LOCAL GOVERNMENT HEALTH PLAN

OPEN ACCESS PLAN
SUMMARY PLAN DESCRIPTION

JULY 1, 2017

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1. Introduction

The State of Illinois maintains the State of Illinois Employee Health Benefits Plan (the "Plan") for the exclusive benefit of and to provide health benefits to its eligible full-time and retired employees, their spouses or civil union partners and other eligible dependents.

These benefits (including information about who is eligible to receive benefits) are summarized in this document.

2. General Information About the Plan

Plan Name:	State of Illinois Employee Health Benefits Plan
Type of Plan:	A group health plan
Plan Year:	July 1 through June 30
Plan Number:	Contact Plan Administrator for further information.
Original Effective Date:	July 1, 2011
Funding Medium and The Plan is self-funded by the Type of Plan Administration:	Group. Contributions for the Plan are made in part by the Plan Sponsor and in part by employees' pre-tax payroll deductions. Plan Sponsor has a contract with Aetna Inc. ("Claims Administrator") to process claims under the Plan. Claims Administrator does not serve as an insurer but merely a claims processor. Claims for benefits are sent to the Claims Administrator. It processes the claims, then requests and receives funds from the Plan to pay the claims. The Plan Sponsor is ultimately responsible for providing the plan benefits, not the Claims Administrator
Plan Sponsor:	State of Illinois 401 South Spring Springfield, IL 62706
Plan Sponsor's Employer Identification Number:	Contact Plan Administrator for further information.
Plan Administrator:	State of Illinois 401 South Spring Springfield, IL 62706

Claims Administrator:	Aetna, Inc. 151 Farmington Ave Hartford, CT 06156 Please contact the Claims Administrator at the telephone number on the back of the Plan identification card for questions or concerns regarding Covered Services or any required procedure. Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed above.
Named Fiduciary:	State of Illinois 401 South Spring Springfield, IL 62706
Agent for Service of Legal Process:	State of Illinois 401 South Spring Springfield, IL 62706 Service of legal process may also be made on the Plan Administrator.
Plan Document:	This document constitutes the written plan document for Plan Participants.
Membership ID Card:	Every Participant receives a membership ID card. Participants need to carry the Plan ID card with them at all times and present it whenever Participant receives health care services. If a Plan ID card is missing, lost, or stolen, contact the Claims Administrator's Concierge Team at 855-339-9731 to obtain a replacement.

3. Important Notices

3.1 Important Notice for Mastectomy Patients

If Participant elects breast reconstruction in connection with a mastectomy, Participant is entitled to coverage under this Plan for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Such services will be performed in a manner determined in consultation with the attending physician and the patient. See Section 6 for further detail regarding this coverage.

3.2 Special Rights on Childbirth

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan or the Claims Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3.3 Out-of-Network Option

This Plan has an Out-of-Network Option which gives Participants the opportunity to seek care from Non-Participating Providers. Utilizing the Out-of-Network Option will increase the amount the Participant pays for care received. Please read the provisions entitled "Out-of-Network Coverage Option" which appears in Section 6.4 below or call the Claims Administrator's Concierge Team with questions.

3.4 Notice of Patient Protection Rights

Notice of Your Right to Choose a Primary Care Physician or Pediatrician

The Plan generally allows the designation of a primary care provider. For children, you may designate a pediatrician as the primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the Customer Service phone number on your ID card.

Notice of Your Right to Obtain Obstetrical or Gynecological Care Without Prior Authorization

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the Customer Service phone number on your ID card.

3.5 Notice of No Lifetime Limit and Enrollment Opportunity

You do not have a lifetime limit on the dollar value of benefits under your group health plan. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the Claims Administrator at the Customer Service phone number on your ID card.

3.6 Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in group health plan health insurance coverage. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to the first day of the first plan year beginning on or after July 1, 2017. For more information contact the Claims Administrator at the Customer Service phone number on your ID card.

3.6 Notice About Emergency Services

The Plan covers Emergency Services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Care for Emergency Services provided by a Non-participating Provider will be paid at no greater cost to the Covered Person as if the services were provided by a Participating Provider.

4. Eligibility – Enrollment – Effective Dates

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

5. Continuation Rights

Upon the termination of coverage from this Plan, you and/or your enrolled dependents may be eligible for continuing coverage. Please see your Group Insurance Representative or contact CMS for more information.

6. Summary of Plan Benefits

6.1 Contributions

The cost of the benefits provided through the Plan will be funded in part by Plan Sponsor contributions and in part by pre-tax employee contributions. The Plan Sponsor will determine and periodically communicate your share of the cost of the benefits provided through the Plan, and it may change that determination at any time.

6.2 Co-payments, Coinsurance and Deductibles

A Co-payment is a specified dollar amount you must pay as a condition of the receipt of certain Covered Services as provided in this Plan Document. The applicable Co-payments you must pay for those services are outlined in your Schedule of Benefits. Co-Payments do not count towards your Deductible, if any, until your total Out-of-Pocket Maximum is met. You are responsible for paying Co-payments to Providers at the time of service.

A Coinsurance is the specified percentage of the cost you must pay as a condition of the receipt of Coverage for certain Covered Services. The applicable Coinsurance, if any, you must pay for those services are outlined in your Schedule of Benefits. Coinsurance amounts will not be applied against your Deductible, if any, and/or your Out-of-Pocket Maximums. Your Provider may bill you at a later time for the Coinsurance amounts for which you are responsible under the terms of the Plan as determined by the contracted rates that have been established between the Health Plan and its Providers.

A Deductible is the specific dollar amount of the cost of Covered Services that you are responsible for paying before benefits subject to the Deductible are payable under this Agreement. The applicable Deductibles, if any, you must pay are outlined in your Schedule of Benefits. You must meet the applicable Deductibles, if any, before benefits will be payable to Providers on your behalf. Deductibles must be met by each Participant covered under the Plan during each Plan year. Tier I and Tier II Deductibles cross-accumulate across tiers; that is, dollars applied towards your Tier I Deductible will also be applied towards your Tier II Deductible, and vice versa.

6.3 Out-of-Pocket Maximums

The individual out-of-pocket maximum is a limit on the total amount a Participant must pay out-of-pocket for specified Covered Services in a Plan year. The family out-of-pocket maximum is a limit on the total amount Participants of the same family covered under this Plan must pay for specified Covered Services in a Plan year. Once the individual out-of-pocket maximum is met, the Plan will pay 100% of Covered Services incurred by that individual for the remainder of the Plan Year. Once the family out-of-pocket maximum is met, the Plan will pay 100% of Covered Services incurred by the family for the remainder of the Plan year. The amounts of the out-of-pocket maximums are set forth in the Schedule of Benefits. Tier I and Tier II individual and family out-of-pocket maximums cross-accumulate across tiers; that is, dollars applied towards your Tier I individual and

family out-of-pocket maximums will also be applied towards your Tier II individual and family out-of-pocket maximums, and vice versa.

Out-of-pocket maximums do not include the following:

1. Any amounts for Covered Services beyond Plan visit/day limits;
2. Any amounts above the Maximum Allowable Charge for Tier III benefits;
3. Costs of medical services not covered by the Plan; and
4. Penalties assessed for failure to obtain prior authorization for Covered Services received from Tier III providers.

6.4 How Your Three-Tiered Benefit Plan Works

Under your three-tiered Open Access Plan ("OAP"), you and your dependents have three different levels of benefits to choose from each time you receive Covered Services from a medical provider. Which benefit level will apply for each Covered Service you receive will be determined by whether the medical provider who provides the Covered Service is a Tier I, Tier II or Tier III medical provider. You can determine the Tier status of a medical provider you wish to see by visiting the Claims Administrator's website at www.aetnastateofillinois.com or calling the Claims Administrator at 855-339-9731 and requesting a provider directory for your area. Please note that the participation status of providers may change from time to time, so it is advisable to consult our online provider directory or contacting our Concierge Team before receiving medical services.

How each of these benefit levels works is described more fully below:

Tier I: Tier I provides you with the highest level of benefits under your OAP. Tier I benefits have no Deductible or Coinsurance. Co-payments apply for some Covered Services, such as physician office visits, emergency room visits and in-patient hospitalizations. The Plan pays 100% of Covered Services after payment of the applicable Co-payment, if any. In you wish to maximize your benefits, you should receive Covered Services from Tier I medical providers. In order to receive Tier I benefits, the Covered Services you receive must be performed by a Tier I medical provider who participates in the Aetna provider network as set forth on our website at www.aetnastateofillinois.com.

Tier II: When you receive Covered Services under Tier II, you will generally have more member responsibility than under Tier I but less than you would under Tier III. A Deductible must be met under Tier II before the Plan pays amounts towards Covered Expenses. While a Co-payment applies for some Covered Services, you are responsible for a Tier II Coinsurance for most Covered Services received from Tier II medical providers after your Tier II Deductible has been met. The Coinsurance amount you are responsible to pay is determined based upon the contracted rate agreed to between Aetna and the contracted medical provider. Amounts paid for Coinsurance are applied towards your out-of-pocket maximum; once the out-of-pocket maximum(s) have been met, the Plan pays 100% of the cost of most Covered Expenses incurred by you for the remainder of the Plan year. In order to receive Tier II benefits, the Covered Services you

receive must be performed by a Tier II medical provider who participates in the Coventry Health Care National provider network as set forth on our website at www.aetnastateofillinois.com.

Tier III: Tier III provides you with the lowest level of benefits under your OAP. When you receive Covered Services that apply to Tier III, you can expect to have the highest level of member responsibility under the Plan. No coverage is available under Tier III for some medical services that are covered under Tiers I or II. Examples of medical services for which there is no coverage under Tier III include: preventive care, chiropractic services, skilled nursing care and transplants. You are also responsible for ensuring that a Tier III provider has complied with our utilization management policies, including receipt of Prior Authorization for some services, prior to receiving a Covered Service. A higher Deductible must be met under Tier III before the Plan pays amounts towards Covered Expenses. While a Co-payment applies for some limited Covered Services, you are responsible for a Tier III Coinsurance for most Covered Services received from Tier III medical providers after your Tier III Deductible has been met. Tier III medical providers include any medical provider who has not entered into a contract with Aetna. The Coinsurance amount you are responsible to pay under Tier III is not determined based upon a negotiated contract rate but upon a Maximum Allowable Charge. You will be responsible for payment of any amount charged by the medical provider that is over and above the Maximum Allowable Charge, in addition to applicable Deductible, Co-Payment, and/or Coinsurance amounts. Amounts above the Maximum Allowable Charge do not apply towards your individual or family out-of-pocket maximum amounts. Amounts paid for your Tier III Coinsurance are applied towards your out-of-pocket maximum; once the out-of-pocket maximum(s) have been met, the Plan pays 100% of the cost of most Covered Expenses incurred by you for the remainder of the Plan year. However, amounts above the Maximum Allowable Charge also do not apply towards your individual or family out-of-pocket maximum amounts.

6.5 Identification Cards

You and each of your eligible dependents enrolled in the OAP will receive a Participant identification card. This card identifies you as a person enrolled in the OAP who is eligible to receive coverage for Covered Services in accordance with the terms and conditions of the OAP. You should show your identification card to your medical provider at the time you receive medical services. Your identification card will inform your medical provider and you about applicable financial responsibility for some Covered Services as well as instruct the provider on where to send claims in order to receive payment for medical services provided to you. (Note: Aetna contracted providers will file claims for Covered Services they provide to you directly with the Claims Administrator. You may be required to submit claims for emergent or elective medical services provided by Tier III providers.) Should your identification card become lost or stolen, you can order a replacement identification card by visiting our website at

www.aetnastateofillinois.com or by contacting our Concierge Team at 855-339-9731.

6.6 Medical Management

Review of Health Care Services and Supplies

The Claims Administrator engages in various forms of review of health care services and supplies utilized by Participants, and of claims for reimbursement for such services and supplies, to determine if the services and supplies are Medically Necessary. These types of reviews include, but are not limited to, pre-admission review and Prior Authorization of in-patient admissions; concurrent review of treatment during in-patient hospital stays; and post-service review of claims submitted to the Claims Administrator. You agree that, upon request, you will cooperate in these types of utilization management review programs by authorizing the release of medical records for review by the Claims Administrator. Coverage for Covered Services is subject to the terms and conditions as contained in this subsection and this Plan Document.

Pre-Admission Review and Prior Authorization

Pre-admission review / Prior Authorization is the process through which you and/or your medical providers are required to obtain Prior Authorization or approval from the Plan before you incur, and the Plan agrees to cover, expenses for certain Covered Services. Examples of the types of medical services that require Prior Authorization include the following:

Inpatient and observation services:

- All hospital admissions, including observations. (Maternity Admissions which exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section).
- All admissions to Skilled Nursing Facilities or inpatient Specialty care programs such as Rehabilitation; Hospice Mental Health & Substance Abuse
- Transplants

Outpatient services:

- Diagnostics/services:
  - PET scans
  - MRI/MRA
  - CT scans
  - All cardiac stress imaging
  - Stress Echocardiogram
  - Cardiac Catheterizations
- Durable Medical Equipment over $500 (billed amount) and all rental equipment
- Experimental/investigational services
- Genetic testing

- Hyperbaric treatment
- Infertility services
- Injectable Medications administered by the physician's office (see www.aetnastateofillinois.com for prior authorization list)
- Mental health and substance abuse (call MHNET at 800-423-8070)
- Pain management injections including epidural and facet injections
- Prosthetics over $10,000
- Radiation Therapy: Brachytherapy; Steriotactic Radiation Therapy; Proton Beam Therapy
- Sleep studies
- Surgical procedures at outpatient hospital or ambulatory surgical center

You or your medical provider must request Prior Authorization from the Claims Administrator at least seven (7) business days prior to the date you receive the above types of elective medical services. (In the case of an Emergency hospital admissions, authorization should be obtained on the next business day following admission.) Within two (2) days of receipt of all necessary information, the Claims Administrator will review the request for Prior Authorization and determine if the medical service is Medically Necessary for the care and treatment of your Injury or Illness and/or a covered benefit under the Plan. When approved, notice of authorization of coverage will be provided to you, your Physician and the Hospital to which admission is being sought, if applicable. Those same parties will also be notified if coverage for a requested medical service is denied. Prior Authorization is not a guarantee coverage or payment for the service or procedure being reviewed.

In-Network Providers will generally obtain any required Prior Authorization for you. On the other hand, you are responsible for obtaining Prior Authorization for the above types of services you receive from, or hospitalization at, Out-of-Network Providers, including services obtained while you are traveling or live outside of the State of Illinois. Out-of-Network Providers may assist you in obtaining Prior Authorization, but it is your responsibility to verify that it has been received. If elective hospital admissions are not authorized in advance or Emergency hospital admissions are not reported for authorization by the next business day, or as soon as reasonably possible following admission, your benefits may be reduced, regardless of whether the admission was Medically Necessary. Penalties for failure to obtain Prior Authorization will not apply towards your Deductible or Out-of-Pocket Maximums. No coverage or benefits will be provided for services that are not Medically Necessary.

Concurrent Review

The Claims Administrator's staff will review and monitor your care and progress during an inpatient hospital stay on a concurrent basis. We perform concurrent review daily. During the process of concurrent review, we review your continued hospital stay for Medical Necessity. We will provide you and the hospital or

skilled nursing facility with advance notice if it is decided your hospital stay has been determined to be no longer Medically Necessary.

Complex Case Management

We all want to make sure that your health care is provided in the most appropriate and cost effective setting available to treat your condition. As a result, the Claims Administrator will work with you and your medical providers in managing your care to arrange for alternate care settings, such as skilled nursing facilities, step-down units or home health care. Alternate care settings will only be covered when arranged and approved in advance by the Plan.

