

**STATE OF ILLINOIS
EMPLOYEE HEALTH BENEFITS PLAN**

**OPEN ACCESS PLAN
SUMMARY PLAN DESCRIPTION**

JULY 1, 2011

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1. Introduction

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

Facts

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 Type of Plan Administration:	The Plan is self-funded by the 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 Coventry Health Care of Illinois, 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	Contact Plan Administrator for

Identification Number: further information.

Plan Administrator: State of Illinois
401 South Spring
Springfield, IL 62706

Claims Administrator: Coventry Health Care Illinois, Inc.,
2110 Fox Drive, Champaign,
Illinois; 217-366-1226 or 866-557-
8751

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 Customer Service Department at 217-366-1226 or 866-557-8751 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 Customer Service Department 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, 2011. 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, or your Out-of-Pocket Maximums. 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 is outlined in your Schedule of Benefits. Coinsurance amounts will 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 II and Tier II Deductibles cross-accumulate across tiers; that is, dollars applied towards your Tier II Deductible will also be applied towards your Tier III 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 II and Tier II individual and family out-of-pocket maximums cross-accumulate across tiers; that is, dollars applied towards your Tier II individual and family out-of-pocket maximums will also be applied towards your Tier III individual and family out-of-pocket maximums, and vice versa.

Only Coinsurance Dollars paid for Covered Services received from Tier II or Tier III providers apply towards your individual and/or family out-of-pocket maximums. Out-of-pocket maximums do not include the following:

1. Deductibles;
2. Co-payments;
3. Any amounts for Covered Services beyond Plan visit/day limits;
4. Any amounts above the Maximum Allowable Charge for Tier III benefits;
5. Costs of medical services not covered by the Plan; and
6. 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.chcillinois.com or calling the Claims Administrator at 1-800-431-1211 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 Customer Service Department 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 Coventry Health Care provider network as set forth on our website at www.chcillinois.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 Coventry Health Care 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.chcillinois.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, home health care, 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 Coventry Health Care. 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: Coventry Health Care and Coventry Health Care National 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.chcillinois.com or by contacting our Customer Service Department at 1-800-431-1211.

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.chcillinois.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; Stereotactic 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 Coventry 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.

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. Limited benefit.	Prior Authorization is required. Elective abortions that are directly intended to terminate pregnancy before viability or directly intended to destroy a viable fetus are not covered.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	<p>Coverage for allergy testing and treatment is limited to services received from Tier I or Tier II providers. There is no coverage for allergy testing and treatment received from Tier III providers.</p> <p>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. You are also not covered for allergy drops or allergy treatment by a chiropractor.</p>

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Ambulance	<p>Covered Service for the following ambulance services:</p> <ol style="list-style-type: none"> 1. Emergency transportation by ground or air ambulance when the following circumstances have been met: <ol style="list-style-type: none"> a) An Emergency Medical Condition exists, and b) The ambulance is licensed in its state as an emergency vehicle and has the necessary patient care equipment, supplies, and personnel to provide emergency care, and c) Your medical condition is such that any other form of transportation would be medically unsafe, and d) Transportation is to the nearest Hospital with the appropriate facilities to treat your Emergency Medical Condition, or after appropriate stabilization, to a Hospital. 2. Non-emergency facility-to-facility transportation by ambulance when the following circumstances have been met: <ol style="list-style-type: none"> a) Transportation is to another Hospital, inpatient rehabilitation facility, or skilled nursing facility, where additional treatment is intended to be delivered, and b) Your medical condition makes other forms of transportation medically unsafe, and c) The Plan may determine the most cost effective and medically appropriate mode of non-emergent transportation. 	<p>Prior Authorization is not required for ground or air ambulance transportation for an Emergency Medical Condition. However, if it is determined that an Emergency Medical Condition did not exist, and Prior Authorization was not obtained for the ambulance, claims associated with the ambulance transportation may not be Covered, and the resulting costs will be your financial responsibility. Prior Authorization may be required for non-emergent facility-to-facility ambulance transportation.</p> <p>You are not covered for the following ambulance services:</p> <ol style="list-style-type: none"> 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.
Autism Spectrum Disorders	<p>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 and ordered by a physician licensed to practice medicine in all of its branches. Covered services for the treatment of Autism Spectrum Disorders shall include the following:</p> <ol style="list-style-type: none"> (1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist. (2) Psychological care, meaning direct or consultative services provided by a licensed psychologist. (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: <ol style="list-style-type: none"> (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavioral analysis, intervention and modification, (v) motor planning, and (vi) sensory processing. 	<p>Coverage shall be subject to Co-payment, Deductible and Coinsurance provisions applicable to other medical services but shall not be subject to any limits on the number of visits to a service provider.</p>

**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.	<p>Prior Authorization may be required for plasma fractions which include, but are not limited to, antihemophilic factor (factor VIII), prothrombin complex (factor VII, IX, X) and gamma globulin, except in the event of an Emergency Medical Condition.</p> <p>You are not covered for the following blood and blood products services and supplies:</p> <ol style="list-style-type: none"> 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 Implant Removal	Covered Service if the implants were inserted because of a Medically Necessary mastectomy, and the implants are causing Illness or Injury.	<p>Limited benefit. Prior Authorization required.</p> <p>You are not covered for the removal of breast implants if implanted solely for cosmetic or other non-covered reasons, even if removal is determined to be Medically Necessary.</p>

