has lasted for a continuous period of not less than 12 months.

- **Donor Sperm, Eggs, and Embryos means** 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 donors 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 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. 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** means an oocyte donor or sperm donor. (see "Oocyte Donor" for further explanation)

- **Educational in Nature** means the primary purpose of any drug, device, medical treatment or procedure is to provide the patient with any training in matters that are other than directly medical.

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

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

- **Emergency** means the sudden, unexpected onset of a health condition with symptoms so severe that a prudent layperson, possessing an average knowledge of health and medicine, would believe that immediate medical care is required.

- **Enrollee, Covered Individual, Covered Person, Participant or Plan Participant** means an eligible person under the Act who is enrolled in the Open Access III Plan.

- **Gamete** means a reproductive cell. In a man, the gametes are sperm; in a woman, they are eggs or ova.

- **Gamete Intrafallopian Tube Transfer or GIFT** means the direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

- **Gender Dysphoria also known as Gender reassignment** means a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. People with gender dysphoria often report a feeling of being born the wrong sex. Important medical and psychological evaluations, medical therapies and behavioral trials should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

- **Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. With respect to an individual, genetic information includes information about the manifestation of a disease or disorder in the individual's family members. Genetic information also includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research which includes genetic services, by the individual or any family members.

- **HealthLink** refers to HealthLink HMO and HealthLink PPO, provided however, that in connection with any contracted services or responsibilities of the Claims Administrator, such term only refers to HealthLink HMO.

- **HealthLink HMO or HealthLink HMO, Inc.** is the Claims Administrator and the HMO Network Administrator for plan participants who enroll in the Open Access III Program.

- **HealthLink PPO or HealthLink, Inc.** is the PPO Network Administrator and Medical Management manager for plan participants who enroll in the Open Access III Program.

- **HMO Contracted Provider, HealthLink HMO Contracted Network Provider, HMO Contracted Network Provider, Tier I (HMO) Contracted Provider or Tier I Contracted Provider** means a contracted hospital, physician or other medical provider participating in the HealthLink HMO contracted provider network as designated by HealthLink HMO, Inc. from time to time.

- **Home Health Agency** means a contracted agency that provides contracted skilled nursing services and other contracted therapeutic services in the patient's home and is certified to participate in the Medicare program.

- **Hospital** means a contracted facility that: a) Operates pursuant to law; b) Provides 24-hour nursing services by registered nurses on duty or on call; and, c) Provides contracted services under the supervision of a staff of one or more contracted physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions. Hospitals are classified as follows: 1) HealthLink participating contracted hospital means a hospital that has a HealthLink HMO or PPO participating hospital contract with HealthLink. 2) Non-participating hospital means a hospital that does not have a HealthLink HMO or PPO participating hospital contract with HealthLink. Hospital does NOT include: residential or non-residential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; skilled nursing facilities; places that are primarily for the care of convalescents; clinics; physician or practitioner offices; private homes; ambulatory surgical centers.

- **Infertility** is the inability to conceive after one year of unprotected sexual intercourse with same partner, the inability to conceive after one year of attempts to produce conception with same partner, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy. A woman shall be considered infertile without having to engage in one year of unprotected sexual intercourse if a physician determines that: 1) a medical condition exists that renders conception impossible through unprotected sexual intercourse; or 2) efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

- **Intensive Outpatient Treatment** means a structured array of treatment services including medication monitoring if applicable, evaluation by a psychiatrist if indicated, and coordination of care provided by a multidisciplinary team of Behavioral Health professionals, including at least three treatment hours per day at least three times per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- **In Vitro Fertilization or IVF** means 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.

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

- **Medically Necessary or Medical Necessity** means health care services, supplies or treatment that are provided or ordered by a contracted physician, are approved under the Medical Management program as required, are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

- **Maximum Allowable Charge (MAC)** means Medicare rates by locality for out-of-network rate fee calculation, otherwise referred to as usual and customary (U&C) rates. The out-of-network rate is utilized for your plan. 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. **This calculation will be utilized for services rendered January 1, 2014 and after.**

- **Member, Employee or Subscriber** means an eligible employee, retiree, or annuitant under the Act who has enrolled in the plan for the Open Access III Program.