6.7 Benefits

The Plan provides Participants with coverage and benefits for medical services that are Covered Services and not excluded from coverage under the Plan. A summary of medical services that constitute Covered Services under the Plan is set forth in this Plan Document. This Plan will provide benefits in accordance with the applicable requirements of federal laws, such as COBRA, FMLA, the Health Insurance Portability and Accountability Act ("HIPAA"), the Mental Health Parity Act ("MHPA"), the Newborns' and Mothers' Health Protection Act ("NMHPA"), the Women's Health and Cancer Rights Act ("WHCRA") and the Patient Protection and Affordable Care Act ("PPACA"). The Plan Administrator has the sole and discretionary authority to interpret the Plan and to determine all questions arising in the administration, interpretation and application of the Plan provisions. The Plan Administrator may delegate part of its authority and duties to others as it deems necessary and desirable.

The Plan covers only those health services and supplies that are deemed Medically Necessary by the Plan and not excluded under the exclusions and limitations section of this Plan Document. Covered transplants must be rendered by a Participating Aetna Transplant Network Provider in order to receive coverage.

The following Schedule of Covered Services sets forth the health care services and supplies Covered under this Plan. The schedule is provided to assist Participants with determining the level of coverage, authorization requirements, limitations, and exclusions that apply for Covered Services. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, the service is not a Covered Service.

NOTE: Sex-specific Eligible Health Services are Eligible Health Services when medically appropriate, regardless of identified gender.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Abortion	Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected.	Elective abortions that are directly intended to terminate pregnancy before viability or directly intended to destroy a viable fetus are not covered.
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	You are not covered for non-Physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers or air ventilation system cleaning.
Ambulance	Eligible Health Services include transport by professional ground Ambulance services: • To the first Hospital to provide Emergency Services. • From one Hospital to another Hospital if the first Hospital cannot provide the Emergency Services you need. • From your home to a Hospital if an Ambulance is the only safe way to transport you. Your Plan also covers transportation to a Hospital by professional air or water Ambulance when: • Professional ground Ambulance transportation is not available. • Your condition is unstable, and requires medical supervision and rapid transport. • You are traveling from one Hospital to another and the first Hospital cannot provide the Emergency Services you need and the two conditions above are met.	Prior Authorization is required for transportation by fixed wing air plane for an Emergency Medical Condition. You are not covered for the following ambulance services: 1. Transportation by ambulance because you did not have any other form of transportation. 2. Routine transportation. 3. Transportation for outpatient care.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Anesthesia and Associated Services for Certain Dental Care	Eligible health services include general anesthesia and associated hospital care for dental care if you are: • A dependent child age 6 or under • Have a medical condition that requires hospitalization or general anesthesia for care or • Disabled. As used in this section, you are "disabled" if you have a chronic condition that meets all of the following: • It is due to a mental and/or or physical impairment • It is likely to continue • It results in substantial limitations in 1 or more of the following activities: – Self-care – Open and expressive language – Learning – Ability to move – Ability to live alone – Financial independence. Eligible health services also include dental anesthesia by a dental provider, for an autism spectrum disorder or a developmental disability. You must: • Be under 19 years of age • Make 2 visits to the dental provider before seeking other coverage We define developmental disability as a disability that meets all of the following conditions: • Is cerebral palsy, epilepsy, or any other condition, other than mental illness. It must results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services that are similar. For	Eligible health services only include the anesthesia and associated hospitalization. The dental care services are not a covered benefit.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	purposes of this definition, autism is considered a related condition. • It is likely to continue indefinitely. • It results in substantial limitations in 3 or more areas of major life activity: – Self-care – Speech or self-expression – Learning – Being able to move – Self-direction – The ability to live alone Eligible health services can be provided in a dental office, oral surgeon's office, hospital, or outpatient surgical treatment center.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Autism Spectrum Disorders	Care and services for the diagnosis of and treatment for Autism Spectrum Disorders when prescribed, provided, or ordered for a person diagnosed with an Autism Spectrum Disorder by a Physician licensed to practice medicine in all its branches or 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. Covered services for the treatment of Autism Spectrum Disorders shall include the following: A. Psychiatric and psychological care B. Habilitative or rehabilitative care, meaning speech, occupational, and physical therapies that provide treatment in the following areas: - self-care and feeding, - pragmatic, receptive, and expressive language, - cognitive functioning, - applied behavioral analysis, intervention and modification, - motor planning and sensory processing.	Prior Authorization required for Applied Behavior Analysis.
Behavioral/ Mental Health	In an emergency or a life-threatening situation, call 911, or go to the nearest Hospital emergency room. Plan Participants must call the behavioral health Plan administrator within 48 hours to avoid a financial penalty. Precertification or notification requirements still apply when Plan Participants have other Coverage, such as Medicare. 1. Inpatient services must be Pre-certified prior to admission or within 48 hours of an emergency admission to receive In-Network or Out-of-Network benefits. Prior Authorization is required with each new admission. Failure to notify the behavioral health Plan administrator of an admission to	Prior Authorization is required for Inpatient, Partial Hospitalization and Intensive Outpatient Program for mental health services. You are not Covered for the following mental health services: 1. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling. 2. Mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	an inpatient facility within 48 hours will result in a financial penalty and risk incurring non-Covered charges. 2. Partial Hospitalization and intensive outpatient treatment must be Pre-certified prior to admission to receive In-Network or Out-of-Network benefits. Prior Authorization is required before beginning each treatment program. Failure to notify the behavioral health Plan administrator of a Partial Hospitalization or Intensive Outpatient Program will result in a financial penalty and risk incurring non-Covered charges. 3. Most routine outpatient services (such as therapy sessions and medication management) will be Eligible Health Services without the need for Precertification. Prior Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a Plan Participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the Plan Participant's Provider to discuss the treatment if a review will be applied. Outpatient services received at the Out-of-Network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or Psychiatrist to be eligible for Coverage. 4. Electroconvulsive therapy, psychological testing and applied behavioral analysis must be Prior Authorized. Failure to obtain Authorization will result in the risk of incurring non-Covered charges.	chronic rehabilitative services. 3. Psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school. 4. Mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility. 5. Institutional care which is for the primary purpose of controlling or changing your environment. 6. Milieu therapy, biofeedback, behavior modification therapy, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Blood and Blood Products	Covered Service for Medically Necessary blood and blood products, including procurement and administrative charges, in connection with services covered under the Plan.	You are not covered for the following blood and blood products services and supplies: 1. The cost of whole blood and blood products replacement to a blood bank. 2. Services and related expenses for personal blood storage, unless associated with a scheduled surgery for you. 3. Administration costs related to the procurement, processing and storage of blood from a person you designate as a donor. 4. Fetal cord blood harvesting and storage.
Breast Reconstruction	Covered Service for the following breast reconstruction related services and supplies: A. Breast reconstruction surgery following a Medically Necessary mastectomy. Consistent with the Women's Health and Cancer Rights Act ("WHCRA"), if you elect breast reconstruction after a Medically Necessary mastectomy, Coverage will be provided for: 1. Reconstruction of the breast upon which the mastectomy was performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment for physical complications at all stages of the mastectomy, including lymph edemas. B. Inpatient treatment following mastectomy for a length of time to be determined by attending Physician. C. Availability of post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge.	Prior Authorization is required. You are not covered for the following breast reconstruction related services and supplies or diagnostic testing related to those services and supplies: 1. Removal of breast implants if implanted solely for Cosmetic or other non-covered reasons, even if removal is determined to be Medically Necessary. 2. Removal of breast implants, regardless of their indication for placement due to alleged or diagnosed systemic or rheumatologic disorders. 3. Breast enhancement or augmentation mammoplasty, with or without implants, unless associated with breast reconstruction surgery following a Medically Necessary mastectomy incurred secondary to active

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	D. Standard prosthetic breast devices, including surgical implants, external breast prostheses, and post-mastectomy surgical bras, subject to applicable limitations. E. Removal of breast implants but only if the implants were inserted because of a Medically Necessary mastectomy, and the implants are causing Illness or Injury.	disease. 4. Breast reduction/ reconstruction for male gynecomastia. Coverage for external prostheses is also limited. Contact the Plan's Concierge Team for current applicable benefit limits. 1. You may elect to purchase a more expensive external breast prosthesis by paying the excess cost. 2. Initial Coverage is limited to one (1) of each external breast prostheses (right and/or left). 3. Coverage for replacement of each external breast prostheses is limited to once every two (2) years. 4. Post-mastectomy surgical bras are limited to the standard model and limited to three (3) bras every six (6) months.
Breast-Related Services	Covered Service for the following breast-related services: A. Services related to the prevention of breast cancer and its early detection, B. Services related to the diagnosis and treatment of abnormalities of the breast. C. Mammogram Coverage as follows: 1. Screening by low-dose mammography including digital mammography and breast tomosynthesis for all women over 35 (including baseline mammogram for women 35-39 and annual mammogram for women 40 and older). 2. Mammograms for women under 40 with a family history of breast cancer or other risk factors at ages and intervals as considered Medically Necessary.	Coverage for preventive services is limited to services received from Tier I or Tier II providers. There is no coverage for preventive services received from Tier III providers.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	3. Comprehensive ultrasound screening and MRI of an entire breast or breasts when a mammogram demonstrates heterogeneous or dense breast tissue and when Medically Necessary as determined by your Physician. Clinical breast exams at least every three (3) years for women aged 20-39 and annually for women 40 years of age or older.	
Cancer Treatment	Covered Service for the following cancer treatment: A. Services related to the prevention of cancer and its early detection, including those services outlined in the Preventive Services section of this Schedule of Benefits. B. Services related to the diagnosis and treatment of cancer, including those outlined below and in other sections of this Schedule of Benefits. C. Covered cancer treatments include surgery, chemotherapy, and radiation therapy under the following conditions: 1. the treatment must be Medically Necessary; 2. chemotherapeutic drugs used in the treatment of cancer are limited to those drugs (1) which have been approved by the Federal Food and Drug Administration (FDA) and (2) recognized by the medical community for the specific type of cancer or which the drug has been prescribed in one of the following compendia: (a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; or (c) the United States Pharmacopoeia Drug Information or (3) if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two	Prior Authorization may be required for some services, such as brachytherapy, stereotactic radiation therapy and proton beam therapy. You are not covered for the following cancer treatment: 1. Services related to the diagnosis and treatment of cancer that are not Medically Necessary or are not considered to be consistent with the standard treatment for that particular cancer. 2. Services related to alternative or nutritional treatments for cancer. 3. Phase I and Phase II clinical trials as well as any randomized and controlled Phase III clinical trials for the treatment of cancer that are not sanctioned by the National Cancer Institute (NCI). Note, however, that your Coverage may not be cancelled or non-renewed simply because of your participation in a qualified cancer trial as defined by Illinois law. 4. Services related to an Experimental or Investigational trial or clinical

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	Peer-Reviewed professional journals published in the United States or Great Britain; 3. the treatment, including treatment combinations and treatment intervals, is considered to be the standard treatment for that particular cancer as recognized by a majority of the national medical community and as published in Peer-Reviewed medical journals. The published results must clearly demonstrate either a survival or quality of life enhancement advantage in clinical trials; 4. the treatment is currently not considered to be Experimental or in clinical trials. D. Medically Necessary health care services provided as part of a randomized and controlled Phase III clinical trial for the treatment of cancer that is sanctioned by the National Cancer Institute (NCI). E. Medically Necessary pain medication and pain therapy related to the treatment of breast cancer. Prescription drugs may be covered separately through your pharmacy coverage.	trial. 5. Costs associated with an approved investigational cancer trial that are specifically excluded, including: a. the cost of any clinical trial therapies, regimens or combinations thereof; b. the cost of any drugs or pharmaceuticals in connection with the approved clinical trial; c. the cost of any diagnostic testing which is part of the clinical trial; d. any costs associated with the provision of any goods, services or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer; e. any additional costs associated with the provision of any goods, services or benefits that previously have been provided to, paid for, or reimbursed, including diagnostic testing; or any other similar costs; or f. the costs of services provided for the convenience of the Physician or you.
Cardiac Rehabilitation Therapy	Eligible Health Services include cardiac rehabilitation services for Phase 1 and Phase II you receive at a Hospital, Skilled Nursing Facility or Physician's office, but only if those services are part of a treatment Plan determined by your risk level and ordered by your Physician.	Coverage for cardiac rehabilitation therapy is limited to Phases I and II only. In addition, you are limited to 20 visits for cardiac rehabilitation alone and to 30 visits for cardiac rehabilitation post-cardiac surgery, which visits will

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		not count towards your visit limit maximums for Outpatient Rehabilitation Services as identified in your Schedule of Benefits. You are not covered for the following: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 6. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.
Chiropractic Care	Covered include spinal manipulation to correct a muscular or skeletal problem, but only if your Provider establishes or approves a treatment Plan that details the treatment, and specifies	Coverage is limited to services received from Tier I or Tier II providers. There is no coverage for services received from a Tier

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	frequency and duration.	III provider. You are not Covered for the following chiropractic care: 1. Chiropractic therapy that is preventive in nature. 2. Chiropractic therapy that is long-term in nature or designed to provide for long-term maintenance and/or periodic adjustment of musculoskeletal alignment. 3. Massage therapy. 4. Chiropractic therapy for all non-musculoskeletal diseases and injuries. Examples include, but are not limited to, diabetes, asthma, obesity, hypertension, allergies, and infections. 5. Chiropractic services not otherwise defined as a Covered Service.
Clinical Trial Therapies (Experimental or Investigational)	Eligible Health Services include Experimental or Investigational drugs, devices, treatments or procedures from a Provider under an "approved clinical trial" only when you have cancer or Terminal Illnesses and all of the following conditions are met: 1. Standard therapies have not been effective or are not appropriate. 2. You may benefit from the treatment based on published, peer-reviewed scientific evidence. An "approved clinical trial" is a clinical trial that meets all of these criteria: 1. The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA	

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	approval. 2. The clinical trial is approved by an Institutional Review Board that will oversee the investigation. 3. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization. 4. The trial conforms to standards of the NCI or other, applicable federal organization. 5. The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution. 6. You are treated in accordance with the protocols of that study. "Routine patient costs" are the items and services that are typically Eligible Health Services when you are not enrolled in an "approved clinical trial". Eligible Health Services include "routine patient costs" incurred by you from a Provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	
Dental & Oral Surgical Services	Covered Services include the following services: • Surgical removal of complete bony impacted teeth • Excision of tumors or cysts of the: - Jaws - Cheeks - Lips - Tongue - Roof and floor of the mouth • Excision of exostoses of the jaws and hard palate, when the procedure is not done to prepare for dentures or other prostheses • Treatment of fractures of the facial bone	You are not Covered for the following types of dental and oral surgical services: 1. The care, filling, removal or replacement of teeth 2. Dental services related to the gums 3. Apicoectomy (dental root resection) 4. Orthodontics 5. Root canal treatment 6. Removal of soft tissue impactions 7. Alveolectomy 8. Augmentation and

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	• External incision and drainage of cellulitis • Incision of accessory sinuses, salivary glands or ducts • Corrections from an accidental Injury. The Surgery must be performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected. Surgery to fix teeth injured due to an accident is a Eligible Health Service when: - Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the Injury. The Surgery returns the injured teeth to how they functioned before the accident.	vestibuloplasty treatment of periodontal disease 9. False teeth 10. Dental implants, appliances or splints 11. Dental care delivered during the treatment of accidental Injury to sound, natural teeth that are not related to the accidental Injury. 12. Dental services relating to the diagnosis or treatment, including appliances, for temporomandibular joint disorders (TMJ) and myofunctional disorders, craniofacial pain disorders and orthognathic surgery. 13. Dental related oral surgical services to correct an overbite or under-bite. **NOTE**: Basic dental care is provided by the dental benefit carrier.
Dermatological Services	Covered Service for diagnosis and treatment of diseases of the skin, acne treatment, and the removal of skin lesions that interfere with normal body functions or are suspected to be malignant.	You are not covered for: 1. The removal of benign skin lesions, growths (such as warts), or skin tags. 2. Any dermatological services that are primarily for Cosmetic purposes. 3. Anti-aging services. 4. Salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes. 5. Services performed for the treatment of acne scarring,