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Breast Reconstruction</p>	<p>Covered Service for the following breast reconstruction related services and supplies:</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> Reconstruction of the breast upon which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment for physical complications at all stages of the mastectomy, including lymph edemas. <p>This also includes nipple reconstruction.</p> <ol style="list-style-type: none"> Inpatient treatment following mastectomy for a length of time to be determined by attending Physician. Availability of post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge. Standard prosthetic breast devices, including surgical implants, external breast prostheses, and post-mastectomy surgical bras, subject to applicable limitations. 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. <p>Ø Note: when a mastectomy has been performed and there is no evidence of malignancy, Coverage is limited to the provision of prosthetic devices and Reconstructive Surgery to within two (2) years after the date of the mastectomy.</p> <p>Ø Note: We will not deny you eligibility or continued eligibility to enroll or to renew Coverage under the terms of the Plan solely for the purpose of avoiding the requirements of this Section. We also will not penalize or reduce or otherwise limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending Provider to induce the Provider to provide you care in a manner inconsistent with this Section.</p>	<p>Prior Authorization is required.</p> <p>You are not covered for the following breast reconstruction related services and supplies or diagnostic testing related to those services and supplies:</p> <ol style="list-style-type: none"> Reconstructive or Cosmetic surgery of the breast, except as stated. Removal of breast implants if implanted solely for Cosmetic or other non-covered reasons, even if removal is determined to be Medically Necessary. Removal of breast implants, regardless of their indication for placement due to alleged or diagnosed systemic or rheumatologic disorders. Breast enhancement or augmentation mammoplasty, with or without implants, unless associated with breast reconstruction surgery following a Medically Necessary mastectomy incurred secondary to active disease. Breast reduction/reconstruction for male gynecomastia. <p>Coverage for external prostheses is also limited. Contact the Plan’s Customer Service Department for current applicable benefit limits.</p> <ol style="list-style-type: none"> You may elect to purchase a more expensive external breast prosthesis by paying the excess cost. Initial Coverage is limited to one (1) of each external breast prostheses (right and/or left). Coverage for replacement of each external breast prostheses is limited to once every two (2) years. Post-mastectomy surgical bras are limited to the standard model and limited to three (3) bras every six (6) months.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Breast-Related Services	<p>Covered Service for the following breast-related services:</p> <ol style="list-style-type: none"> 1. Services related to the prevention of breast cancer and its early detection, 2. Services related to the diagnosis and treatment of abnormalities of the breast. 3. Mammogram Coverage as follows: <ol style="list-style-type: none"> a. Screening by low-dose and/or digital mammography for all women over 35 (including baseline mammogram for women 35-39 and annual mammogram for women 40 and older). b. Mammograms for women under 40 with a family history of breast cancer or other risk factors at ages and intervals as considered Medically Necessary. c. Comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates Medical Necessity. 4. Clinical breast exams at least every three (3) years for women aged 20-39 and annually for women 40 years of age or older. 	<p>Depending on the service, Prior Authorization may be required. 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.</p>