- **Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight.

- **Multiple Surgery Guidelines** means when two or more surgeries are performed, the Multiple Surgery guidelines will be implemented when calculating covered services. If the surgical procedures are not considered separate and distinct procedures, a reduction in the reimbursement amount is applied. Similarly, if multiple surgeries occurred within the same general operative area and at the same time, reimbursement for duplicative services (e.g., multiple preps, surgical trays, etc.) could constitute waste of plan funds. This is well-recognized in the health insurance industry and in proper coding and reimbursement guidelines.

- **Non-Participating Provider Reimbursement Method** means services provided by doctors and health care professionals who have not contracted with HealthLink to treat payors' members ("Non-Participating Providers"), the amounts that will be allowed for such services ("Non-Participating Provider Reimbursement Amounts") are based on the payors' member contracts. These amounts may be subject to deductibles, co-pays, and other limitations under the terms of the applicable payor's member contracts. Because there is no provider contract or participating agreement, a non-participating provider has not agreed to a reimbursement rate for services provided to payors' members. Therefore, absent a regulation or law, the non-participating provider can bill the member for the difference between the amounts they charge and the non-participating provider reimbursement amount. Members are responsible for paying non-participating providers this difference. Depending on the service, this difference can be substantial.

- **Oocyte** means the female egg or ovum, formed in an ovary.

- **Oocyte Donor** means 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** means 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 III Plan, Open Access III Program or Open Access Program** means the group health benefit plan (and related documents and materials describing the benefits available thereunder) sponsored by the State under which enrollees are provided various incentives to use Tier I (HMO) contracted providers and Tier II (PPO) contracted providers in accordance with the following: a) the benefit tier with the greatest benefits applies when enrollees utilize contracted providers who are designated by HealthLink HMO as "Tier I (HMO) contracted providers", b) the benefit tier that does not contain the least benefits applies when enrollees utilize contracted providers who are designated by HealthLink PPO as "Tier II (PPO) contracted providers", and c) the benefit tier that contains the least benefits applies when enrollees utilize providers who are not Tier I (HMO) contracted providers or Tier II (PPO) contracted providers.

- **Out-of-Network Provider or Tier III Provider** means a physician, hospital or other medical care provider that is not designated by HealthLink as a Tier I (HMO) contracted provider or Tier II (PPO) contracted provider on the date of service and is subject to usual and customary (U&C) guidelines.

- **OutPatient** means shall be considered to be an "OutPatient" if he/she is treated at a Hospital and is confined less than 23 consecutive hours.

- **Partial Hospitalization Program (Mental Health/Substance Abuse)** is an intensive structured setting providing six or more hours of treatment or programming per day or evening, in a program that is available five days a week. The intensity of services is similar to inpatient settings and includes evaluation, medical monitoring and regular meetings by a psychiatrist if psychiatric diagnosis is indicated, nursing care if indicated, individual and group therapy, family therapy as indicated, and coordination of care by a multidisciplinary team of Behavioral Health professionals.

- **Physician** means a medical doctor (MD), doctor of dental medicine (DMD), doctor of osteopathy (DO), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of podiatric medicine (DPM), doctor of optometry (OD), consulting psychologist, social worker (MSW, LSW), registered dietitian (RD), and physician's assistant (PA), provided the practitioner is legally qualified, licensed or certified in accordance with the laws of the certification.

- **Plan Year** means July 1 through June 30 and subsequent annual plan years, unless this plan is sooner terminated.

- **PPO Provider, HealthLink PPO Contracted Network Provider, PPO Contracted Network Provider, Tier II (PPO) Contracted Provider or Tier II Contracted Provider** means a contracted physician, hospital, or other medical provider participating in the HealthLink PPO provider network as designated by HealthLink from time to time.

- **Pre-certification** means the process of having inpatient admissions to hospitals, hospice or convalescent skilled nursing facilities, high-tech imaging, outpatient surgery, ancillary, all behavioral health services and diagnostic services authorized in advance under the HealthLink Medical Management program including AIM.

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

- **Reconstructive Breast Surgery Coverage** means medical 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 Covered Persons, who are receiving Plan benefits in connection with such 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; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions if applicable.