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		even when medical or surgical treatment for acne has been provided by the Plan.
Diagnostic Tests and Procedures	Eligible Health Services for Medically Necessary diagnostic tests and procedures (including, but not limited to, laboratory tests, radiographic tests, and other diagnostic procedures). 1. Diagnostic lab work includes lab services, pathology and other tests when performed from a licensed lab. 2. Radiological services when performed from a licensed lab. 3. Complex imaging services by a Provider, including: 1. Computed tomography (CT) scans 2. Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA) 3. Nuclear medicine imaging including positron emission tomography (PET) scans.	You are not Covered for the following diagnostic tests and procedures: 1. That is considered to be Experimental or Investigational. 2. That has not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. That is not done to evaluate current health problems or symptoms (e.g., premarital blood testing, paternity testing, screening for various conditions in the absence of symptoms or significant risk factors.) 4. That is part of a non-Covered clinical trial.
Dialysis	Covered Service for hemodialysis and peritoneal services provided by an outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies and maintenance are Covered.	
Durable Medical Equipment (DME)	Eligible Health Services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your Plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for Coverage if you need it for long-term use. When it's pre-certified, we cover the instruction	Prior Authorization required for some equipment. You are not Covered for the following: 1. Eyeglasses, contact lenses, and other equipment intended to improve vision. 2. Equipment for environmental

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	and appropriate services needed for a member to learn how to properly use the item. Coverage includes: 1. One item of DME for the same or similar purpose. 2. Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse. 3. A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item. Your Plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your Plan does not. All maintenance and repairs that result from misuse or abuse are your responsibility.	control, such as air conditioners, furnaces or heaters, air filters or purifiers, humidifiers or dehumidifiers. 3. Allergenic pillows or mattresses. 4. Improvements or modifications to your home or place of business. 5. Whirlpool baths or portable whirlpool pumps. 6. Fitness or exercise equipment. 7. Repair or replacement of DME due to misuse, neglect or loss. 8. Convenience or comfort items, including, but not limited to, tub grab bars, over the bed tables and raised toilet seats. 9. Replacement items, including, but not limited to, replacement batteries, tires, and light bulbs. 10. Cranial caps and helmets, except for certain diagnoses. 11. Message devices, communication aids and telephone alert systems.
Emergency Services for Emergency Medical Conditions	Covered Service for Emergency Services for the evaluation, treatment and stabilization of accidental Injury or emergency Illness that constitutes an Emergency Medical Condition as that term is defined in the Definitions Section and by Illinois law. Emergency Services are Covered in and outside of the Plan's Service Area 24 hours a day, 7 days a week by a Provider qualified and licensed to provide those types of services. Emergency Services also include outpatient visits and referrals for emergency mental health problems. Emergency Services do not include post-stabilization services. Once your Emergency	While emergency room visits do not require Prior Authorization or initial notification, if you are admitted to the Hospital following an emergency room visit, you should notify the Plan within 48 hours of admission, the next business day or as soon as reasonably possible after care begins. You are not covered for the following: 1. Visits to a Hospital emergency room when you do not have an

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	Medical Condition has been stabilized and the Emergency no longer exists, you must obtain all further care from Participating Providers in order to receive continued In-Network Coverage.	Emergency Medical Condition. (This includes follow-up care provided in an emergency room). 2. Visits to the emergency room for services that are otherwise not covered under the Plan (*e.g.*, non-traumatic dental services).
Eyeglasses and Corrective Lenses (Vision Services)	Covered Service for Medically Necessary vision services required for the diagnosis and treatment of diseases of, or injuries to, the eye.	You are not covered for the following vision services: 1. Routine eye examinations to check visual acuity, except as provided by your PCP in his or her office. 2. The measurement, fitting or adjustment, or polishing of eyeglasses or contact lenses. 3. Contact lenses, eyeglass frames, corrective lenses, tints, or other lenses, services, or treatments, except for the first pair of eyeglasses or corrective lenses immediately following cataract surgery performed while you are enrolled in the Plan. 4. Vision therapy or orthoptics treatment (eye exercises). 5. Surgery for the correction of a refractive disorder, including, but not limited to: radial keratotomy (RK), astigmatic keratotomy (AK), automated lamellar keratoplasty (ALK), (excimer laser) photorefractive keratectomy (PKR), phototherapeutic keratectomy (PTK) and laser assisted in situ keratomieusis (LASIK).

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Hearing Services	Covered Service for Medically Necessary hearing services required for the diagnosis and treatment of diseases of, or injuries to, the ears. Coverage is also provided for: A. an annual hearing screening if performed by your Primary Care Physician; B. hearing screenings to determine hearing loss; C. and newborn screening examinations, any necessary re-screening, audiological assessment and any required follow-up.	You are not Covered for: 1. Ear molds, and other equipment intended to improve hearing.. 2. Hearing aid evaluation, hearing aid repair, reconditioning, supplies or batteries. 3. Hearing therapy and related diagnostic hearing tests. 4. Replacement of a hearing aid that is lost, stolen or broken. 5. Replacement parts, cords or repairs to a hearing aid.
Home Health Care	Eligible Health Services for Medically Necessary Home Health Care and/or home infusion services provided in your home under the following circumstances: 1. The services are provided in lieu of Hospitalization or placement in a Skilled Nursing Facility or you are unable to receive the same services outside your home. 2. You are homebound because of Illness or Injury. 3. The services have been ordered by your Physician. 4. The services are part of a Home Health Care Plan. 5. The services are Skilled Nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy. 6. Home health aide services are provided under the supervision of a registered nurse. 7. Medical social services are provided by or supervised by a Physician or social worker **NOTE:** Rehabilitation services provided in the home will be Eligible Health Services under the applicable rehabilitative services sections of this	You are not Covered for the following Home Health Care services: 1. Housekeeping services. 2. Private duty nursing. 3. Home care that is full-time, continuous or long-term. 4. Services provided by a person who ordinarily resides in your home or is in your immediate family. 5. Custodial Care. 6. Services outside the home or to help meet personal, family or domestic needs.

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	Plan and will be subject to the applicable Co-payments and/or Coinsurance as described in your Schedule of Benefits.	
Hospice Care	Eligible Health Services include inpatient and outpatient Hospice care when given as part of a Hospice care program. The types of Hospice care services that are eligible for Coverage include: 1. Room and Board 2. Services and supplies furnished to you on an inpatient or outpatient basis 3. Services by a Hospice care agency or Hospice care provided in a Hospital 4. Psychological and dietary counseling 5. Pain management and symptom control 6. Respite care 7. Nursing services – skilled and non-skilled Hospice care services provided by the Providers below may be Eligible Health Services, even if the Providers are not an employee of the Hospice care agency responsible for your care: 1. A Physician for consultation or case management 2. A physical or occupational therapist 3. A Home Health Care agency for: a. Physical and occupational therapy b. Medical supplies c. Outpatient Prescription drugs d. Psychological counseling e. Dietary counseling	You are not Covered for the following types of services under a Hospice care program: 1. Private or special nursing services. 2. Funeral arrangements. 3. Financial or legal counseling, including estate Planning or drafting of a will. 4. Homemaker or caretaker services that may include: a. Sitter or companion services. b. Transportation c. House cleaning or household maintenance. d. Services by volunteers or persons who do not regularly charge for their services. e. Services rendered by or at the direction of a person residing in the Member's household, including Family Members such as the Member's Spouse, child, parent, grandparent, sibling or any person related in the same way to the Member. 5. Pastoral Counseling
Hospital Care (Acute Inpatient)	Covered Service for Medically Necessary inpatient Hospital Services, including, but not limited to, the following: A. Pre-admission testing.	Prior Authorization is required unless the admission is Emergent. You are not covered for the following inpatient hospital care

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	B. Semi-private room and board or specialty units, such as intensive care and coronary care. C. General nursing care. D. Lab, X-ray, diagnostic tests, medical treatment, and the administration and processing of whole blood and blood plasma. E. Use of an operating room and related facilities, including anesthesia. F. Medical supplies used by you during your inpatient stay. G. Non-experimental, FDA-approved drugs administered to you during your inpatient stay. H. Therapy services, including rehabilitative therapy, radiation therapy, and inhalation therapy. I. Oxygen and its administration. J. Intensive or special care units of a Hospital. K. Discharge Planning	services: 1. Take-home drugs dispensed prior to your release, whether billed directly or separately by the Hospital. 2. Expenses incurred prior to your Effective Date of Coverage or after your Coverage has ended. 3. Private duty nursing. 4. Hospitalization for the purpose of receiving services, such as Cosmetic surgery, that are not covered under this Certificate. 5. Personal comfort or convenience items, such as, but not limited to, in-hospital television, telephone, guest trays and housekeeping. 6. Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home. 7. Any confinement for which the Member is not legally obligated to pay.
Immunizations	Covered Service for preventive childhood and adult immunizations to prevent or arrest the further manifestation of human Illness or Injury. These are Covered according to the Plan's recommended immunization schedule guidelines and the guidelines of the Centers for Disease Control (CDC). Copies of recommended immunization schedules are available upon request. This includes, but is not limited to, influenza shots, shingles vaccines (for Members 60 years of age and older) and human papillomavirus ("HPV") vaccines.	Coverage for preventive services is limited to services received from Tier I or Tier II providers. There is no coverage for preventive services received from Tier III providers. You are not covered for: 1. Immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entities whose role it is to establish eligibility guidelines and recommend preventive

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		guidelines. 2. Immunizations where you do not meet the recommended eligibility guidelines. 3. Immunizations for non-health related reasons, such as for travel, education or employment. 4. Immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups.
Infertility	Eligible Health Services for basic Infertility includes: 1. Diagnoses and evaluation of the underlying medical cause of Infertility. 2. Surgery to treat the underlying medical cause of Infertility. Examples are endometriosis Surgery or, for men, varicocele surgery. Eligible Health Services for comprehensive Infertility services includes: 1. Ovulation induction with menotropins 2. Intrauterine insemination/artificial insemination Your eligible for comprehensive Infertility services only if: 1. There exists a condition that: a. Meets the definition of Infertility b. Has been identified by your Physician or Infertility specialist and documented in your medical records. 2. You have not had a voluntary sterilization, without surgical reversal, or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.	Precertification or notification required. You are not Covered for: 1. Non-medical costs of an egg or sperm donor. 2. Selected termination of an embryo or fetus, unless the life of the mother would be in danger if all embryos were carried to full term. 3. Charges associated with cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved substance are Covered 4. Reversal of voluntary sterilizations. However, if voluntary sterilization is successfully reversed, Infertility benefits shall be available if the diagnosis meets the definition of Infertility. 5. Services provided to a surrogate. A surrogate is a

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	3. You do not have Infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause). 4. You are unable to conceive or sustain a successful pregnancy through reasonable, less costly Infertility treatment for which Coverage is available under this Plan. Eligible Health Services also include Advanced Reproductive Technology (ART) only if: 1. There exists a condition that: a. Meets the definition of Infertility b. Has been identified by your Physician or Infertility specialist and documented in your medical records. 2. You have not had a voluntary sterilization, without surgical reversal, or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. 3. You do not have Infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause). 4. You are unable to conceive or sustain a successful pregnancy through reasonable, less costly Infertility treatment for which Coverage is available under this Plan. 5. You have exhausted the comprehensive Infertility services benefits or have a clinical need to move on to ART procedures based on our clinical policy bulletin. Comprehensive services did not result in a documented fetal heartbeat. Eligible Health Services for Fertility Preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when you:	female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. If you choose to use a surrogate, this exclusion does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a Covered individual. 6. Travel costs within 100 miles of your home or travel cost not required by Aetna 7. Experimental or Investigational Infertility treatment as determined by the American Society for Reproductive Medicine. 8. Infertility treatments rendered to Dependents under the age of 18.

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	1. Are believed to be fertile 2. Have Planned services that will result in Infertility such as: - Chemotherapy - Pelvic radiotherapy - Other gonadotoxic therapies - Ovarian or testicular removal Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example: 1. You, your partner or Dependent child are Planning treatment that is proven to result in Infertility. Planned treatments include: - Bilateral orchiectomy (removal of both testicles) - Bilateral oophorectomy (removal of both ovaries) - Hysterectomy (removal of the uterus) - Chemotherapy or radiation therapy that is established in medical literature to result in Infertility 2. The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below: A. A female under 35 years of age, You need to have an unmedicated day 3 FSH test done with in the past twelve (12) months and the results must be less than 19 mIU/ml in your most recent lab test to use your own eggs. B. A female 35 years of age or older, You need to have an unmedicated day 3 FSH test done with in the past six (6) months and the results must be: - If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. - If you are age 40 and older, must be less than 19 mIU/mL in all prior tests to use your own eggs.	

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	Eligible Health Services for fertility preservation are paid on the same basis as other ART services benefits for individuals who are infertile. Coverage is provided for the following ART services: 1. In vitro fertilization (IVF) 2. Uterine embryo lavage 3. Zygote intrafallopian tube transfer (ZIFT) 4. Gamete intrafallopian tube transfer (GIFT) 5. Low tubal ovum transfer (LTOT) 6. Cryopreserved (frozen) embryo transfers 7. Prescription drug therapy used during an oocyte retrieval cycle 8. Intracytoplasmic sperm injection (ICSI) or ovum microsurgery. 9. Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not a Eligible Health Service. 10. Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you. 11. Medical costs of oocytes or sperm donors for ART procedures used to retrieve occytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the Covered recipient. We will also cover associated donor medical expenses, established by us, as a prerequisite to donation. 12. The procedures are done while not confined in a Hospital or any other facility as an inpatient.	

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Injectables	Eligible Health Services for any charges for the administration or injection of Prescription drugs or injectable insulin and other injectable drugs Covered by us. Needles and syringes, except those used for self-administration of an injectable drug. For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified Provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.	You are not Covered for the following prescribed injectables: 1. Injectables which are related to the treatment of a non-Covered service. 2. Experimental or Investigational drugs or drugs that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA. 3. Certain classes of injectables, such as anabolic steroids, when used for performance enhancement.
Maternity and Prenatal Services	Eligible Health Services for prenatal services include your routine prenatal physical exams as preventive care, which includes the initial and subsequent physical exam services such as: 1. Maternal weight 2. Blood pressure 3. Fetal heart rate check 4. Fundal height 5. Anemia screening 6. Chlamydia infection screening 7. Hepatitis B screening 8. Rh incompatibility screening 9. Expanded tobacco intervention and counseling for pregnant tobacco users 10. HIV testing You can get this care at your Physician's, PCP's, OB's, GYN's, or OB/GYN's office. After your child is born, Eligible Health Services include: 1. A minimum of 48 hours of inpatient care in a Hospital after a vaginal delivery. 2. A minimum of 96 hours of inpatient care in a Hospital after a cesarean delivery. 3. A shorter stay, if the attending Physician, with the consent of the mother, discharges	You are not Covered for the following maternity related services: 1. Expenses of obtaining an abortion, induced miscarriage or induced premature birth are not Covered unless, in the opinion of a Physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment. In addition, an induced premature birth intended to produce a live viable child is Covered only where such procedure is necessary for the health of the mother or the unborn child. 2. Planned home deliveries. 3. Maternity care delivered by non-Physicians, such as doulas. 4. Personal comfort or convenience items.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	the mother or newborn earlier. If an earlier discharge is recommended, Eligible Health Services include an in-home nurse visit. Coverage for your child includes: 1. Routine inpatient Hospital nursery charges. 2. One routine inpatient exam when done by a Physician other than the delivering Physician. 3. One inpatient hearing test. 4. The services and supplies needed for circumcision by a Provider.	
Morbid Obesity Surgery	Surgical treatment, vertical-banded gastroplasty (gastric stapling), gastric banding and roux-en-Y gastric bypass, of Morbid Obesity will be Covered when all of the following criteria are met: • Presence of Morbid Obesity; • Physician documentation that outlines the Member has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a twelve-month Physician-supervised multidisciplinary program within the past six months that included: - dietary therapy; - physical activity; and - behavior therapy and support • It is documented in the patient's medical record that the patient has completed a psychological evaluation by a licensed mental health professional, all psychosocial issues have been identified and addressed and the patient has been recommended for bariatric surgery; • Morbid Obesity has persisted for at least 5 years after reaching adulthood of >/= 18 years of age; • There is no treatable metabolic cause for the Morbid Obesity;	Prior Authorization is required. In order for benefits to be paid, services must be received from one of the Plan's Bariatric Surgery Centers of Excellence. Members must meet all of the Coverage criteria in order to be eligible for these benefits. You are not covered for: • Morbid Obesity surgical services received from any Provider not designated by the Plan as a Bariatric Surgery Center of Excellence. • Members who have any of the following are not eligible for Morbid Obesity surgical services: - Active substance abuse; - Active peptic ulcer disease; - Illnesses that greatly reduce life expectancy and are unlikely to be improved with weight reduction, including but not limited to cancer, symptomatic coronary artery disease, and end-