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Cancer Treatment	<p>Covered Service for the following cancer treatment:</p> <ol style="list-style-type: none"> 1. 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. 2. Services related to the diagnosis and treatment of cancer, including those outlined below and in other sections of this Schedule of Benefits. <ol style="list-style-type: none"> a) Covered cancer treatments include surgery, chemotherapy, and radiation therapy under the following conditions: <ol style="list-style-type: none"> i. the treatment must be Medically Necessary; ii. 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 Peer-Reviewed professional journals published in the United States or Great Britain; iii. 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; iv. the treatment is currently not considered to be Experimental or in clinical trials. 3. 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). 	<p>Prior Authorization may be required for some services, such as brachytherapy, stereotactic radiation therapy and proton beam therapy.</p> <p>You are not covered for the following cancer treatment:</p> <ol style="list-style-type: none"> 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 trial. 5. Costs associated with an approved investigational cancer trial that are specifically excluded, including: <ol style="list-style-type: none"> 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.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Cardiac Rehabilitation Therapy</p>	<p>Covered Service for cardiac rehabilitation therapy delivered in an approved, Hospital-based cardiac rehabilitation program under the supervision of a cardiologist.</p> <ol style="list-style-type: none"> 1. The cardiac rehabilitation therapy must be required and Medically Necessary due to a documented cardiac (heart) condition; 2. You must have a loss of function as a result of the cardiac condition; 3. The cardiac rehabilitation therapy must be significantly likely to substantially improve your functional status and result in either improved pain (angina) control or quality of life within a period of two (2) months; and 4. The cardiac rehabilitation therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a non-monitored exercise program). 	<p>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 not count towards your visit limit maximums for Outpatient Rehabilitation Services as identified in your Schedule of Benefits.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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. Phases III or IV of a cardiac rehabilitation program. 6. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 7. Alternative rehabilitation services (<i>e.g.</i>, massage therapy). 8. 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.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Chiropractic Care	<p>Covered Service for the initial examination, diagnosis and chiropractic treatment of pain due to certain limited musculoskeletal conditions which can be expected to improve through the manipulation of the spinal column and/or other skeletal structures under the following circumstances:</p> <ol style="list-style-type: none"> 1. The chiropractic care must be Medically Necessary, and 2. The musculoskeletal condition must reasonably be expected to improve with short-term (up to six (6) weeks of) chiropractic treatment. 	<p>Coverage for chiropractic care services is limited to services received from Tier I or Tier II providers. There is no coverage for chiropractic care services received from Tier III providers.</p> <p>You are not covered for the following chiropractic care:</p> <ol style="list-style-type: none"> 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. Holistic, homeopathic, acupuncture or naturopathic care. 5. Chiropractic therapy for musculoskeletal conditions that are typically not improved with chiropractic care. Examples include, but are not limited to, any benign or malignant neoplasms; fractures or dislocations; and organic/genetic musculoskeletal diseases and illness, such as multiple sclerosis, muscular dystrophy and osteomyelitis. 6. Chiropractic therapy for all non-musculoskeletal diseases and injuries. Examples include, but are not limited to, diabetes, asthma, obesity, hypertension, allergies, and infections. 7. Chiropractic services not otherwise defined as a Covered Service.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Contraceptive Services and Devices</p>	<p>Covered Service for the following for both Enrollees and Dependents alike:</p> <ol style="list-style-type: none"> 1. Outpatient contraceptive services, including consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. 2. All outpatient contraceptive devices approved by the Food and Drug Administration <p>You may also have Coverage for outpatient contraceptive prescription drugs approved by the Food and Drug Administration under a separate prescription drug benefit.</p>	<p>The Plan will not impose any Deductible, Coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any outpatient service or outpatient prescription drug or device otherwise Covered by this Certificate.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Elective abortions. 2. Contraceptive devices not approved by the Food and Drug Administration. 3. Over-the-counter or other non-prescribed forms of contraception, such as male and female condoms, spermicidal foams and creams and sponges.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Dental & Oral Surgical Services	<p>This is a health insurance policy, not a dental insurance policy. Consequently, Coverage for dental services is significantly limited. Covered Service for the following types of dental and oral surgical services:</p> <ol style="list-style-type: none"> 1. Emergent and restorative services due to accidental injury or trauma resulting in fracture of the jaw, laceration of the mouth, tongue or gums or injury to sound, natural teeth so long as the services are initiated and completed within twelve (12) months of the date of the accident or trauma. Covered Services include but are not limited to stabilization services necessary to prevent functional deficits, dentures, crowns, crown repair, bridges and repair of broken teeth. In certain situations, two or more dental treatment alternatives may produce comparable results. When alternative options may be utilized, the Plan determines the method which will be eligible for Coverage. <ul style="list-style-type: none"> Ø Note: Accidental injury is defined as an injury related to an external trauma to the teeth, gums, or jaw. It does not include injuries resulting from natural function, such as biting or chewing. Additionally, accidental injury is that type of injury which, if left untreated, would result in the loss of the tooth or severe dysfunction. Ø Note: Sound, natural tooth is defined as a tooth with a normal root structure and no previous restoration (such as root canals, caps, fillings). Ø Note: The emergent evaluation and treatment related to the accidental injury can be provided by any Provider. Any further treatment to sound natural teeth must be performed by a Provider approved in advance by the Plan. Ø Note: Coverage for emergent or restorative services ends if your Coverage terminates, even if the twelve months has not yet elapsed. 2. Medical (non-dental) treatment of severe medical Illness or Injury to your jaws, lips, cheeks, tongue, roof and floor of mouth or surrounding tissues. Examples include: <ol style="list-style-type: none"> a) Treatment and correction of a pathological condition, such as a cyst, tumor, or infection involving the jaw or surrounding tissues, which is not dental in origin. b) Treatment and correction of cleft lip or palate. c) Removal of bony growths of the jaw, soft and hard palate. d) Treatment and correction of Illness or Injury to the temporomandibular joint (TMJ) resulting from Acute dislocation of the mandible from direct and external trauma, fractures, neoplasms, or other inflammatory rheumatologic or infectious conditions, such as rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, or osteomyelitis. e) Severe medical, but not dental, complications of dental work. 3. Charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a Covered individual in a Hospital or ambulatory surgical treatment center if: a) the individual is a child age 6 or under; b) the individual has a medical condition that requires hospitalization or general anesthesia for dental care; or c) the individual is disabled as that term is defined by Illinois law. The actual dental services provided while hospitalized or performed in an ambulatory surgical treatment center are not covered. 	<p>Limited benefit. Prior Authorization required. You are not covered for the following types of dental and oral surgical services:</p> <ol style="list-style-type: none"> 1. General dental care. <ol style="list-style-type: none"> a. General and preventive dental services, including, but not limited to, fillings, root canals, crowns, bridges, dentures, dental X-rays and other routine dental care. b. Dental splints, supplies, appliances (including occlusal splints/orthodontia), dental implants, dental prostheses or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist, unless related to trauma treatment. c. Treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, including, but not limited to, gum disease such as periodontitis and gingivitis. d. 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. e. Prescription medications written by a dentist or Physician for the purpose of treating a dental condition. 2. Dental care delivered during the treatment of accidental injury to sound, natural teeth that is not related to the accidental injury. 3. Dental implants. 4. Other dental and oral surgery procedures: <ol style="list-style-type: none"> a. Surgical correction of malocclusion of the teeth and/or jaw, including, but not limited to, maxillofacial orthognathic and prognathic surgery. b. Orthodontic correction of tooth alignment or malocclusion. c. Removal of dentiginous cysts, mandibular tori and odontiod cysts, which are dental in origin. d. Treatment of TMJ or craniomandibular joint disease, resulting from dislocation of the cartilage without dislocation of the mandible or from other dental causes or anomalies, including osteoarthritis. e. Dental related oral surgical services to correct an overbite or underbite. 5. Hospital costs or related costs resulting from services that are excluded. 6. Emergent and restorative services due to accidental injury to sound, natural teeth rendered 12 months or more after the date of injury or after your insurance Coverage under the Plan has ended.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
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.	<p>Limited benefit. Prior Authorization may be required for some services. Contact the Claims Administrator's Customer Service Department for more information.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 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, even when medical or surgical treatment for acne has been provided by the Plan.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Diabetic Self-Management Training and Education</p>	<p>Covered Service for the prevention, diagnosis and treatment of diabetes, which shall include the following:</p> <ol style="list-style-type: none"> 1. Services related to the prevention of diabetes and its early detection are Covered as described in the Preventive Services section of this Schedule of Benefits. 2. Services related to the diagnosis and treatment of diabetes as part of this general medical benefit. 3. Outpatient self-management training and education, including medical nutrition education, for the treatment of type 1 diabetes, type 2 diabetes and gestational diabetes mellitus, as part of an office visit, group setting, or home visit, limited to the following: <ol style="list-style-type: none"> a) Up to 3 Medically Necessary visits to a qualified Provider upon initial diagnosis of diabetes by your Physician; b) Up to 2 Medically Necessary visits to a qualified Provider upon a determination by your Physician that a significant change in your symptoms or medical condition has occurred. <p>Ø Note: A significant change in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in your medical condition that would require a significantly different treatment regimen.</p> <ol style="list-style-type: none"> 4. Diabetic equipment, including blood glucose monitors; blood glucose monitors and cartridges for the legally blind; and lancets and lancing devices. 5. Regular foot care examinations by your Physician or by a Physician to whom your Physician has referred you. 6. Regular eye examinations by your Physician. (This does not include Coverage for refractive exams to check visual acuity.) <p>Ø Note: Diabetic pharmaceuticals and supplies, including insulin, syringes and needles, test strips for glucose monitors, FDA-approved oral agents used to control blood sugar, and glucagon emergency kits may be covered under a separate prescription drug benefit.</p>	

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Diagnostic Tests and Procedures	<p>Covered Service for diagnostic tests and procedures (including, but not limited to, laboratory tests, radiographic tests, and other diagnostic procedures) under the following circumstances:</p> <ol style="list-style-type: none"> 1. The diagnostic test and/or procedure must be Medically Necessary, and 2. The diagnostic test and/or procedure must provide useful information that affects diagnosis and treatment decisions by your Physician, and 3. The diagnostic test and/or procedure must be done because of currently recognized health problems or symptoms, and 4. The diagnostic test and/or procedure must be ordered by your PCP, WPHCP, or another Provider. 	<p>Prior Authorization may be required for some services. Contact the Claims Administrator's Customer Service Department for further information.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Diagnostic tests and procedures that are considered to be Experimental or Investigational. 2. Diagnostic tests and procedures that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Diagnostic tests and procedures that are 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. Diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Diagnostic tests or screening procedures determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation. 6. Diagnostic tests and procedures that are part of a non-covered clinical trial.
Dialysis	<p>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.</p>	