- **Sleep Apnea Device** means a device prescribed by a medical provider for patients that are unable to utilize a c-pap machine and is not for snoring. Only codes E0485 or E0486 may be considered for benefits. Medical necessity will be reviewed.

- **Stabilize** means, 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 individual from a facility.

- **Surrogate** means a woman who carries a pregnancy for a woman who has infertility coverage.

- **Temporomandibular Joint Dysfunction Syndrome (TMJ)** means a disease or symptoms of the jaw joint(s) and/or symptoms of the associated parts resulting in pain or the inability of the jaw to work properly. Associated parts of the jaw mean those functional parts that make the jaw work.

- **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.

- **Usual and Customary (U&C) Charge** is the maximum covered expense for services provided by an out-of-network provider (or facility) of health care services (or supplies). It is the lesser of the billed charge, or a reasonable compensation amount. Usual and Customary will be calculated utilizing Medicare rates by locality. This may also be referred to as Maximum Allowable Charge (MAC), or usual and customary (U&C) rates. The out-of-network rate fee schedule is used for your plan. Physician and ancillary claims are priced at 125% of current Medicare fee schedule 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. 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.

- **Uterine Embryo Lavage** means a procedure by which the uterus is flushed to recover a preimplantation embryo.

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

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

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

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

- **Zygote** means a fertilized egg before cell division begins.

- **Zygote Intrafallopian Tube Transfer or ZIFT** means 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 day and the embryo is transferred at a later time.

NOTICE OF PRIVACY PRACTICES

For individuals enrolled in an Open Access Plan (OAP), the Local Care Health Plan (LCHP) and the Local Care Dental Plan (LCDP)

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 Local Care Health Plan, and the Local 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. Cigna HealthCare is the Medical Plan Administrator for LCHP. HealthLink and Coventry Health Care are the Medical Plan Administrators for the OAPs. CVS/caremark is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator. 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.

How We May Use or Disclose Your PHI

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

Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan, 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.

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.

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

Legal Requirements

We may use and disclose PHI **as required or authorized by law. We are also prohibited from use or disclosure of certain information.** For example:

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.

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.

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

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

Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons or similar process. We may use and disclose 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.

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.

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.

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.

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

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

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

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.

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.

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

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

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

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.

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.

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:

For the LCHP Medical Plan Administrator and Notification/Medical Case Management:	For Behavioral Health Benefits:
Cigna HealthCare, Privacy Office P.O. Box 5400 Scranton, PA 18503 800-762-9940	Magellan Behavioral Health, Privacy Officer PO Box 1719 Maryland Heights, MO 63043 (800) 513-2611
For HealthLink OAP: HealthLink, Complaints in care of Privacy Office P.O. Box 411424 St. Louis, MO 63103 (800) 624-2356	**For Pharmacy Benefits:** CVS/caremark Privacy Office P.O Box 52072 Phoenix, AZ 85072 (866) 443-0933
For Coventry OAP: Illinois Claims, Customer Service 1720 South Sykes Street Bismarck, ND 58504 (800) 431-1211	**For Dental Plan Benefits:** Delta Dental, Privacy Officer 111 Shuman Boulevard Naperville, IL 60563 (630) 718-4700

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.

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

Inspect and Access: You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter 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.

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

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

Copy of Notice and Changes to the Notice: You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, 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.

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, (217) 782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C. if you feel your privacy rights have been violated. **EFFECTIVE DATE: July 1, 2015**

GENERAL PLAN INFORMATION

Plan Name	State of Illinois Local Government Health Plan Members
Plan Numbers	160001
Plan Effective Date	July 1, 2016
Plan Year Ends	June 30, 2017

Plan Sponsor, Plan Administrator, Name Fiduciary and Agent for Legal Services
State of Illinois, Department of Central Management Services

Type of Funding	Self-Funded by the State of Illinois
Claims Administrator	HealthLink HMO, Inc. 877-284-0101
Network Administrator	HealthLink, Inc. 800-624-2356
Medical Management	HealthLink, Inc. 877-284-0102
Behavioral Health Management	HealthLink, Inc. 877-284-0102, Option 3