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	• The patient has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use; • The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; • Following surgery, the patient has agreed to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and behavior and social support.	stage renal disease; - Psychiatric disorders, including but not limited to schizophrenia, borderline personality disorder, and uncontrolled depression. - Members that have a documented history of not complying with recommended medical care are not eligible for coverage. - Members who have voluntarily ended a weight loss program that produced demonstrable weight loss are not eligible for coverage. The following are also not covered: • Jejunoileal bypass • Biliopancreatic bypass • Gastric Balloon • Duodenal Switch • Abdominoplasty and other Cosmetic surgery • Panniculectomy and other procedures for removal of excess skin • Reversals of surgical treatments for morbid obesity • Surgical treatment of Morbid Obesity in adolescents • Weight reduction therapy, supplies and services including but not limited to diet programs, food or food supplements, diet pills, tests,

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		examinations or services.
Morbid Obesity Travel-Related Expenses	You are eligible for Coverage for lodging, meal charges, and transportation to and from a Bariatric Surgery Center of Excellence for evaluation and surgical treatment of Morbid Obesity when this Plan is the primary insurer, an approved Bariatric Surgery Center of Excellence is used, and you live greater than 50 miles one way from the approved facility. A complex case manager will assist the Member in coordinating travel arrangements through the corporate travel agency. The benefit is as follows: A. Lodging: $75.00 per day for the Member; $150.00 per day for the Member plus one other person. B. Meals: $30.00 per day, per person (limit 2 people) C. Air travel is recommended when the Member lives greater than 500 miles one way from the approved facility**.** Airfare will be reimbursed for the Member plus one other person. Air travel will be arranged for by the Plan. We will pay a maximum of $500 per ticket, per person (limit 2 people). D. Ambulance charges are Covered according to your Plan benefits E. Auto mileage: reimbursement will be at the then current mileage reimbursement rate set by the IRS at the time the expense is incurred. F. Reasonable expenses as determined by the Plan are Covered for parking, taxi and shuttle buses. The Member may travel to the approved facility where the Morbid Obesity surgery was performed for all related Covered Services required for 12 months following discharge of the Member from the facility.	Lifetime maximum morbid obesity related travel benefit of $5,000 for use by the Member. Car rental is not covered. Subject to the limitations set forth herein.

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Newborn Care	Covered Service for the following newborn care services: A. Illness or Injury and premature birth. B. Congenital defects and birth abnormalities and Reconstructive Surgery related to the same, when specific criteria are met. (See Reconstructive Surgery Section for further details). C. Preventive care for all eligible newborns according to published preventive care guidelines and for them to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. D. Newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up. E. Nursery charges. F. Routine care of a newborn provided by a Pediatrician while in the Hospital, including circumcision. **Note:** Coverage for children shall be granted immediately with respect to a newly born child from the moment of birth but is subject to eligibility requirements and other policy limitations. (See the Eligibility section for further information).	
Nutritional Support	Eligible Health Services include amino acid-based formula products ordered by a Physician for the treatment of eosinophilic disorders or short bowel syndrome, regardless of the delivery method. Eligible Health Services also include formula and low protein modified food products ordered by a Physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids. For purposes of this benefit, "low protein modified food product" means foods specifically formulated to have less than one	You are not Covered for: 1. Any food item, including infant formulas, nutritional supplements, vitamins, plus Prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. 2. Non-FDA approved drugs, vitamins, minerals or supplements. 3. Diet pills, diet programs,

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	gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.	weight reduction therapy, services, tests, examinations or supplies. 4. Exercise or fitness equipment or other equipment used to promote health or wellness. 5. Gym or fitness club memberships.
Outpatient Rehabilitative Therapy	Covered Service for up to sixty (60) day treatment per condition for speech therapy, physical therapy and occupational therapy outpatient visits directed at improving physical functioning of the Member for conditions which are expected to result in significant improvement within two months as determined by the Member's Primary Care Physician. The therapy must be delivered by, or under the direct supervision of, a licensed occupational, physical and/or speech therapist, and each of the following conditions must be met: 1. The therapy must be required and Medically Necessary due to a documented medical condition; 2. You must have a loss of function as a result of the medical condition; 3. The therapy must be significantly likely to substantially improve your functional status and result in either improved pain control or quality of life within a period of two (2) months; and 4. The therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a home exercise program or school speech therapy program). Covered Service also for Medically Necessary preventive physical therapy for those diagnosed with multiple sclerosis. For purposes of this section, preventive physical therapy means physical therapy that is prescribed by a Physician licensed to practice medicine in all of	Limited benefit. Prior Authorization may be required. Please refer to your Schedule of Benefits for visit limits and benefit maximums. You are not covered for: 1. Rehabilitative services provided for long-term, chronic medical conditions, except as provided for herein. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Rehabilitative services whose purpose is to treat or improve a developmental/ learning disability or delay or congenital anomalies, except as provided for herein. 6. Rehabilitation services that are Experimental or have not been

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	its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. Covered Service also for twenty (20) additional outpatient visits for speech therapy for the treatment of pervasive developmental disorders as that term is defined by Illinois law and by the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association. Covered service also for habilitative services for children with a congenital, genetic or early acquired disorder so long as all of the following conditions have been met: 1) a licensed physician has diagnosed the child's congenital, genetic, or early acquired disorder; 2) the treatment is administered by a licensed professional upon the referral of a licensed physician; and 3) the initial or continued treatment must be Medically Necessary and therapeutic and not Experimental or Investigational.	shown to be clinically effective for the medical condition being treated. 7. Alternative medical treatment and rehabilitation services, such as holistic medicine, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, massage therapy, herbal therapy, and hypnotherapy. 8. Fees, costs or similar services associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment. 9. Speech therapy or voice training when prescribed for stuttering or chronic hoarseness. 10. Sports-related services designed to affect performance or physical conditioning programs such as athletic training, body-building, exercise fitness, flexibility and diversion.
Outpatient Surgery/ Services	Eligible Health Services for outpatient Surgery include services provided and supplies used in connection with outpatient Surgery performed in a Surgery Center or a Hospital's outpatient department.	Precertification or notification may be required. You are not Covered for the following: 1. Outpatient services that are considered to be Experimental

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		or Investigational. 2. Outpatient services that have not demonstrated significant usefulness in the Peer-Reviewed Medical Literature. 3. Outpatient services otherwise not Covered under the Plan.
Outpatient Therapies	<u>Outpatient infusion therapy</u> Eligible Health Services include infusion therapy you receive in an outpatient setting including but not limited to: • A free-standing outpatient facility • The outpatient department of a Hospital • A Physician in his/her office • A home care Provider in your home Eligible Health Services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy. Immune gamma globulin therapy will be a Eligible Health Service for persons diagnosed with a primary immunodeficiency when medically appropriate and ordered by a Physician. Initial Precertification or notification will be for no less than 3 months with notification every 6 months after. If you have been in treatment for 2 years, notification will be every 12 months, unless more frequently indicated by your Physician. Infusion therapy is the administration of prescribed medications or solutions through an IV. Certain infused medications may be a Eligible Health Service under the outpatient Prescription drug section. You can access the list of specialty Prescription drugs.	

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	When infusion therapy services and supplies are provided in your home, they will not count toward any applicable Home Health Care limits. <u>Outpatient radiation therapy</u> Eligible Health Services include the following radiology services provided by a health professional: • Radiological services • Gamma ray • Accelerated particles • Mesons • Neutrons • Radium • Radioactive isotopes	
Physician Services	Covered Services include services by your Physician to treat an Illness or Injury. You can get those services: • At the Physician's office • In your home • In a Hospital • From any other inpatient or outpatient facility • By way of Telemedicine Other services and supplies that your Physician may provide: • Allergy testing and allergy injections • Radiological supplies, services, and tests <u>Physician surgical services</u> Eligible Health Services include the services of: • The surgeon/assistant surgeon who performs your surgery • Your surgeon who you visit before and after the surgery • Another surgeon you go to for a second opinion before the surgery Eligible Health Services include one additional surgical opinion at your request following a	You are not Covered for the following primary care services: 1. Services, treatments or supplies that are otherwise not a Covered benefit under the Plan. 2. Telephone, computer or internet consultations between your Provider and you or between your Provider and another Provider. 3. Any appointment you did not attend or failed to cancel on a timely basis.

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	recommendation for elective Surgery if, in your opinion, the need for Surgery is not resolved by the first arranged consultation. The additional surgical opinion is limited to one consultation and related diagnostic service by a Physician. We will provide benefits at 100% for this Eligible Health Service.	
Podiatry	Covered Service for regular foot exams if you have diabetes or for Medically Necessary treatment of conditions associated with the foot and ankle.	You are not Covered for the following: 1. Treatment of corns, calluses or the clipping of toenails, unless Medically Necessary for the treatment of diabetes. 2. Treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches, or chronic foot strain. 3. Metatarsalgia or bunions (except an open cutting operation or procedure). 4. Medical or surgical treatment of onychomycosis (nail fungus) for Cosmetic reasons. Coverage is not excluded for the treatment of nail fungus for Members who have metabolic peripheral vascular disease or diabetes. 5. Foot or shoe inserts and other non-Covered orthotic devices.
Preventive Screening and Counseling Services	Eligible health services include screening and counseling by your health professional for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your	Coverage for preventive services is limited to services received from Tier I or Tier II providers. There is no coverage for preventive services received from Tier III providers.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	plan will cover the services you get in an individual or group setting. Services included: A. Obesity and/or healthy diet counseling- screening and counseling services to aid in weight reduction due to obesity: 1. Preventive counseling visits and/or risk factor reduction intervention 2. Nutritional counseling 3. Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors or cardiovascular and diet-related chronic disease. B. Misuse of alcohol and/or drugs- screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance: 1. Preventive counseling visits 2. Risk factor reduction intervention 3. A structured assessment C. Use of tobacco products- screening and counseling services to help you to stop the use of tobacco products: 1. Preventive counseling visits 2. Treatment visits 3. Class visits 4. Tobacco cessation prescription and over-the-counter drugs - Includes FDA approved prescription drugs and over-the-counter drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. ➢ Tobacco product means a substance containing tobacco or nicotine such as: - Cigarettes - Cigars - Smoking tobacco - Snuff - Smokeless tobacco - Cady-like products that contain	

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	tobacco D. Sexually transmitted infection counseling and evaluation services to help you prevent or reduce sexually transmitted infections. E. Genetic risk counseling for breast or ovarian cancer includes the counseling and evaluation services to help you assess whether or not you are at increased risk for breast or ovarian cancer. F. Routine cancer screenings 1. Mammograms 2. Prostate specific antigen (PSA) tests 3. Digital rectal exams 4. Fecal occult blood tests 5. Sigmoidoscopies 6. Double contrast barium enemas (DCBE) 7. Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps 8. Lung cancer screenings These benefits will be subject to any age, family history and frequency guidelines that are: - Evidence based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force - Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration G. Prenatal Care-Includes routine prenatal physical exams as Preventive Care, provided at a physician's, obstetrician or gynecologist office, which is the initial and subsequent history and physical exam such as: 1. Maternal weight 2. Blood pressure 3. Fetal heart rate check	

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	4. Fundal height H. Comprehensive lactation support and counseling services include comprehensive lactation support (Assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover counseling only when you get it from a certified lactation support provider. I. Breast feeding durable medical equipment includes renting or buying durable medical equipment you need to pump and store breast milk as follows: 1. Breast pump: - Renting a hospital grade electric pump while your newborn child is confined in a hospital. - The buying of: • An electric breast pump (non-hospital grade). Your plan will cover this cost once every three (3) years, or • A manual breast pump. Your plan will cover this cost once per pregnancy. 2. Breast pump supplies and accessories are limited to only one purchase per pregnancy in any year where covered female would not qualify for the purchase of a new pump. J. Family planning services such as: Counseling services provided by a physician, obstetrician or gynecologist on contraceptive methods in an individual or group setting.	
Preventive Contraceptives and Devices	For females who are able to become pregnant, your outpatient Prescription drug Plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a	You are not Covered for the following: 1. Elective abortions. 2. Contraceptive devices not

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	Prescriber and the Prescription is submitted to the pharmacist for processing. Your outpatient Prescription drug Plan also covers related services and supplies needed to administer Eligible Health Service devices. At least one form of contraception in each of the methods identified by the FDA is included. We cover over-the-counter (OTC) and generic Prescription drugs and devices for each of the methods identified by the FDA at no cost share. If a generic Prescription drug or device is not available for a certain method, you may obtain certain brand-name Prescription drugs or devices for that method at no cost share.	approved by the Food and Drug Administration.
Prosthetic and Customized Orthotic Devices	Covered Services include the initial provision and subsequent replacement of a prosthetic device and a customized orthotic device that your Physician orders and administers. Prosthetic device means: • A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or Injury Customized orthotic device means: • A prosthetic device based on your physical Illness Coverage includes: • Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed • Replacements required by ordinary wear and tear or damage Instruction and other services (such as attachment or insertion) so you can properly use the device.	You are not Covered for the following: 1. Eyeglasses, contact lenses, and other equipment intended to improve vision (except for the first pair of eyeglasses or contact lenses, but not both, purchased within 30 days following cataract surgery). 2. Ear molds, and other equipment intended to improve hearing. 3. Dentures; dental implants techniques, including prosthetic devices related to such techniques. 4. Implants for Cosmetic purposes. 5. Over-the-counter or convenience items. 6. Wigs, hair-pieces or prostheses, toupees, hair transplants and/or other equipment or supplies for the treatment of the loss of hair (except as provided herein). 7. Prosthetic devices that are

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		non-durable, such as support garments, Ted hose, Jobst or compression stockings, clothing and like items. 8. Repair or replacement of prostheses, prosthetic devices or PA due to misuse or loss. 9. Replacement of prostheses when the item being replaced is one that would continue to meet your basic medical needs as determined by the Plan.
Pulmonary Rehabilitation Therapy	Eligible Health Services include pulmonary rehabilitation services as part your inpatient Hospital stay if it is part of a treatment Plan ordered by your Physician. A course of outpatient pulmonary rehabilitation may also be eligible for Coverage if it's: • Performed at a Hospital, Skilled Nursing Facility, or Physician's office • Used to treat pulmonary disease states Part of a treatment Plan ordered by your Physician.	You are not Covered for the following: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 6. Alternative rehabilitation services (*e.g.,* massage therapy). 7. Fees or costs associated with services that are primarily

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		exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.
Reconstructive Surgery	Covered Services include all stages of reconstructive Surgery and related supplies provided in an inpatient or outpatient setting only in the following circumstances: 1. Your Surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It includes Surgery on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses. It also includes a Physician office visit or in-home nurse visit within 48 hours after discharge. 2. Your Surgery is needed to improve a significant functional impairment of a body part. 3. Your Surgery corrects a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury). The Surgery will be a Eligible Health Service if: - The defect results in severe facial disfigurement or major functional impairment of a body part. - The purpose of the Surgery is to improve function.	Prior Authorization required. You are not Covered for the following: 1. Any Surgery from which no significant improvement in physiologic function could be reasonably expected or that does not meaningfully promote the proper function of the body or prevent or treat Illness or disease or is done primarily to improve the appearance or diminish an undesirable appearance of any portion of the body. 2. Any medical or surgical treatment, drug or Hospitalization for plastic or Cosmetic Surgery and/or which is undertaken to improve your appearance. 3. Pharmacological regimens, plastic Surgery and non-Medically Necessary dermatological procedures. 4. Surgery to remove excess skin, including pannus, and services of a similar nature resulting from Morbid Obesity Surgery or severe weight loss.
Routine cancer screenings	Covered Services include the following routine cancer screenings: 1. Low-dose mammography screening for women age 35 and over (including x-ray examination, digital mammography and	Coverage for preventive services is limited to services received from Tier I or Tier II providers. There is no coverage for preventive services received from Tier III

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	breast tomosynthesis) for the presence of occult breast cancer as follows: - For women 35-39, a baseline mammogram - For women 40 years of age and older, annually - For woman under 40, with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, at Medically Necessary age and intervals - Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue and when Medically Necessary, as determined by your Physician - Screening MRI when Medically Necessary, as determined by your Physician 2. Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your Physician, PCP. This includes: - Asymptomatic men age 50 and older - African-American men age 40 and over - Men age 40 and over with family history of prostate cancer 3. Colorectal cancer screening for adults over 50 4. Fecal occult blood tests 5. Sigmoidoscopies 6. Double contrast barium enemas (DCBE) 7. Colonoscopies which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp 8. Lung cancer screenings for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15	providers.