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Disposable Medical Supplies (DMS)</p>	<p>Covered Service for disposable medical supplies (DMS) under your durable medical equipment (DME) benefit in limited quantities as follows:</p> <ol style="list-style-type: none"> 1. DMS such as dressings, casts, splints, and other supplies when applied in the Physician’s office by your PCP, WPHCP or another Provider. 2. DMS such as dressings, casts, splints, and other supplies when applied in your home by a Home Health Provider. 3. DMS that are essential for the correct and effective operation of DME and have a direct medical function. <p>Ø Note: DMS must be prescribed by a Provider.</p> <p>Ø Note: The Plan maintains a list of Covered DMS. You may contact the Claims Administrator’s Customer Service Department for Coverage information.</p>	<p>Limited benefit.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Self-administered dressings, splints, and supplies. 2. Supplies that are typically purchased over-the-counter, such as ACE wraps, elastic supports and other supplies. 3. Products that provide for nutritional needs, including, but not limited to, formula, feeding solutions, and supplements, except for amino acid-based elemental formulas for conditions as specified by Illinois law. 4. Disposable supplies that do not perform a medical function or purpose. 5. Other DMS, such as catheters, and filters. 6. Clothing or garments, including, but not limited to, elastic stockings, support hose, Jobst and TEDS stockings, foot coverings, corsets, or any elastic joint supports (which are not considered orthopedic appliances).

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Durable Medical Equipment (DME)</p>	<p>Durable medical equipment (DME) is defined as equipment that meets all four of the following criteria:</p> <ul style="list-style-type: none"> • Is primarily and customarily used to serve a medical purpose; • Generally is not useful to a person in the absence of Illness or Injury; • Is designed to withstand repeated use; and • Is appropriate for use in the home. <p>(Examples of DME include, but are not limited to, standard wheelchairs, standard hospital-type beds, oxygen and the rental of equipment for the administration of oxygen, home ventilators and respirators, and continuous passive motion devices after surgery.)</p> <p>Covered Service for DME as follows:</p> <ol style="list-style-type: none"> 1. Your Coverage for DME is limited to the standard model equipment that meets your needs, as determined by the Plan. You may decide to purchase a more advanced model of equipment, but you are responsible for any amount in excess of the charge for the standard model, in addition to applicable Co-payments, Coinsurance, and Deductibles. 2. You are Covered for the professional services for delivery, set-up, fitting, and adjusting of your DME. 3. You are Covered for the repair, refitting, and/or replacement of your DME so long as it has been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. The Plan will determine if the DME should be repaired or replaced. <p>Ø Note: The DME, or the repair of the DME, must be prescribed by a Provider.</p> <p>Ø Note: The Plan will make the decision whether the DME will be rented or purchased.</p> <p>Ø Note: The Plan maintains a list of Covered DME. You may contact the Plan’s Customer Service Department for Coverage information.</p>	<p>Prior Authorization required for all DME over \$500 and all rental equipment.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Eyeglasses, contact lenses, and other equipment intended to improve vision. 2. Hearing aids, ear molds, and other equipment intended to improve hearing, except as otherwise provided. 3. Equipment for environmental control, such as air conditioners, furnaces or heaters, air filters or purifiers, humidifiers or dehumidifiers. 4. Allergenic pillows or mattresses. 5. Improvements or modifications to your home or place of business. 6. Whirlpool baths. 7. Fitness or exercise equipment. 8. Educational materials, books, videotapes. 9. Repair or replacement of DME due to misuse, neglect or loss. 10. DME which may be used by multiple individuals. 11. Electrical continence aids, either anal or urethral. 12. Convenience or comfort items, including, but not limited to, tub grab bars and raised toilet seats. 13. Items necessary for the operation of DME that are not directly related to the medical function of the equipment. 14. Replacement items, including, but not limited to, replacement batteries, tires, and light bulbs. 15. Replacements of DME when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan. 16. Cribs, special strollers, standing frames. 17. Cranial caps and helmets, except for certain diagnoses. <p>Glucometers may be obtained from the Plan's National Vendor, when available. Coverage limited to the standard model equipment that meets your needs, as determined by the Plan. Upgrades to the equipment are your financial responsibility.</p>

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Elective Sterilization	Covered Service.	Prior Authorization may be required. You are not covered for reversals of voluntary sterilizations.
Emergency Services for Emergency Medical Conditions	<p>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.</p> <p>Emergency Services do not include post-stabilization services. Once your Emergency 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.</p> <p>In the event your condition is not an Emergency Medical Condition, you should contact your PCP for advice prior to seeking emergency room treatment. Your PCP or a Physician covering for him or her is available 24 hours a day, 7 days a week.</p>	<p>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.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Visits to a Hospital emergency room when you do not have an 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 (<i>e.g.</i>, non-traumatic dental services). 3. Visits to Hospital emergency rooms to renew prescriptions or remove sutures.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Eyeglasses and Corrective Lenses (Vision Services)</p>	<p>Covered Service for Medically Necessary vision services required for the diagnosis and treatment of diseases of, or injuries to, the eye.</p>	<p>Limited benefit. Prior Authorization may be required for some services.</p> <p>You are not covered for the following vision services:</p> <ol style="list-style-type: none"> 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).
<p>Family Planning</p>	<p>Covered Service for outpatient contraceptive service, including consultations, examinations, procedures and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Covered Service also for all outpatient contraceptive devices approved by the Food and Drug Administration, such as intra-uterine devices (IUD's), implants, cervical caps and diaphragms. You may have Coverage for outpatient FDA-approved contraceptive drugs and devices purchased through a pharmacy through a separate prescription drug benefit.</p>	<p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Elective abortions. 2. Emergency room treatment for the sole purpose of receiving the "morning after" pill. 3. Outpatient contraceptive devices and/or drugs not approved by the FDA. 4. Over-the-counter contraceptives (e.g., foams, condoms and spermicidal creams). 5. Reversal of a voluntary sterilization. 6. Costs of any services rendered by a surrogate mother.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Genetic Counseling and Testing	Covered Service for genetic counseling, studies and testing only when required for the diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities, and the testing will alter the outcome of treatment.	Prior Authorization required. You are not covered for 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.
Growth Hormone	Covered Service when prescribed by a certified endocrinologist and when Medically Necessary for the treatment of Members in specified diagnostic categories who meet applicable criteria. Contact the Claims Administrator's Customer Service Department for further information. Ø Note: Self-administered injectables may be covered under a separate prescription drug benefit.	Prior Authorization required.
Gynecological Examinations	Covered Service for an annual self-referred well-woman examination by a Provider specializing in obstetrics or gynecology or family practice, including services, supplies and related tests in accordance with the current American Cancer Society guidelines. Includes clinical breast exam, mammogram, and cervical smear or Pap smear test for female Members.	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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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Health Education	Covered Service for instructions on achieving and maintaining physical and mental health and preventing Illness and Injury when provided in your Primary Care Physician's office.	<p>Health education does not require Prior Authorization when provided in your Primary Care Physician's office. Any other Provider setting must be Prior Authorized. 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.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 1. Charges and fees associated with health education classes, such as smoking cessation programs, stress management and childbirth education classes. 2. Equipment and supplies to promote health and healthy lifestyles including exercise videos, software and equipment, whirlpools and Jacuzzis. 3. Educational materials, books and videotapes. 4. Membership or fees associated with health clubs, weight loss clinics and fitness programs. 5. Educational services for remedial education, including, but not limited to, evaluation and treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, developmental learning disorders and behavioral training. 6. Educational or psychological testing, unless part of a treatment program for Covered Services.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
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: an annual hearing screening if performed by your Primary Care Physician; hearing screenings to determine hearing loss; and newborn screening examinations, any necessary re-screening, audiological assessment and any required follow-up.	<p>Prior Authorization may be required for some services. 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.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 1. Hearing aids, ear molds, and other equipment intended to improve hearing, with the exception of a limited hearing aid benefit of \$600 for hearing aids every three (3) years and up to \$150 for exam(s). 2. Hearing aid evaluation, hearing aid repair, reconditioning, supplies or batteries. 4. Digital and programmable hearing devices. 5. Hearing therapy and related diagnostic hearing tests.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Home Health Care	<p>Covered Service for Medically Necessary home health care and/or home infusion services provided in your home under the following circumstances:</p> <ol style="list-style-type: none"> 1. The services are provided in lieu of hospitalization or placement in a skilled nursing facility or receiving outpatient services outside the home. 2. You must be homebound because of Illness or Injury and unable to be reasonably transported for necessary medical care, as determined by the Plan. 3. The services have been ordered by a Provider and are directly related to an active treatment plan of care established by your Physician. 4. The services provided must be specific, effective, and reasonable for the treatment of your diagnosis and physical condition and the most cost-effective approach to care. 5. The services are provided on a part-time, intermittent basis. 6. The services are short-term and used to treat a specific medical problem that is likely to significantly improve with treatment. 7. The services must be delivered by or under the supervision of a licensed healthcare professional (nurse or therapist) and provided by a licensed and certified agency. 8. Covered Services include nursing care, therapy services, medical and surgical supplies, and FDA-approved prescription drugs furnished by the Home Health Care agency or infusion program that are specific to the delivery of the Home Health Care services. 9. Services consist primarily of caring for the patient. 10. Prior to beginning Home Health Care services, a treatment plan must be reviewed and approved by the Plan. <p>Ø Note: Rehabilitation services provided in the home will be Covered under the applicable rehabilitative services sections of this Plan and will be subject to the applicable Co-payments and/or Coinsurance as described in your Schedule of Benefits.</p>	<p>Coverage for home health care services is limited to services received from Tier I or Tier II providers. There is no coverage for home health care services received from Tier III providers.</p> <p>You are not covered for the following home health care services:</p> <ol style="list-style-type: none"> 1. Housekeeping services. 2. Health aid services. 3. Private duty nursing. 4. Home care that is full-time, continuous or long-term. 5. Services provided by a person who ordinarily resides in your home or is in your immediate family. 6. Custodial Care. 7. Services to help meet personal, family or domestic needs.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Hospice	<p>Covered Service for the treatment of a terminally ill Plan Member when each of the following five criteria has been met:</p> <ol style="list-style-type: none"> 1. Services are ordered by a Provider; 2. Your Physician certifies that your life expectancy is six (6) months or less; 3. The care is palliative in nature (<i>i.e.