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	years These benefits will be subject to any age, family history and frequency guidelines that are: 1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force. 2. Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Routine physical exams	Covered Services include office visits to your Physician, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and it includes: 1. Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. 2. Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. 3. Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: – Screening and counseling services on topics such as: • Interpersonal and domestic violence • Sexually transmitted diseases • Human Immune Deficiency Virus	Coverage for preventive services is limited to services received from Tier I or Tier II providers. There is no coverage for preventive services received from Tier III providers.

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	(HIV) infections for everyone ages 15-65 and other ages at increased risk - Screening for gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes - Screening for diabetes (type 2) for adults with high blood pressure - High risk Human Papillomavirus (HPV) DNA testing for women - Bone density screenings for osteoporosis - Aspirin use to prevent cardiovascular disease for men and women of certain ages - Blood pressure screening - Cholesterol screening for adults of certain ages or at higher risk - Depression screening - Hepatitis B screening for adults and adolescents ages 11-17 at high risk. This includes: • People from countries with 2% or more Hepatitis B prevalence • U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence - Hepatitis C screening for: • Adults at increased risk • 1 time for everyone born 1945-1965 - Falls prevention in community-dwelling adults age 65 and older who are at increased risk for falls. This includes: • Vitamin D supplementation • Exercise or physical therapy - Tuberculosis screening for populations at increased risk	

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	– Skin cancer behavioral counseling for fair skinned individuals ages 10-24 4. Radiological services, lab and other tests given in connection with the exam. 5. For Covered newborns, an initial Hospital checkup.	
Skilled Nursing Facility Services	Covered Services include inpatient Skilled Nursing Facility care. The types of Skilled Nursing Facility care services that are eligible for Coverage include: 1. Room and Board, up to the Semi-Private Room Rate 2. Services and supplies that are provided during your stay in a Skilled Nursing Facility For your stay in a Skilled Nursing Facility to be eligible for Coverage, the following conditions must be met: • The Skilled Nursing Facility admission will take the place of: - An admission to a Hospital or sub-acute facility. - A continued stay in a Hospital or sub-acute facility. • There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time. • The Illness or Injury is severe enough to require constant or frequent Skilled Nursing care on a 24-hour basis.	Prior Authorization required. You are not Covered for the following: 1. Custodial, convalescent, or domiciliary Care in a Hospital, Skilled Nursing Facility, or any other facility. This includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, and dressing, feeding and using the toilet. 2. Charges for services or supplies which are for the primary purpose of controlling or changing your environment or providing you with a rest cure or respite care. 3. Private duty nursing. 4. Preparation of special diets and supervision of medication that is usually self-administered regard-less of who orders the services. 5. Personal comfort or convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Sleep Studies	Covered Service.	You are not Covered for the following: 1. Sleep studies provided within

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
		the home. 2. Alternative therapies, such as sleep therapies.
Substance Abuse Services	Covered Services include the treatment of substance use disorders provided by a Hospital, psychiatric Hospital, Residential Treatment Facility, Physician or Behavioral Health Provider as follows: 1. Inpatient Room and Board at the Semi-Private Room Rate and other services and supplies provided during your stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Treatment of substance use disorders in a general medical Hospital is only a Eligible Health Service if you are admitted to the Hospital's separate substance use disorders section or unit, unless you are admitted for the treatment of medical complications of substance use disorders. 2. As used here, "medical complications" include, but are not limited to, Detoxification, electrolyte imbalances, malnutrition, and cirrhosis of the liver, delirium tremens and hepatitis. 3. Outpatient treatment received while not confined as an inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility, including: a. Office visits to a Physician or Behavioral Health Provider such as a Psychiatrist, psychologist, social worker or licensed professional counselor (includes Telemedicine consultation) b. Other outpatient substance use disorders treatment such as: - Outpatient Detoxification - Partial Hospitalization treatment provided in a facility or program for substance use disorders treatment provided under the direction of a Physician	Prior Authorization required for inpatient, Partial Hospitalization and Intensive Outpatient Program for substance abuse services. You are not Covered for the following substance abuse services: 1. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling. 2. Alcohol or substance abuse services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services. 3. Court-ordered intoxication evaluations, programs or treatments or therapy related to judicial or administrative proceedings or orders, when employer requested or when required for school. 4. Care in lieu of detention or correctional placement or that is required to be treated in a public facility. 5. Institutional care which is for the primary purpose of controlling or changing your environment. 6. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electro sleep therapy or electronarcosis.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	- Intensive Outpatient Program provided in a facility or program for substance use disorders treatment provided under the direction of a Physician - Ambulatory Detoxification which are outpatient services that monitor withdrawal from alcohol or other substance use disorders, including administration of medications - Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • You are homebound • Your Physician orders them • The services take the place of a stay in a Hospital or a Residential Treatment Facility, or you are unable to receive the same services outside your home • The skilled behavioral health care is appropriate for the active treatment of a condition, Illness or disease to avoid placing you at risk for serious complications o Treatment of withdrawal symptoms o Substance use disorder injectables o 23 hour observation	7. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine habits or addictions. 8. An addiction to a controlled substance or cannabis that is used in violation of law.
Transplants	Covered Services include transplant services provided by a Physician and Hospital only when Preauthorization is obtained. If the transplant donor does not have medical Coverage (from any source) for organ transplant services, Eligible Health Services include organ transplant services provided to the donor. If you are the donor to an organ transplant, Eligible Health Services include organ transplant services provided to you. In this case,	Prior authorization is required. Transplant services must be performed at a Institutes of Excellence™ (IOE) facility. There is no Coverage for transplantation services received from a non-Institutes of Excellence™ (IOE) facility You are not Covered for the following:

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	Eligible Health Services do not include those organ transplant services for the recipient. <u>Network of transplant specialist facilities</u> The amount you will pay for Eligible Health Service transplant services is based upon where you get transplant services. You can get transplant services from: • An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants and other specialized care you need.	1. Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing Illness 2. Outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence 3. Harvesting and/or storage of bone marrow or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing Illness 4. Organ and tissue procurement, evaluation and transplantation provided by a non- Institutes of Excellence™ (IOE) facility.
Transplant Coordination of Donor/ Recipient Benefits	When both the donor and the recipient are Covered under the Plan, both are entitled to benefits under the Plan, under separate claims. When only the recipient is Covered, the donor's charges are Covered as part of the recipient's claim if the donor does not have insurance Coverage, or if the donor's insurance denies Coverage for medical expenses incurred. When only the recipient is Covered and the donor's insurance provides Coverage, the Plan will coordinate with the donor's Plan. When only the donor is Covered, only the donor's charges will be Covered under the Plan. When both donor and recipient are members of the same family and are both Covered by the Plan, no Deductible or Coinsurance shall apply. The transplant Hospital Network is subject to change throughout the year. Call the Notification/Medical Case Management Plan	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	administrator for current transplant Hospitals.	
Transplant Travel and Other Related Services	The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals. 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 accepted as a candidate for transplant services. Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to: Organ Transplant Reimbursement DCMS Group Insurance Division 801 S. 7th Street P.O. Box 19208 Springfield, IL 62794-9208 The Plan Participant has twelve months from the date expenses were incurred to submit eligible charges for reimbursement. Requests submitted after the twelve (12) month limit will not be considered for reimbursement.	
Urgent Care	Covered Service for care for an unexpected Illness or Injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention when provided at an alternate facility, such as an Urgent Care center or after hours facility. Some examples of cases involving Urgent Care include but are not limited to: • High fever; • Non-severe bleeding; • Sprains Your Primary Care Physician can help you	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	determine whether your condition is urgent and/or whether you need to receive care at an alternate facility. If possible, contact your Primary Care Physician in the event you receive Urgent Care. Your PCP is available to provide guidance and direction in situations that may require Urgent Care. If follow-up care related to your initial Urgent Care services is required, you should contact your PCP and coordinate such follow-up care with him or her.	
Voluntary sterilization	Eligible Health Services include charges billed separately by the Provider for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.	You are not Covered for reversal of voluntary sterilization procedures.
Walk-in clinic	Eligible Health Services include health care services provided at Walk-In Clinics for: • Unscheduled, non-medical emergency Illnesses and injuries • The administration of immunizations administered within the scope of the clinic's license.	
Well child preventive visits	Covered Services include routine: 1. Autism screening for children at 18 and 24 months 2. For children ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years, the following: – Behavioral assessments – Dyslipidemia screening for children at higher risk of lipis disorders – Height, weight and Body Mass index (BMI) measurements – Medical history throughout development – Tuberculin testing for children at higher risk of tuberculosis	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	1. Cervical dysplasia screening for sexually active females 2. Developmental screening for children under age 3 3. Fluoride chemoprevention supplements for children without fluoride in their water source 4. Gonorrhea preventive medication for the eyes of all newborns 5. Hemotocrit or hemoglobin screening 6. Hemoglobinopathies or sickle cell screening for newborns 7. HIV screening for adolescents at higher risk 8. Hypothyroidism screening for newborns 9. Iron supplements for children ages 6-12 months at risk for anemia 10. Lead screening for children at risk of exposure 11. Oral health risk assessment for young children ages: 0-11 months, 1-4 years and 5-10 years 12. Phenylketonuria (PKU) screening for newborns	
Well woman preventive visits	Covered Services include your routine: 1. Well woman preventive exam office visit to your Physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes annual Pap smears, including surveillance tests for ovarian cancer for women at risk for ovarian cancer. Your Plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified Illness or Injury. 2. Preventive care breast cancer (BRCA) gene blood testing by a Physician and lab. 3. Preventive breast cancer genetic counseling	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	provided by a genetic counselor to interpret the test results and evaluate treatment. 4. Clinical breast exams as follows: - For women over 20 years of age but less than 40, at least every 3 years - For women 40 years of age and older, annually. 5. Breast cancer chemoprevention counseling. 6. Cervical cancer screening for sexually active woman. 7. Chlamydia infection screening for younger women and other women at higher risk. 8. HIV screening and counseling for sexually active woman. 9. Osteoporosis screening for women over age 60 depending on risk factors. Eligible Health Services for pregnant or women who may become pregnant include: 1. Anemia screening on a routine basis 2. Folic acid supplements for women who may become pregnant 3. Gonorrhea screening for all women at higher risk 4. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk 5. Syphilis screening 6. Urinary tract or other infection screening	

6.8 Exclusions and Limitations

The items and expenses listed below are excluded from Coverage by the Plan. Therefore, no payment will be made by the Plan for any of the following items or expenses:

1. **Abortions** – elective abortions are not covered except in the case of rape or incest; therapeutic abortions are Covered if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected.
2. **Allergy services** – those non-physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers, air ventilation system cleaning, carpet cleaning, treatment of environmental factors such as mold, hypo-allergenic pillows, mattresses and blankets, allergy drops and allergy treatment by a chiropractor; allergy treatment and services received from a Tier III provider.
3. **Alternative therapies** – alternative therapies, including, but not limited to, holistic, homeopathic or naturopathic care, aroma or massage therapy, acupressure, acupuncture, milieu, recreational, wilderness, educational, music, or sleep therapies, biofeedback (except in limited circumstances), ecological or environmental medicine, ayurveda and ayruvedic nutrition, craniosacral therapy, yoga, aquatic classes, movement therapy tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion) therapy except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, herbal or vitamin therapy and hypnotherapy or hypnosis, any treatment that is provided to enhance the life style of a person without treating an Injury or Illness.
4. **Ambulance service** – Non-emergency and non-medically appropriate ambulance services, regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Member; charges for general travel to and/or from a healthcare Provider or facility; routine transportation; transportation for outpatient care; travel out of the U.S. when the travel is for the sole purpose of obtaining medical care.
5. **Autopsies** – services and associated expenses related to the performance of autopsies.
6. **Behavior modification** – those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of: behavioral conduct problems, oppositional defiant disorder, learning disabilities, developmental delay, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-Acute head injuries or cerebral palsy, except as otherwise provided herein.
7. **Biofeedback** - unless as part of the treatment for fecal/urinary incontinence.
8. **Blood** – the cost of whole blood and blood products replacement to a blood bank; services and related expenses for personal blood storage, unless associated with a scheduled surgery; administration costs related to the procurement, processing and storage of blood from a designated donor; and fetal cord blood harvesting and storage.
9. **Charges** – charges resulting from the failure to appropriately cancel a scheduled appointment or in connection with treatments or medications where the Member is either non-compliant or is discharged from a facility against medical advice; charges for non-healthcare related items, such as shipping charges, copying charges and postage; charges for copying of medical records; charges for chart reviews and other assessments where the Member is not physically present; charges for services or

supplies which are not otherwise specifically stated to be a Covered benefit; charges for services or supplies provided before or after the Member's Effective Date of Coverage; charges for services or supplies that are prohibited by federal, state or local law; charges for services or supplies that have not been prescribed or ordered by a Physician; charges for lost or stolen items, such as durable medical equipment or injectable medications; services or supplies for which no charge is made or for which no payment would have been made absent this Coverage.

10. **Chiropractic services –** chiropractic services not otherwise defined as a Covered benefit in the Schedule of Covered Services; spinal manipulations for all non-musculoskeletal diseases and injuries or musculoskeletal disorders that are not improved with short-term chiropractic care; chiropractic services received from a Tier III provider.
11. **Clinical Trial Therapies (Experimental or Investigational) -** Your Plan does not cover clinical trial therapies (Experimental or Investigational), except where described in the Schedule of Covered Services.
12. **Clinical Trial Therapies (Routine Patient Costs) -** Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs); Services and supplies provided by the trial sponsor without charge to you; The Experimental intervention itself (except Medically Necessary Category B Investigational devices and promising Experimental and Investigational interventions for Terminal Illnesses in certain clinical trials in accordance with Aetna's claim policies).
13. **Cosmetic services** – those services, associated expenses and the complications resulting from Cosmetic services or surgeries that alter or improve physical appearance but do not correct or materially improve a physiological function and are not Medically Necessary for the prompt repair of accidental Injury or Illness or to improve the function of a congenital anomaly. These services include, but are not limited to, pharmacological regimens, plastic surgery, rhinoplasty, Cosmetic procedures, non-Medically Necessary dermatological procedures, implantation and/or removal of breast implants for Cosmetic or other non-covered reasons, even if the implant removal is considered Medically Necessary; breast reduction (unless Medically Necessary), enhancement or augmentation mammoplasty; breast reduction or reconstruction for male gynecomastia; removal of benign skin lesions, growths (such as warts) or skin tags; anti-aging services; salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes; services for the treatment of acne scarring; elective or voluntary enhancement procedures, services and medications (growth hormones and testosterone), such as weight loss, hair growth, sexual performance, athletic performance; however, Reconstructive Surgery and other expenses mandated by the Women's Health and Cancer Rights Act of 1998 will be Covered.
14. **Counseling** – Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.
15. **Court-ordered services** –court-ordered services or services that are a condition of probation or parole.
16. **Custodial Care** – Custodial, convalescent, sanitarium, extended care facility charges or domiciliary care, private duty nursing, respite care or rest care. This includes care

that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered, regardless of who orders the services; skilled nursing facility services received from Tier III providers.