</i>, you are no longer in an active course of treatment); 4. The care is provided through a licensed hospice care Provider approved by the Plan; and 5. Prior to receiving Coverage for hospice services, a treatment plan has been reviewed and approved by the Plan. <p>Eligible Expenses include, but are not limited to, the following:</p> <ul style="list-style-type: none"> - Part-time nursing care by or supervised by a registered nurse (RN). - Medical social services provided to a Member or his/her immediate family, including the assessment of social, emotional and medical needs, and the home and family situation; identification of community resources that are available; and assistance in obtaining those resources. - Dietary counseling. - Consultation and case management services. - Physical or occupational therapy. - Covered medical supplies, drugs and medicines as prescribed by a Physician. 	<p>Prior Authorization required for any in-patient hospice care.</p> <p>You are not covered for the following types of services under a hospice care program:</p> <ol style="list-style-type: none"> 1. Private or special nursing services. 2. Confinement not required for pain control or other Acute chronic symptom management. 3. Funeral arrangements. 4. Financial or legal counseling, including estate planning or drafting of a will. 5. Homemaker or caretaker services. 6. Sitter or companion services. 7. House cleaning or household maintenance. 8. Services by volunteers or persons who do not regularly charge for their services. 9. 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. 10. Services provided by an agency not licensed to provide the services rendered. 11. Services by a licensed pastoral counselor to a member of his or her congregation.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Hospital Care (Acute Inpatient)</p>	<p>Covered Service for Medically Necessary inpatient Hospital Services, including, but not limited to, the following:</p> <ol style="list-style-type: none"> 1. Pre-admission testing. 2. Semi-private room and board or specialty units, such as intensive care and coronary care. 3. General nursing care. 4. Lab, X-ray, diagnostic tests, medical treatment, and the administration and processing of whole blood and blood plasma. 5. Use of an operating room and related facilities, including anesthesia. 6. Medical supplies used by you during your inpatient stay. 7. Non-experimental, FDA-approved drugs administered to you during your inpatient stay. 8. Therapy services, including rehabilitative therapy, radiation therapy, and inhalation therapy. 9. Oxygen and its administration. <p>Inpatient Hospital Services are Covered only when they are:</p> <ol style="list-style-type: none"> a) Medically Necessary; b) can be safely and/or effectively delivered only within a Hospital inpatient setting; c) a Provider arranges for, and manages, your care within the Hospital; and d) You are admitted to a Hospital. <p>As set forth in other sections of this Certificate, Coverage is also provided for inpatient hospitalization following a mastectomy for a length of time determined to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the Coverage for and availability of a post-discharge Physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.</p>	<p>Prior Authorization is required unless the admission is Emergent. Prior Authorization is also required for inpatient specialty care programs, such as rehabilitation, hospice, mental health and substance abuse. Consistent with the Plan's utilization management policies, all Acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or any portion thereof is determined not to be Medically Necessary, your Provider and you will be notified that Coverage will cease.</p> <p>In addition, you are not covered for the following inpatient hospital care services:</p> <ol style="list-style-type: none"> 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. Private rooms, unless one is determined to be Medically Necessary. (You shall be responsible for the payment of the difference between the private room rate and the semi-private room rate if a private room is requested, and it is not Medically Necessary.) 7. Hospital confinement primarily for diagnostic purposes or related to a surgical operation when suitable outpatient facilities are available or solely on account of a surgical operation scheduled the next day. 8. Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home. 9. Any confinement for which the Member is not legally obligated to pay.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Immunizations	<p>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, when applicable criteria are met.</p>	<p>Immunizations for routine childhood immunizations and flu shots do not require Prior Authorization by the Plan. Prior Authorization may be required for immunizations other than routine childhood and/or adult immunizations. 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.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 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 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.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Infertility	<p>Covered Service for the diagnosis and treatment of Infertility, including, but not limited to: diagnostic testing, treatments to enhance ovulation, surgical procedures to correct tubal defects not caused by elective sterilization, in vitro fertilization (IVF), uterine embryo lavage, embryo transfer, artificial insemination (AI), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and low tubal ovum transfer (LTOT), when applicable criteria have been met. Covered Service also for the medical expenses and the associated donor medical expenses of an oocyte or sperm donor for procedures for retrieval of oocytes or sperm and for transfer of the oocytes or sperm to the Covered recipient.</p> <p>Ø Note: Infertility means a woman who: is unable to conceive after one year of unprotected sexual intercourse; is unable to sustain a successful pregnancy; has been diagnosed by a physician as having a medical condition that renders conception impossible through unprotected sexual intercourse; or has undergone one year of medically based and supervised methods of conception, including artificial insemination, which a physician has determined to have failed and are not likely to lead to a successful pregnancy.</p> <p>You have Coverage for procedures for IVF, GIFT and ZIFT only if:</p> <ol style="list-style-type: none"> 1. You have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments for which Coverage is available under this Plan Document; (this requirement shall be waived in the event you or your partner has a medical condition that renders such treatment useless); 2. You have not undergone four (4) completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two (2) more completed oocyte retrievals shall be Covered; and <p>Ø Note: the maximum number of completed oocyte retrievals that shall be eligible for Coverage is six (6); this Coverage limitation applies to the Covered person per Lifetime of that Covered person, for treatment of Infertility, regardless of the source of payment; if an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count against the Member as one completed oocyte retrieval; following the final completed oocyte retrieval for which Coverage is available, Coverage for one (1) subsequent procedure used to transfer the oocytes or sperm to the Covered recipient shall be provided.</p> <ol style="list-style-type: none"> 3. The procedures are performed at Participating medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization. 	<p>Prior Authorization required.</p> <p>If known donors are used, Participating Providers must be used for all of the donor's medical treatment, including, but not limited to, testing, prescription drug therapy and ART procedures as a condition for Coverage. If no arrangements have been made with a known donor, a Participating Provider must be used.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 1. Non-medical costs of an egg or sperm donor; 2. Selected termination of an embryo or fetus; provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, said termination shall be Covered; 3. Costs associated with cryo preservation and storage of sperm, eggs and embryos; provided however, that subsequent procedures of a medical nature necessary to make use of the cryo preserved substance shall not be similarly excluded if deemed non-experimental and non-investigational; 4. Reversal of voluntary sterilization; (however, if voluntary sterilization is successfully reversed, Infertility benefits shall be available if the Covered Member's diagnosis meets the definition of Infertility); 5. Payment for services rendered to a surrogate; (however, costs for procedures to obtain eggs, sperm or embryos from a Covered individual shall be Covered if the individual chooses to use a surrogate); 6. Travel costs for travel within 100 miles of the Member's home address; which are not Medically Necessary; or not mandated or required by the Plan; 7. Infertility treatments deemed Experimental or Investigational; and 8. Infertility treatments rendered to Dependents under the age of 18. <p>Coverage for certain Infertility procedures may be restricted or denied for Members insured under a plan sponsored by a religious institution or organization or an entity sponsored by a religious institution or organization that finds the procedure in violation of the religious and moral teachings or beliefs.</p>