17. **Dental services** – dental services provided by a Doctor of Dental Surgery ("DDS"), a Doctor of Medical Dentistry ("DMD") or a Physician licensed to perform dental-related oral surgical procedures, including, but not limited to general and preventive dental services (fillings, root canals, crowns, bridges, dentures, dental X-rays and other routine dental care), services for overbite or underbite, dental splints, supplies, appliances (including occlusal splints/orthodontia), orthodontia and related services; dental implants and dental implantology techniques, including prosthetic devices related to such techniques, dental prostheses, treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, gum disease such as peridontitis and gingivitis; prescription medication written by a dentist or Physician for the purpose of treating a dental condition; dental care delivered during the treatment of accidental injury to sound natural teeth that is not related to the accidental injury.
18. **Dental or oral surgery**. - surgical or non-surgical removal of wisdom teeth or impacted teeth; removal, replacement, repair, artificial restoration of the teeth (either natural or artificial); removal of teeth as a complication of or in preparation for radiation therapy or as a result of radionecrosis; dental implants; services related to surgery for cutting through the lower or upper jaw bone, services for the non-surgical and surgical treatment of temporomandibular joint disorder ("TMJ") and craniomandibular joint disease, resulting from dislocation of the cartilage without dislocation of the mandible or from other dental anomalies including osteoarthritis; removal of dentiginous cysts, mandibular tori and odontoid cysts; surgical correction of malocclusion of the teeth and/or jaw, such as maxillofacial, orthognathic and prognathic surgery; orthodontic correction of tooth alignment or malocclusion; dental related oral surgical services to correct an overbite or underbite.
19. **Diagnostic tests** – diagnostic tests, laboratory tests and procedures that are considered to be Experimental or Investigational; that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature; that are not done to evaluate current health problems or symptoms; that are done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question; that are inappropriate for the delivery to or screening of an entire population or subpopulation; prophylactic procedures to prevent a sickness that has not yet occurred.
20. **Disposable medical supplies** – self-administered dressings, splints and supplies; supplies that are typically purchased over the counter, such as ACE wraps, elastic supports and other supplies; supplies that do not perform a medical function; filters; paper or fabric face masks, irrigating kits; clothing and garment items, such as elastic stockings, support hose, Jobst and TEDS stockings, foot coverings, corsets and any elastic joint supports (which are not considered orthopedic appliances).
21. **Durable medical equipment –** equipment for environmental control, such as air conditioners, furnaces, heaters, heat lamps, room heaters; air filters or air purifiers,

humidifiers or dehumidifiers; improvements or modifications to a home or place of business; whirlpool or sauna baths; portable whirlpool pumps; fitness or exercise equipment; repair or replacement of Durable Medical Equipment due to misuse, neglect or loss; Durable Medical Equipment which may be used by multiple individuals; electrical continence aids, either anal or urethral; convenience or comfort items, such as tub grab bars, over the bed tables and raised toilet seats; items necessary for the operation of the Durable Medical Equipment that are not directly related to the medical function of the equipment; replacement items, such as batteries, tires and light bulbs; replacement of the Durable Medical Equipment when the existing one continues to meet basic medical needs; cribs, special strollers, standing frames; cranial caps and helmets, except in limited circumstances; electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, water circulation cold pads with pumps or Cryo-cuff); home traction units; Message devices, communication aids or telephone alert systems.

22. **Education –** Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs; Services provided by a school district.
23. **Emergency –** visits (including follow-up care) to a Hospital emergency room when no Emergency Medical Condition exists (*e.g.*, remove sutures, renew prescriptions); care at an emergency room for non-covered services (such as dental conditions);
24. **Examinations –** physical, psychiatric, educational or psychological examinations or testing (unless part of a treatment program for a Covered Service), vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, licensing, adoption, premarital, marital or those ordered by a third party; exams directed or requested by a court of law.
25. **Exercise –** exercise or fitness equipment or supplies or equipment used to promote health and fitness; exercise videos, software and equipment; membership or fees associated with health and athletic club memberships, weight loss clinics and fitness programs; services for weight control or weight reduction; dietary consultations or programs; body composition or underwater weighing procedures; exercise therapy weight control or reduction programs; hot tubs, steam rooms, swimming pools and saunas.
26. **Experimental or Investigational –** any procedure or treatment that are determined to be Experimental or Investigational as that term is defined herein.
27. **Eyes -** eye refractive exams to check visual acuity, except as otherwise provided; measurement, fitting, adjustment or polishing of eyeglasses and contact lenses; contact lenses, eyeglass frames, corrective lenses, tints or other lenses, services or treatments, except for the first pair of eyeglasses or corrective lenses within thirty (30) days following cataract surgery; contact lenses except for bandage contact lenses for the treatment of keratoconus; eye exercises, video equipment, vision therapy (orthoptics), radial keratotomy, astigmatic keratotomy, automated lamellar keratoplasty, photorefractive keratectomy, phototherapeutic keratectomy and laser assisted in situ keratomieusis and similar surgeries for the correction of a refractive disorder and other equipment intended to improve vision.

28. **Family planning –** outpatient contraceptive drugs and devices not approved by the FDA; reversal of a voluntary sterilization; payment for services rendered to a surrogate (except that costs for procedures to obtain eggs, sperm or embryos from a Covered individual shall be Covered if the individual chooses to use a surrogate).
29. **Food or food supplements -** products that provide nutritional needs, such as formulas, feeding solutions and supplements, vitamins and dietary foods and programs, except as otherwise provided herein.
30. **Foot care –** foot care, including the treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches or chronic foot strain; metatarsalgia or bunions (except open cutting operations); treatment of corns, calluses or toenails (except in the treatment of diabetes); foot or shoe inserts or other non-covered orthotic devices.
31. **Genetic counseling –** genetic testing and counseling done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question.
32. **Hair care –** services relating to the analysis of hair unless used as a diagnostic tool to determine poisoning; hairstyling, hairpieces, hair transplants and hair prostheses or wigs (except for hair loss as a direct result of chemotherapy or radiation therapy with a $300 Lifetime limit); treatment of hair loss or alopecia, including drugs and treatments to promote hair growth, whether or not prescribed by a Physician.
33. **Hearing –** ear molds, and other equipment intended to improve hearing, except as otherwise provided herein; hearing aid evaluation, except as otherwise provided herein; hearing aid repair, reconditioning, supplies or batteries; digital and programmable hearing devices; hearing therapy and related diagnostic hearing tests.
34. **Home health –** housekeeping, house cleaning or household maintenance services; health aid services; home care that is full-time, continuous or long-term; services provided by a relative of the Member or who ordinarily resides in the home of the Member; Custodial Care; services to help meet personal, family or domestic needs; homemaker or caretaker services; sitter or companion services; services by volunteers or persons who do not regularly charge for their services; services provided by an agency not licensed to provide the services rendered; home health care services received from Tier III providers.
35. **Hospitalization –** hospitalization for the purpose of receiving non-covered services or primarily for diagnostic purposes or related to a surgical operation when suitable outpatient facilities are available; hospitalization solely because of a surgical procedure scheduled the next day; Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home; any confinement for which the Member is not legally obligated to pay; personal comfort or convenience items, such as television, telephone, guest trays and housekeeping services; private rooms, unless one is determined to be Medically Necessary; take home drugs; charges for services or supplies provided before or after your Effective Date of Coverage.
36. **Infertility –** charges associated with services provided to a surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. If you choose to use a surrogate, this exclusion does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a Covered individual;

cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-experimental or investigational procedures that use the cryopreserved substance are Eligible Health Services; Reversal of voluntary sterilizations; travel costs within 100 miles of your home or travel cost not required by Aetna; treatment for Covered Dependents under age 18; non-medical costs of an egg or sperm donor; selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term; Experimental or investigational Infertility treatment as determined by the American Society for Reproductive Medicine.

37. **Injectables –** injectable medications that are related to the treatment of a non-covered service or are Experimental or Investigational; injectable medications, such as anabolic steroids, when used for performance enhancement.
38. **Maternity services –** X-rays, laboratory tests, diagnostic tests or other procedures that are not Medically Necessary; planned home deliveries; doulas; delivery by Caesarean section scheduled for the convenience of the Member and not because it is Medically Necessary.
39. **Medical complications –** medical complications that arose from a non-covered service, even if the requested service is Medically Necessary; medical complications which occurred because the Member did not follow the course of treatment prescribed by the Physician.
40. **Medical Necessity –** any procedure, service or supply that is determined not to be Medically Necessary, as that term is defined herein: those services, supplies, equipment and facility charges that are provided to a Member, not excluded under this Agreement and are determined by the Plan to be:
    a. Medically appropriate, so that the expected health benefits (such as but not limited to increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks;
    b. Necessary to meet your health needs, improve physiological function and required for a reason other than improving appearance;
    c. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;
    d. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
    e. Consistent with the diagnosis of the condition at issue;
    f. Required for reasons other than your comfort or the comfort and convenience of your Physician; and
    g. Of demonstrated value based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic medical experts; not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.
41. **Mental health -** care or treatment of family problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats; services for the treatment of those circumstances which are not considered mental illness based on standard diagnostic classifications; any form of therapy or

treatment for mental retardation and/or developmental and/or learning disabilities or delays. Mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services; psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school; mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility; institutional care which is for the primary purpose of controlling or changing your environment; milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis; surgery performed solely to address psychological or emotional factors; treatment of mental retardation, unless otherwise Covered as a mental illness.

42. **Military health services** – those services for treatment of military or service-connected disabilities when the Member is legally entitled to other coverage and for which facilities are reasonably available to the Member; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
43. **Miscellaneous charges** – telephone, computer or Internet consultations between Provider and Member or between Provider and another Provider; telephone assessments in general.
44. **Non-covered service** – any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service.
45. **Non-FDA approved items** – any drugs, vitamins, minerals or supplements not approved by the FDA; any medical procedure or drug that is approved for use but is not used for the specific indication that led to its approval.
46. **No Physician care or prescription** – services or supplies provided while you were not under the care of a Physician or which were not authorized or prescribed by a Physician.
47. **Orthotics** – foot orthotics; orthopedic shoes (unless they are an integral part of a lower body brace), diabetic shoes, foot or shoe inserts, shoe lifts, shoe orthotics, other special shoe accessories, arch supports, heel lifts, heel cups, heel or sole wedges, heel pads, insoles (whether custom-made or prefabricated) and other similar items, except as otherwise provided for herein; braces, supports and other orthotic appliances needed for sports or athletic participation, recreational activities or employment; convenience items or model enhancements; repair or replacement of orthotic appliances due to misuse, neglect or loss; replacement of orthotic appliances when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan; over-the-counter items, such as ACE wraps or bandages, elastic supports, finger splints, foot orthotics, braces and the like.
48. **Outpatient rehabilitation services** - rehabilitative services provided for long-term, chronic medical conditions, except as provided for herein; rehabilitative services whose primary goal is to maintain current level of function, as opposed to improving functional status; rehabilitative services whose primary goal is to return to a specific occupation or job, such as work-hardening or work-conditioning programs; educational or vocational therapy, schools or services designed to retrain for employment; rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay or congenital anomalies, except as provided for herein; rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated; speech therapy or voice training when prescribed for stuttering or hoarseness; sports-related services designed to

affect performance or physical conditioning programs such as athletic training, body-building, exercise fitness, flexibility and diversion.

49. **Primary plan** – any charges that would have been paid by a primary plan had you complied with all of the pre-certification guidelines or requirements of that plan.
50. **Prohibited services --** charges for services or supplies that are prohibited by federal, state or local law.
51. **Relative care** – charges for services or supplies ordered by, or care rendered to you by, a Family Member or relative or someone who ordinarily resides with you in your home.
52. **Replacement items** – replacement items, such as batteries, tires and light bulbs.
53. **Sleep studies** – sleep studies provided within the home.
54. **Sports-related services** – services or devices specifically used as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, including braces and orthotics.
55. **Substance abuse** –care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats; alcohol or substance abuse services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services; court-ordered intoxication evaluations, programs or treatments or therapy related to judicial or administrative proceedings or orders, when employer requested or when required for school; care in lieu of detention or correctional placement or that is required to be treated in a public facility; institutional care which is for the primary purpose of controlling or changing your environment; milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis; treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine habits or addictions.
56. **Third party liability** – services for which a third party has primary liability, such as when services are covered by any governmental agency as a primary plan, coordination of benefits, workers' compensation and claims under policies of automobile or homeowner insurance.
57. **Transplants** – animal transplants or transplants that involve artificial or mechanical devices designed to replace human organs; organ or tissue transplants which are considered to be Experimental or Investigational or not considered to be clinically acceptable; organ donor treatment or services, including the treatment of surgical or medical complications of the organ or tissue procurement process, where you serve as the organ donor and the recipient is not covered under the Plan; organ and tissue procurement, evaluation and transplantation provided by a Provider not Participating in the Aetna Transplant Network.
58. **Travel** – travel or transportation expenses, even if prescribed by a Provider, except as specifically provided for herein.
59. **Weight or Obesity services** – weight reduction therapy, supplies and services, including, but not limited to, diet programs, diet pills, tests, examinations or services and medical or surgical treatments, such as jejunoileal bypass, biliopancreatic bypass, gastric balloon, duodenal switch, stomach stapling, wiring of the jaw and the like.
60. **Work** – work-hardening or work-conditioning programs; vocational therapy.

61. Work-related Injury or Illness – any Injury or Illness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any workers compensation or occupational disease act or law, regardless of whether a claim was filed for such benefits.

6.9 Prescription Drug Program

You have prescription drug coverage under a separate prescription drug program through the State of Illinois and its direct contract with Medco. Aetna as Claims Administrator does not administer that prescription drug program for the State of Illinois and, therefore, has limited information regarding it. For more information concerning your prescription drug coverage, please contact your Group Insurance Representative or consult the customer service number on your separate pharmacy benefit plan member identification card.

7. Coordination with Other Coverages

7.1 COORDINATION WITH OTHER PLANS

7.1.1 Applicability

This Coordination of Benefits ("**COB**") provision applies to This Plan when an employee or the employee's Covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section entitled, "Effect on the Benefits of This Plan."

7.1.2 Definitions

"Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or

uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 USCA 301, *et seq.*) as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. In the event Medicaid or any other social program directs services, the Plan will Cover the resulting charges only if you have followed the requirements as set forth in this Evidence of Coverage (Certificate).

Each contract or other arrangement for coverage under (i) or (ii) above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Plan also includes the medical benefits coverage, including any funds available under uninsured motorist or underinsured motorist provisions, in group automobile contracts, in group or individual automobile "no-fault" contracts, in traditional automobile "fault" type contracts, individual or otherwise, to the extent benefits provided under such contracts must be determined without taking the existence of any other Plan into consideration.

"This Plan" is the part of the group contract that provides benefits for health care expenses.

"Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable and customary item of expense for heath care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is Medically Necessary either in terms of generally accepted

medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

7.1.3 Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

- The other plan has rules coordinating its benefits with those of This Plan; and
- Both those rules and This Plan's rules, in the Rules subsection below, require that this Plan's benefits be determined before those of the other plan.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) **Non-Dependent/Dependent**. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, Medicare is:

i. Secondary to the plan covering the person as a dependent; and

ii. Primary to the Plan covering the person as other than a dependent, for example, a retired employee.

(2) **Dependent Child/Parents Not Separated or Divorced.** Except as stated in the next subparagraph below, when This Plan and another plan cover the same child as a dependent of different persons called "parents":

i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

ii. If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of

the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

i. First, the plan of the parent with custody of the child;

ii. Then, the plan of the Spouse of the parent with custody of the child; and

iii. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

(4) **Dependent Child/Joint Custody**. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Rule 2 above.

(5) **Active/Inactive Employee**. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

(6) **Continuation Coverage**. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

i. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

ii. Second, the benefits under the continuation coverage.

If the other plan does not contain the order of benefits determination described within this subsection, and if, as a result, the plans do not agree on the order of benefits, this requirement shall be ignored.

(7) **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

7.1.4 Effect on the Benefits of this Plan

If the order of benefit determination rules as set for above are applied, and it is determined that This Plan determines its benefits before another Plan, the benefits of This Plan shall not be reduced and shall be paid without regard to the other plan.

If the order of benefit determination rules are applied, and it is determined that another plan determines its benefits first, the benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of

this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Note: Reimbursement will not exceed one hundred percent of the total Allowable Expense incurred under This Plan and any other plan.

7.1.5 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give insurer any facts it needs to pay the claim.

7.1.6 Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7.1.7 Right to Recover

If the amount of the payments made by insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

7.1.8 Credit Bank Savings

If you are covered by two insurance plans, and This Plan is the Secondary Plan, the difference between what was paid by This Plan as the Secondary Plan and what it would have paid if it was the Primary Plan creates a savings. Those savings, which accumulate on a Calendar Year basis, may

be used to pay expenses for claims incurred by you during the same Calendar Year, which may not otherwise be paid by This Plan. For example, This Plan may make payment of expenses for services received by you that are received from Non-Participating Providers; or provided outside the Service Area; or which are not covered under This Plan. However, the service must be a covered benefit under one of the plans, and the savings and the expenses must arise out of the same Claims Determination Period.

7.2 COORDINATION OF BENEFITS WITH MEDICARE

7.2.1 Active Employees and Spouses Age 65 and Older

If an employee is eligible for Medicare and works for a Group with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer. Medicare will pay its benefits first. This Plan will pay benefits on a secondary basis.

If an employee works for a group with exactly 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, This Plan will be primary. However, an employee may decline coverage under This Plan and elect Medicare as primary. In this instance, This Plan, by law, cannot pay benefits secondary to Medicare for Medicare-covered services.

You will continue to be Covered by This Plan as primary unless you (a) notify the insurer, in writing, that you do not want benefits under This Plan or (b) otherwise cease to be eligible for benefits under This Plan.

7.2.2 Disability

If you are under age 65 and eligible for Medicare due to disability and actively work for a group with fewer than 100 employees, then Medicare is the primary payer. This Plan will pay benefits on a secondary basis.

If you are under age 65 and actively work for a group with exactly 100 or more employees and you become entitled to benefits under Medicare due to disability (other than ESRD as discussed below), This Plan will be primary for you and your eligible dependents, and Medicare will pay benefits on a secondary basis.

7.2.3 End Stage Renal Disease (ESRD)

If you are entitled to Medicare due to End Stage Renal Disease (ESRD), This Plan will be primary for the first 30 months. If This Plan is currently paying benefits as secondary, This Plan will remain secondary upon your entitlement to Medicare due to ESRD.

7.2.4 Coordination of Benefits for Retirees

If you are retired and you or one of your dependents is covered by Medicare Parts A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if you or your dependents had been covered by Medicare; or
- Amounts paid under all other plans in which you participate.

7.2.5 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement, you agree to:

- Provide your insurer with information about other coverage and promptly notify Us of any coverage changes;
- Give your insurer the right to obtain information as needed from others to coordinate benefits; and
- Return any excess amounts to your insurer if We make a payment and later find that the other coverage should have been primary.

8. How the Plan Is Administered

8.1 Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. Designated representatives of the State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) of the Plan Sponsor are the persons who have been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make

factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan may also delegate its discretionary authority.

The Plan Sponsor will bear its incidental costs of administering the Plan.

8.2 Power and Authority of Claims Administrator

Plan Sponsor has contracted with Aetna Inc. ("Claims Administrator") to administer the Plan's group health benefits. The Claims Administrator is responsible for (1) initial determination of the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be followed and the claim forms to be used by Participants. Plan Sponsor is ultimately responsible for providing Plan benefits.

8.3 Questions

If Participant has any general questions regarding the Plan, please contact the Plan Administrator.

If Participant has questions concerning eligibility for, or the amount of, any benefit payable under the Plan, please contact the Claims Administrator.

9. Amendment or Termination of the Plan

9.1 Amendment or Termination

Plan Sponsor has the right to amend or terminate the Plan at any time.

The Plan may be amended or terminated by a written instrument duly adopted by the Plan Sponsor or any of its delegates. No change in this document shall be valid unless approved by an officer of the Plan Sponsor and evidenced by endorsement on this document and/or by amendment to this document. Such amendment will be incorporated into this document.

Designated representatives of the State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) of the Plan Sponsor may sign contracts for this Plan (including contracts with the Claims Administrator) on behalf of the Plan Sponsor, including amendments to those contracts, and may adopt (by written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

10. Claims Procedures

10.1 Notice of Benefit Determination

10.1.1 Urgent Care Claims. When the Plan receives a request for Urgent Care that is not an Emergency Service and that satisfies the requirements of the Urgent Care Claims definition, the Plan will notify the Participant and/or

Authorized Representative of the decision within seventy-two (72) hours after the request is received. This notification will be made whether or not there is an Adverse Benefit Determination. If there is insufficient information for the Plan to make a decision, the Plan will notify the Participant and/or Authorized Representative no later than twenty-four (24) hours after receiving the request for Urgent Care. The notice will detail the information that is needed to make the decision. The Participant and/or Authorized Representative have twenty-four (24) hours to provide the requested information. The Plan will make the decision within twenty-four (24) hours after the earlier of:

- the receipt of the additional information; or
- the end of the twenty-four (24) hour period in which the Participant or Authorized Representative has to provide the information.

10.1.2 Pre-Service Claims. When the Plan receives a request for Prior Authorization of a hospital admission or other service that is not an Urgent Care Claim, if the required clinical information is received within twenty-four (24) hours, the Plan will notify the Participant and/or Authorized Representative of the authorization decision, in the case of an Adverse Benefit Determination, no later than seventy-two (72) hours after the request and all necessary information are received by the Plan. If additional clinical information is required the Participant and/or Authorized Representative has forty-eight (48) hours to provide the requested information. The Plan will notify the Participant and/or Authorized Representative of the authorization decision, in the case of an Adverse Benefit Determination, no later than forty-eight (48) hours after the additional information is received. In the case of all other requests, no later than fifteen (15) days after the request and all necessary information are received by the Plan. This notification will be made whether or not there is an Adverse Benefit Determination. If the Plan does not have all the necessary information to make the authorization decision, the Plan will notify the Participant and/or Authorized Representative and explain in detail what information is required. The Plan must receive the information requested within forty-eight (48) days from the Participant's and/or Authorized Representative's receipt of the notice to provide the additional information.

If the Prior Authorization procedures are not followed, the Plan will notify the Participant and/or Authorized Representative of the failure to follow the procedures within five (5) days of the request. The notice will include the proper procedures for requesting Prior Authorization.

10.1.3 Post-Service Claims. The Plan will send a notice of an Adverse Benefit Determination (in an Explanation of Benefits) to the Participant or Authorized Representative within thirty (30) days after Claims Administrator receives the claim for payment. If Claims Administrator does not have the necessary information to make a payment determination, Claims Administrator will notify the Participant or the Authorized Representative of the need for an extension before the end of the initial thirty (30) days. The extension notice will explain in detail what information is required. The Participant or Authorized Representative has forty-eight (48) days from the receipt of the notice to provide the requested information. The Plan has fifteen (15) days from receipt of the clarifying information or the end of the forty-eight (48) day period, whichever is earlier, to make a determination.

10.1.4 Ongoing Treatment. The Plan does not reduce or terminate coverage for care that is Pre-Authorized, as long as the information the Plan was provided to obtain the Prior Authorization is accurate and the Participant remains enrolled in the Plan. If the Plan receives a request to extend care beyond what the Plan has Pre-Authorized, the Plan will make a decision within seventy-two (72) hours after the request has been received.

10.1.5 Appeal Rights. If an Urgent Care Claim, a Pre-service Claim or a Post-service Claim results in an Adverse Benefit Determination, the Participant or Authorized Representative may appeal the decision as described below.

10.2 Informal Inquiry Process

Most Appeals begin as an informal inquiry. Participants should direct informal inquiries to the Plan via the Claims Administrator Concierge Team Monday through Friday from 8:00 a.m. to 6:00 p.m. C.S.T. at the following telephone number: 855-339-9731.

A Customer Service Associate will review, research and resolve the inquiry. The Participant will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Participant, the Participant will be advised of his/her right to request a formal Appeal. Participants also have the right to bypass the informal inquiry procedures and immediately file a formal Appeal.

10.3 Claim Appeal Process

Overview

Under the State Employees Group Insurance Program (Program) there are formal procedures to follow in order to file an appeal of an adverse claim determination. The appropriate plan administrator will be able to provide more information regarding the plan administrator's internal appeal process. Except for Urgent Care Claims, the plan administrator's internal appeal process must be followed through before the Plan Participant may seek external review. **A plan participant who**

believes an error has been made in the benefit amount allowed or disallowed must follow appeal procedures outlined below.

Appeal Process for Self-funded Managed Care Plans

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

- **Medical Appeals** pertain to claim determinations involving medical judgment or rescissions of coverage, including claim denials determined by the plan administrator to be based on lack of medical necessity, denials pursuant to certain provisions of the State Employees Group Insurance Act, and denials for services determined by the plan administrator to be experimental or investigational.

- **Administrative Appeals** pertain to claim denials based on plan design and/or plan exclusions and limitations.

The Plan Participant will receive written notification regarding their appeal rights from the plan administrator.

1. Initial Appeal to the Plan Administrator

Appeals must be initiated in writing, unless an Urgent Care issue, with the appropriate plan administrator within 180 days of the initial claim determination. The plan administrator will provide more information regarding the claim determination. All appeals will be reviewed and decided by an individual or group of individuals who were not involved in the initial claim decision. Medical Appeals will be reviewed and considered by a health care professional. Each case will be reviewed and considered on its own merits. In some cases, additional information, such as an operative report or test results, may be required to determine if additional benefits are available. Once all required information has been received by the plan administrator, the plan administrator shall provide a benefit determination within the following time frames:

- For medical pre-service and post-service claims: within 15 business days.
- For administrative pre-service claims: within 30 calendar days.
- For administrative post-service claims: within 60 calendar days.
- For urgent and expedited claims: within 24 hours.

For Administrative Appeals, the plan administrator's final determination shall be final and binding on all parties.

2. Request for External Review

For Medical Appeals, if, after exhausting the review available through the plan administrator, the Plan Participant still feels that the plan administrator's benefit determination is not in accordance with the published benefit coverage, the Plan Participant may request an independent external review of the plan administrator's decision. A request for an external review must be filed in writing within four (4) months of the date of receipt of the plan administrator's benefit determination. The plan administrator will provide more information regarding how to file a request for external review. The Plan Participant will be given the opportunity to submit additional written comments regarding the claim to the external reviewer. The external reviewer will provide a final external review decision within 45 days after receiving the request for external review. If the external reviewer decides in favor of the Plan Participant, the decision shall be final and binding on the Plan Administrator.

3. External Review of Urgent Care Claims

For claims involving urgent care situations, the Plan Participant may make a written or oral request for expedited external review at the time the plan administrator makes an adverse benefit determination, even if the plan administrator's internal appeals process has not been exhausted. The external reviewer will review the request to determine whether the claim qualifies for expedited review. If a request for expedited external review is granted, the external reviewer will provide a final external review decision within 72 hours after receiving the request. If the external reviewer decides in favor of the Plan Participant, the decision shall be final and binding on the Plan Administrator.

11. HIPAA Privacy

Your Privacy Matters

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), the State of Illinois Employee Health Benefits Plan ("the Plan") is sending You important information about how Your medical and personal information may be used and about how You can access this information. Please review the Notice of Privacy Practices carefully. If You have any question, please call the Member Services number on the back of Your Membership identification card.

NOTICE OF PRIVACY PRACTICES

Effective 4/14/2003 (Revised 4/22/2013)

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW

YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment to Your Privacy

We understand the importance of keeping Your personal and health information secure and private. We are required by law to provide You with this notice. This notice informs You of Your rights about the privacy of Your personal information and how we may use and share Your personal information. We will make sure that Your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about You as well as any information that we may receive or create in the future. You may request a copy of this notice at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services the Plan provides to Your particular health benefit plan.

B. What Types of Personal Information Do We Collect?

To best service Your benefits, we need information about You. This information may come from You, Your Employer, or other payors or health benefits plan sponsors, and our affiliates. Examples include Your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from health care Providers and others about You. Examples include the health care services You receive. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive Your information in writing, by telephone, or electronically. In some instances, we may ask You about your race/ethnicity or language, however providing this information is entirely voluntary.

C. How Do We Protect the Privacy of Your Personal Information?

Keeping Your information safe is one of our most important duties. We limit access to Your personal information, including race/ethnicity and language, to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our privacy office also assures the training of our staff on our privacy and security policies.

D. How Do We Use and Share Your Information for Treatment, Payment, and Health Care Operations?

To properly service Your benefits, we may use and share Your personal information for "treatment," "payment," and "health care operations." Below we provide examples of each. We may limit the amount of information we share about You as required by law. For example, HIV/AIDS, Substance Abuse, and Genetic Information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

1. Treatment: We may use and share Your personal information with health care Providers for coordination and management of Your care. Providers include Physicians, Hospitals, and other caregivers who provide services to You.

2. Payment: We may use and share Your personal information to determine Your eligibility, coordinate care, review Medical Necessity, pay claims, obtain external review, and respond to Complaints. For example, we may use information from Your health care Provider to help process Your claims. We may also use and share Your personal information to obtain payment from others that may be responsible for such costs.
3. Health care operations: We may use and share Your personal information, including race/ethnicity and language, as part of our operations in servicing Your benefits. Operations include credentialing of Providers; quality improvement activities such as assessing health care disparities; accreditation by independent organizations; responses to Your questions, or Grievance or external review programs; and disease management, case management, and care coordination, including designing intervention programs and designing and directing outreach materials. We may also use and share information for our general administrative activities such as pharmacy benefits administration; detection and investigation of fraud; auditing; underwriting and rate-making; securing and servicing reinsurance policies; or in the sale, transfer, or merger of all or a part of the Plan with another entity. For example, we may use or share Your personal information in order to evaluate the quality of health care delivered, to remind You about preventive care, or to inform You about a disease management program. We cannot use or disclose your genetic, race/ethnicity or language information for underwriting purposes, to set rates, or to deny Coverage or benefits. We may also share Your personal information with Providers and other health plans for their treatment, payment, and certain health care operation purposes. For example, we may share personal information with other health plans identified by You or Your Plan Sponsor when those plans may be responsible to pay for certain health care benefits or we may share language data with health care practitioners and Providers to inform them about Your communication needs.

E. What Other Ways Do We Use or Share Your Information?

We may also use or share Your personal information for the following:

1. Medical Home/Accountable Care Organizations: Coventry may work with your primary care physician, hospitals and other health care providers to help coordinate your treatment and care. Your information may be shared with your health care providers to assist in a team-based approach to your health.
2. Health care oversight and law enforcement: To comply with federal or state oversight agencies. These may include, but are not limited to, Your state department of insurance or the U.S. Department of Labor.
3. Legal proceedings: To comply with a court order or other lawful process.
4. Treatment options: To inform You about treatment options or health-related benefits or services.
5. Plan sponsors: To permit the sponsor of Your health benefit plan to service the benefit plan and Your benefits. Please see Your employer's plan documents for more information.

6. Research: To researchers so long as all procedures required by law have been taken to protect the privacy of the data.
7. Others involved in Your health care: We may share certain personal information with a relative, such as Your spouse, close personal friend, or others You have identified as being involved in Your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of benefits to the Subscriber. Your family may also have access to such information on our website. If You do not want this information to be shared, please tell us in writing.
8. Personal representatives: We may share personal information with those having a relationship that gives them the right to act on Your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.
9. Business associates: To persons providing services to us and who assure us that they will protect the information. Examples may include those companies providing Your pharmacy or Behavioral Health benefits.
10. Other situations: We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety; tracking diseases or medical devices; or informing military or veteran authorities if You are an armed forces member. We may also share Your information with coroners; for workers' compensation; for national security; and as required by law.