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Injectables	<p>Covered Service for prescribed injectables which are administered by a Physician or Provider but only if each of the following criteria is met:</p> <ul style="list-style-type: none"> • The prescribed injectable must be Medically Necessary and appropriate for your diagnosis or condition; • The prescribed injectable must be FDA-approved and not determined to be Experimental or Investigational; • Because of your medical condition, the injectable can only be administered, or most effectively and appropriately be administered, by an injection, and an appropriate oral alternative drug does not exist; and • A Provider arranges for, and/or provides, the injectable. <p>Ø Note: To be consistent with changes in medical technology, the Plan maintains a list of Covered and non-covered injectables and the medical conditions for which they are approved for Coverage. Coverage can be verified by calling the Plan's Customer Service Department.</p> <p>Ø Note: Immunizations are Covered as part of your Preventive Services benefit.</p> <p>Ø Note: You may also have Coverage for certain injectables which are self-administered by you (e.g., insulin, Imitrex) under a separate prescription drug benefit.</p>	<p>Prior Authorization is required.</p> <p>You are not covered for the following prescribed injectables:</p> <ol style="list-style-type: none"> 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.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Laboratory and Pathology Services</p>	<p>Covered Service for outpatient preventive (<i>e.g.</i>, routine laboratory testing or screening in conjunction with well-child and annual adult physical examinations and for colorectal cancer) and diagnostic laboratory tests, services and studies ordered by a Provider and performed at a laboratory, clinic, or Physician’s office.</p>	<p>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.</p> <p>You are not covered for the following laboratory services:</p> <ol style="list-style-type: none"> 1. Laboratory and pathology services that are considered Experimental or Investigational in nature. 2. Laboratory and pathology services that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Laboratory and pathology services that are not done to evaluate current health problems or symptoms (<i>e.g.</i>, premarital blood testing, paternity testing, screening for various conditions in the absence of symptoms or significant risk factors) unless as part of the preventive health guidelines. 4. Laboratory and pathology services done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Laboratory and pathology services determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Maternity Services	<p>Covered Service for the following maternity care services:</p> <ol style="list-style-type: none"> 1. Prenatal, natal and postnatal care provided by a Provider and/or his or her staff. 2. Clinical preventive services for prenatal care as set forth in the Plan's preventive care guidelines. 3. X-rays, laboratory and other diagnostic tests, including prenatal HIV testing. 4. Medically Necessary operations, procedures and delivery for the mother and newborn child, including complications associated with pregnancy. 5. Consistent with the Federal Newborns' and Mothers' Health Protection Act and Illinois law: <p>Inpatient hospitalization following childbirth for the mother and the newborn child: up to a forty-eight (48) hour Hospital stay following birth by normal vaginal delivery and up to a ninety-six (96) hour Hospital stay following delivery by Caesarean section. A shorter length of Hospital inpatient stay for services related to maternity and newborn care may be provided if your attending Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American College of Pediatrics, that you and your newborn meet the appropriate guidelines for that length of stay based upon evaluation of you and your newborn and the coverage and availability of a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.</p> <p>Ø Note: During your prenatal care, if you are admitted for complications or any medical condition other than your delivery, your inpatient Co-payment will apply for each admission.</p>	<p>We cannot require you to obtain Prior Authorization from the Plan in order for your 48- or 96-hour stay to be Covered. However, it is recommended that you notify the Plan of your pregnancy and upcoming childbirth and also notify Us of a planned or scheduled Caesarean section. Prior Authorization is required if you stay beyond 48 hours after a vaginal delivery or 96 hours after a delivery by Caesarian section. Other services may also require Prior Authorization.</p> <p>You are not covered for the following maternity related services:</p> <ol style="list-style-type: none"> 1. Elective abortions that are directly intended to terminate pregnancy before viability or directly intended to destroy a viable fetus; (however, therapeutic abortions where 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 are Covered). 2. X-rays, laboratory tests, diagnostic tests, or other procedures that are not Medically Necessary. (Examples include, but are not limited to, testing to determine the sex or paternity of your unborn child, excessive testing for unlikely illness or disease or testing that does not add value to the management of the case). 3. Planned home deliveries. 4. Maternity care delivered by non-physicians, such as doulas. 5. Personal comfort or convenience items. 6. Delivery by Caesarean section scheduled for your convenience and not because it is Medically Necessary.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Medical Complications	Covered Service for complications arising from Medically Necessary surgery regardless of whether you were Covered by the Plan at the time of surgery. You are also Covered for the treatment of medical complications of abuse of or addiction to alcohol or drugs on either an inpatient or an outpatient basis on the same terms and conditions as a physical illness.	Prior Authorization Required. You are not covered for the following medical complications: 1. If the medical complications occurred because you did not follow the course of treatment prescribed by a Provider. 2. If the medical complications arose from non-covered services, even if the requested service may be Medically Necessary.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Mental Health Services</p>	<p>Covered service for the following mental health, alcohol and substance abuse services:</p> <ol style="list-style-type: none"> 1. Medically Necessary individual outpatient mental health or rehabilitation care visits to qualified Physicians, duly licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services. Outpatient visits for mental health are covered under the same terms and conditions as outpatient visits for the treatment of physical illness. 2. Medically Necessary inpatient mental health or rehabilitation care at an inpatient facility or hospital. Your coverage for the treatment of inpatient mental health or rehabilitation care shall be under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. 3. Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Coverage for these services is the same as coverage for non-mental health inpatient services for any other illness, condition, or disorder. 	<p>Prior Authorization is required for inpatient mental health services.</p> <p>You are not covered for the following mental health services:</p> <ol style="list-style-type: none"> 1. Care or treatment of marital or 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. 2. Treatment for mental retardation and/or developmental and/or learning disabilities or delays, including, but is not limited to, treatment for pervasive developmental disorders, and chronic organic brain syndrome, except that there is limited Coverage for additional outpatient visits for speech therapy for the treatment of pervasive developmental disorder up to the visit limits as set forth in your Schedule of Benefits, Coverage for psychiatric, psychological and habilitative and rehabilitative care for the treatment of persons diagnosed with autism spectrum disorder, and Coverage for habilitative services for children. 3. Mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services. 4. Psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school. 5. Mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility. 6. Institutional care which is for the primary purpose of controlling or changing your environment. 7. Milieu therapy, biofeedback, behavior modification therapy, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis. 8. Mental illness resulting from the use of a controlled substance or cannabis in violation of the law.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Morbid Obesity Surgery</p>	<p>Surgical treatment, vertical-banded gastroplasty (gastric stapling), gastric banding and roux-en-Y gastric bypass, of Morbid Obesity will be Covered when <u>all</u> of the following criteria are met:</p> <ul style="list-style-type: none"> ◇ 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: <ul style="list-style-type: none"> • 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 \geq 18 years of age; ◇ There is no treatable metabolic cause for the Morbid Obesity; ◇ 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. 	<p>Prior Authorization 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. Coverage for behavior modification will be provided according to the mental health benefit defined in your Plan Document.</p> <p>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.</p> <p>Members who have any of the following are not eligible for Morbid Obesity surgical services:</p> <ul style="list-style-type: none"> • 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-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. <p>The following are also not covered:</p> <ul style="list-style-type: none"> • Jejunioileal 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, examinations or services •