F. What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain Your written permission to use or share Your health information for reasons not identified by this notice and not otherwise permitted or required by law. For example, we will not share your psychotherapy notes, use or share Your health information for marketing purposes or sell Your health information unless You give written permission or applicable law permits the use or disclosure. If You withdraw Your permission, we will no longer use or share Your health information for those reasons.

We do not destroy Your information when Your Coverage ends. It is necessary to use and share Your information, for many of the purposes described above, even after Your Coverage ends. However, we will continue to protect Your information regardless of your Coverage status, as required by law.

However, we will continue to protect Your information regardless of Your Coverage status.

G. Rights Established by Law

1. **Requesting restrictions**: You can request a restriction on the use or sharing of Your health information for treatment, payment, or health care operations. However, we may not agree to a requested restriction.

2. **Confidential communications**: You can request that we communicate with You about Your health and related issues in a certain way, or at a certain location. For example, You may ask that we contact You by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.
3. **Access and copies**: You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor, and supplies related to Your request. We may deny Your request to inspect or copy in some situations. In some cases denials allow for a review of our decision. We will notify You of any costs pertaining to these requests, and You may withdraw Your request before You incur any costs. You may also request your health information in an alternative format.
4. **Amendment**: You may ask us to amend Your health information if You believe it is incorrect or incomplete. You must provide us with a reason that supports Your request. We may deny Your request if the information is accurate, or as otherwise allowed by law. You may send a statement of disagreement.
5. **Accounting of disclosures**: You may request a report of certain times we have shared Your information. Examples include sharing Your information in response to court orders or with government agencies that license us. All requests for an accounting of disclosures must state a time period that may not include a date earlier than six (6) years prior to the date of the request and may not include dates before April 14, 2003. We will notify You of any costs pertaining to these requests, and You may withdraw Your request before You incur any costs.
6. **Breach notification**: You have a right to receive notice from us if there is a breach of your unsecured health information.

H. To Receive More Information or File a Complaint

Please contact Member Services to find out how to exercise any of Your rights listed in this notice, or if You have any questions about this notice, or to receive a copy in an alternative format or a translated version. Para recibir una copia traducida de este document, Ilame al servicio para miembros. The telephone number or address is listed in Your benefit documents or on Your Membership card. If You believe we have not followed the terms of this notice, You may file a Complaint with us or with the Secretary of the Department of Health and Human Services. To file a Complaint with the Secretary, write to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-877-696-6775. You will not be penalized for filing a Complaint. To contact us, please follow the Complaint, Grievance, or Appeal process in Your benefit documents.

[i] For purposes of this notice, the pronouns "we", "us" and "our" and the name "State of Illinois Employee Health Benefits Plan" refers to the State of Illinois Employee Health Benefits Plan, and its licensed affiliated companies.

[ii] Under various laws, different requirements can apply to different types of information. Therefore we use the term "health information" to mean information concerning the provision of, or payment for, health care that is individually identifiable. We use the term

"personal information" to include both health information and other nonpublic identifiable information that we obtain in providing benefits to you.

12. Statement of Your Rights

12.1 Your Rights

As a Participant in the Plan you are entitled to certain rights and protections. As a Participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan and a copy of the latest annual report (form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any collective bargaining agreements, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report.

- **COBRA**, continue health care coverage for yourself and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event: You or your Dependents may have to pay for such coverage. Review this document governing your COBRA continuation coverage rights.

- **HIPAA**, reduction or elimination of exclusionary periods of coverage periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan: If you are enrolled in a health plan before your coverage under this Plan begins, you should be provided a certificate of creditable coverage, free of charge, from your prior group health plan or health insurance issuer when you lose coverage under that group health plan, when you become entitled to elect COBRA continuation coverage under the prior plan, when your prior plan's COBRA continuation coverage ceases, if you request it before losing your prior coverage, or if you request it up to 24 months after losing the prior coverage.

12.2 Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participation, those persons who are responsible for the operation of the employee benefit plan have certain duties. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and

beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights.

12.3 Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. There are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that a fiduciary misuses the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

12.4 No Discrimination

No one, including the Plan Sponsor or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights.

12.5 Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator, or its designee, review and reconsider your claim.

12.6 Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights, or if you need assistance in obtaining documents, you should contact the Claims Administrator's Concierge Team for more information.

13. Miscellaneous

13.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the State of Illinois to the effect that you will be employed for any specific period of time.

13.2 Applicability

The provisions of this document shall apply equally to the Covered Employee and Dependents and all benefits and privileges made available to Covered Employee shall be available to Covered Employee's Dependents.

13.3 Exhaustion of Administrative Remedies

Participant may not bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this document have first been exhausted.

13.4 Nontransferable

No person other than Participant is entitled to receive health care service coverage or other benefits to be furnished by Plan. Such right to health care service coverage or other benefits is not transferable.

13.5 Relationship Among Parties

The relationship between Claims Administrator and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of Claims Administrator, nor is Claims Administrator or any employee of Claims Administrator an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with Participant and are solely responsible to Participant for all Participating Provider services.

Neither the Plan Sponsor nor Participant is an agent or representative of Claims Administrator, and neither shall be liable for any acts or omissions of Claims Administrator for the performance of services under this document.

13.6 Reservations and Alternatives

Plan and Claims Administrator reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

13.7 Severability

In the event that any provision of this document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this document, which shall continue in full force and effect in accordance with its remaining terms.

13.8 Waiver

The failure of Claims Administrator, the Plan Sponsor, or Participant to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy

arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

13.9 Subrogation

We are assigned the right to recover from a negligent third party, or his or her insurer, to the extent of the benefits We paid for your Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

13.10 Reimbursement

If a Covered person recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered person, the Covered person's parents if the Covered person is a minor, or the Covered person's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

13.11 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 confirm 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 Choice Book that is applicable to the Open Access Plan, the terms of the State of Illinois Benefits Choice Book will be followed.

13.12 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 that 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.

If this Plan receives a QMCSO for one (1) or more of your children, your Group Insurance Representative will notify you and each child affected by the order. If you receive the QMCSO as a part of your divorce decree or as a result of a paternity suit, contact the Group Insurance Representative immediately after receipt of your decree. Contact your Group Insurance Representative or the Claims Administrator's Concierge Team for additional information.

13.13 Entire Agreement

This document shall constitute the entire agreement between the parties.

14. Definitions

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this document.

14.1 "Act"

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 may be promulgated thereunder.

14.2 "Adverse Benefit Determination"

A denial of a request for service or failure to provide or make payment (in whole or part) for a Covered Service. Adverse Benefit Determination also includes any reduction or termination of a Covered Service.

14.3 "Appeal"

A request by a Participant or the Participant's Authorized Representative for consideration of an Adverse Benefit Determination.

14.4 "Authorization/Prior Authorization"

Plan has given approval for payment for certain services to be performed and an Authorization Number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by the Plan. Authorization does not guarantee payment if Participant is not eligible for Covered Services at the time the service is provided.

14.5 "Authorized Representative"

An individual authorized by the Participant or state law to act on the Participant's behalf to submit appeals and file claims. A Provider may act on behalf of a Participant with the Participant's express consent, or without the Participant's express consent in an urgent care situation.

14.6 "Autism Spectrum Disorders"

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.

14.7 "Autism Spectrum Disorders Diagnosis

"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.

14.8 "Claims Administrator"

Aetna Inc.

14.9 "Coinsurance"

The percentage amount Participant must pay above the specified benefit payable as a condition of the receipt of certain services as provided in this Plan. Coinsurance amounts are set forth in the Schedule of Benefits.

14.10 "Co-payment"

A specified dollar amount Participant must pay as a condition of the receipt of certain Covered services. Co-payments are set forth in the Schedule of Benefits.

14.11 "Cosmetic Services and Surgery"

Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

14.12 "Coverage" or "Covered"

The entitlement by a Participant to Covered Services under the Plan subject to the terms, conditions, limitations and exclusions contained in this document and the Schedule of Benefits, including the following conditions: (a) health services must be provided prior to the date that any of the termination conditions listed under Section 6 of this document occur; and (b) health services must be provided only when the recipient is a Participant and meets all eligibility requirements specified in this document; and (c) health services must be Medically Necessary.

14.13 "Covered Employee or Retiree"

Regular full-time employees or Retirees of the State of Illinois as described in Section 1 of this document who are eligible as defined by the collective bargaining agreement and/or CMS and who have elected and enrolled in coverage under the Plan through submission of an Enrollment Form.

14.14 "Covered Services"

The services or supplies provided to Participant for which Plan Sponsor will make payment, as described in the document.

14.15 "Aetna Transplant Network"

A Provider designated by the Claims Administrator to provide transplant services and treatment to Participants.

14.16 "Deductible"

The dollar amount of medical expenses for Covered Services that Participant is responsible for paying before benefits subject to the Deductible are payable under this Plan. Deductibles are set forth in the Schedule of Benefits.

14.17 "Dependent"

Any member of a Covered Employee's family who meets the eligibility requirements as outlined by the Plan.

14.18 "Emergency Medical Condition"

A condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who

possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

14.19 "Emergency Services"

Transportation services, including, but not limited to, ambulance services, and Covered inpatient and outpatient hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition. It does not mean post-stabilization medical services.

14.20 "Enrollment Form"

The application for enrollment in the Plan.

14.21 "Experimental or Investigational"

A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

(i) Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring Prior Authorization that is proposed for off-label prescribing;

(ii) Any health product or service that is subject to Investigational Review Board (IRB) review or approval;

(iii) Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations;

(iv) Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

14.22 "Formulary"

A listing of prescription drugs approved by Plan Administrator for coverage under the Plan. These are dispensed through a pharmacy to Participants. This list is subject to periodic review and change by Plan Administrator. The Formulary is available for review in Participating Provider offices or by contacting the Claims Administrator.

14.23 "Genetic Information"

Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Note: pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008 ("GINA"), the Plan will not: adjust premium or contribution amounts on the basis

of genetic information; request or require an individual or a family member of such individual to undergo a genetic test; or request, require or purchase genetic information for underwriting purposes

14.24 "Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

14.25 "Late Enrollees"

Shall mean individuals who fail to enroll with the Plan Sponsor for coverage under the Plan during the required thirty-one (31) day period when they first become eligible for coverage. This term does not include Special Enrollees.

14.26 "Medical Director"

The Physician specified by Plan Administrator or Claims Administrator as the Medical Director or other staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

14.27 "Medically Necessary or Medical Necessity"

Those services, supplies, equipment and facilities charges that: are not expressly excluded under the Plan and determined by the Plan, in its sole discretion to be:

(i) Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks*;*

(ii) Necessary to meet health needs of the Participant, improve physiological function and required for a reason other than improving appearance;

(iii) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;

(iv) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;

(v) Consistent with the diagnosis of the condition at issue;

(vi) Required for reasons other than comfort or the comfort and convenience of the Participant or his or her Physician; and

(vii) Not Experimental or Investigational as determined by the Plan under our Experimental Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from the Claims Administrator's Member Services Department.)

14.28 "Non-Participating Provider or Tier III Provider"

A Provider who has no direct or indirect written agreement with the Claims Administrator to provide health services to Participants

14.29 "Notice of Benefit Determination"

A notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

14.30 "Open Access Plan or OAP"

The Open Access Plan or OAP means the group health benefit plan (and related documents and materials describing the benefits available thereunder) sponsored by the State of Illinois under which Participants are provided various incentives to use Tier I and Tier II Participating Providers in accordance with the following: a) Tier I - the benefit tier with the greatest level of benefits applies when Participants utilize Participating Providers who are designated by the Claims Administrator as Tier I providers who are providers who participate in the Aetna network of providers; b) Tier II - the benefit tier with the level of benefits better than Tier III but less than Tier I applies when Participants utilize Participating Providers who are designated by the Claims Administrator as Tier II providers who are providers who participate in the Aetna Network of providers; and c) Tier III the benefit tier that contains the least level of benefits applies when Participants utilize Non-Participating Providers who are neither Tier I or Tier II providers.

14.31 "Out-of Network Coverage Option"

Covered Services provided to Participants by a Non-Participating Provider. These Covered Services may require Prior Authorization.

14.32 "Out-of-Network Rate"

The amount the Plan pays for Covered Services rendered by a Non-Participating Provider under the Out-of-Network Coverage Option. The Out-of-Network Rate is based upon an actuarial analysis of data supplied by various sources, including Medicare payments and historic billing by Non-participating providers for services provided to plan members. Actual charges by specific providers may be higher or lower than our fee schedule. Related services are grouped together and have an established a rate coefficient for the particular class of claims at issue.

14.33 "Participant"

Any Covered Employee or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for coverage under this Plan in accordance with its terms and conditions.

14.34 "Participant Effective Date"

The date entered on Plan records as the date when coverage for a Participant under the Plan begins in accordance with the terms of this document, which coverage shall begin at 12:01 a.m. on such date.

14.35 "Participating Provider or Tier I or Tier II Provider"

A Provider who has entered into a direct or indirect written agreement with Claims Administrator to provide health services to Participants. "Participating" refers only to those Providers included in the network of Providers described in the Claims Administrator's Provider Directory of Health Care Providers which is available on our website at www.aetnastateofillinois.com or by contacting our Concierge Team. The participation status of Providers may change from time to time.

14.36 "Physician"

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the jurisdiction in which treatment is received

14.37 "Plan"

The State of Illinois Employee Health Benefits Plan—Open Access Plan

14.38 "Plan Sponsor"

The State of Illinois

14.39 "Plan Year"

The period during which the total amount of yearly benefits is calculated. The plan year is the period of twelve (12) consecutive months commencing on July 1 and each subsequent anniversary.

14.40 "Post-service Claim"

A claim for payment for medical care that the Participant has already received.

14.41 "Post-service Appeal"

An Appeal regarding an Adverse Benefit Determination for a Post-Service Claim.

14.42 "Pre-service Claim"

A request for a benefit that has not yet been received and for which Prior Authorization is required. Pre-service Claims do not include Urgent Care Claims.

14.43 "Pre-service Appeal"

An Appeal for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided."

14.44 "Provider"

A Physician, Hospital, skilled nursing facility, home health agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

14.45 "Qualified Beneficiary"

Shall have the meaning set forth in COBRA.

14.46 "Retiree"

Shall mean a former employee of the State of Illinois, or one of its branches thereof, who meets the Plan Sponsor's definition of retired employees and to whom the Plan Sponsor offers coverage under the Plan.

14.47 "Schedule of Covered Services"

Description of Covered Services contained in the chart in Section 6.

14.48 "Schedule of Benefits"

Shall mean the Schedule of Benefits provided with this document.

14.49 "Specialty Care Physician/Specialist"

A Physician who provides medical services to Participants within the range of a medical specialty.

14.50 "Urgent Care Claim"

A claim for payment for medical care or treatment that meets one of the following conditions:

(i) The application of the time periods for making non-urgent care determinations could: (a) seriously jeopardize the life or health of the Participant, or the Participant's ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(ii) The Plan determines that a prudent layperson who possesses an average knowledge of health and medicine would have judged the situation to require Emergency Service; or

(iii) A Physician with knowledge of the Participant's medical condition determines that the claim involves Emergency Service; or

(iv) The claim occurs during the course of a treatment or Hospital stay and is subject to concurrent review, which is a review of all reasonably necessary supporting information during a Hospital stay or course of treatment as the treatment is being rendered that results in a decision by the Plan to approve or deny payment for ongoing or additional treatment.

14.51 "Urgent Care Appeal"

An Appeal that must be reviewed under the expedited Urgent Care Appeal process because the application of non-Urgent Care Appeal timeframes could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function. In determining whether an appeal should be expedited, the Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Urgent Care Appeal is also an Appeal involving care that the treating physician deems urgent in nature, or the treating physician determines that a delay in care would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is being requested.