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<p>Morbid Obesity Travel-Related Expenses</p>	<p>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:</p> <ul style="list-style-type: none"> • Lodging: \$75.00 per day for the Member; \$150.00 per day for the Member plus one other person. • Meals: \$30.00 per day, per person (limit 2 people) • 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). • Ambulance charges are Covered according to your Plan benefits • Auto mileage: reimbursement will be at the then current mileage reimbursement rate set by the IRS at the time the expense is incurred. • 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. • 	<p>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.</p>

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Newborn Care	<p>Covered Service for the following newborn care services:</p> <ol style="list-style-type: none"> 1. Illness or Injury and premature birth. 2. Congenital defects and birth abnormalities and Reconstructive Surgery related to the same, when specific criteria are met. (See Reconstructive Surgery Section for further details). 3. 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. 4. Newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up. 5. Nursery charges. 6. Routine care of a newborn provided by a Pediatrician while in the Hospital, including circumcision. <p>Ø 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).</p>	<p>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.</p>

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Nutritional Counseling	Covered Service when provided (1) by a Registered Dietician and (2) in connection with diabetes, coronary artery disease and hyperlipidemia.	<p>Limited benefit. Contact the Plan for applicable limitations and exclusions.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 1. Food or food supplements, except for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome. 2. Health education classes. 3. Non-FDA approved drugs, vitamins, minerals or supplements. 4. Diet pills, diet programs, weight reduction therapy, services, tests, examinations or supplies. 5. Exercise or fitness equipment or other equipment used to promote health or wellness. 6. Gym or fitness club memberships.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Orthotics, Customized Orthotic Devices and Orthopedic Appliances (OA)</p>	<p>An orthotic or an orthopedic appliance (OA) is defined as an appliance or device that is used to support, align, or correct an orthopedic deformity or to improve the function of a moving body part. (Examples include orthopedic braces, splints and braces.)</p> <p>A customized orthotic device is defined as a supportive device for the body or a part of the body, the head, neck, or extremities, excluding foot orthotics, defined as an in-shoe device designed to support the structural components of the foot during weight-bearing activities.</p> <p>Covered Service for Orthotics, Customized Orthotic Devices and Orthopedic Appliances following the onset or initial diagnosis of the condition for which the device is required, subject to the following conditions:</p> <ol style="list-style-type: none"> 1. The orthotic, device or OA, or the repair of the same, must be prescribed by a licensed provider. 2. The orthotic, device or OA must be custom-fitted for the sole benefit of the Member. 3. Coverage for orthotics and OA is limited to the standard model that meets your needs as determined by the Plan. You may decide to purchase a more advanced model, but you will be responsible for any amount in excess of the charge for the standard model, in addition to applicable Co-payments, Coinsurance, and Deductibles. 4. You are Covered for the professional services for the fitting and adjusting your orthotic, device or OA. 5. You are Covered for the repair, refitting, and/or replacement of your orthotic, device or OA based on your physical condition as Medically Necessary, so long as it has been properly maintained and not subjected to misuse or loss and when not covered by product warranty. The Plan will determine if the item should be repaired or replaced. 6. The general exclusions, limitations and financial requirements of the policy, including coordination of benefits, participating provider requirements, utilization review of health care services, including medical necessity review, case management, and experimental and investigational treatments, and other terms and conditions. 	<p>Prior Authorization may be required. Customized orthotic devices are covered under terms and conditions that are no less favorable than those that apply to substantially all medical and surgical benefits provided under the plan.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. 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. 2. Braces, supports and other orthotics or orthotic appliances needed for sports or athletic participation, recreational activities or employment. 3. Convenience items. 4. Repair or replacement of orthotics, customized orthotic devices or OA due to misuse or loss. 5. Replacement of orthotics or OA when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan. 6. Over-the-counter items, such as ACE wraps or bandages, elastic supports, finger splints, foot orthotics, and braces.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Outpatient Rehabilitative Therapy</p>	<p>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:</p> <ol style="list-style-type: none"> 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). <p>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 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.</p> <p>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.</p> <p>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.</p>	<p>Limited benefit. Prior Authorization may be required. Please refer to your Schedule of Benefits for visit limits and benefit maximums.</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 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 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.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Outpatient Services	<p>Covered Service for the following outpatient services:</p> <ol style="list-style-type: none"> 1. Outpatient surgical procedures that are not otherwise excluded from coverage. This includes the use of an operating room and related facilities, including appropriate anesthesia. 2. Treatment for established Illnesses, such as chemotherapy, inhalation therapy, dialysis, and radiation therapy. 3. Other procedures for the diagnosis or treatment of disease or Illness, such as colonoscopy, endoscopy or laparoscopy and intravenous therapy. 4. Medical supplies administered to, or used by, you as part of the provided outpatient services. <p>Ø Note: Outpatient services are Covered only when:</p> <ol style="list-style-type: none"> a) They can be safely and/or effectively delivered in an outpatient setting; b) A Provider arranges for, and manages, your outpatient services; and c) You obtain the outpatient services at a Hospital, Facility, or Provider. <p>Ø Note: You may also have Coverage for certain outpatient prescription medications through a separate prescription drug benefit.</p>	<p>Prior Authorization may be required.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Outpatient services that are considered to be Experimental 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.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Podiatry	Covered Service for regular foot exams if you have diabetes or for Medically Necessary treatment of conditions associated with the foot and ankle.	<p>Depending on the service, Prior Authorization may be required.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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. (See the Orthotics section for further information.)

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Preventive Services	<p>The following preventive services shall be covered without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply:</p> <ol style="list-style-type: none"> 1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; 2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved; 3. With respect to Covered Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4. With respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <p>For purposes of this section, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. No recommendation of the United States Preventive Service Task Force shall serve to reduce the mammogram benefits required by Illinois law.</p>	<p>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.</p> <p>You are not covered for the following preventive services:</p> <ol style="list-style-type: none"> 1. Unexpected mass immunizations directed or ordered by federal, state or local public health officials for general population groups. 2. Preventive chiropractic services, including, but not limited to, long-term or periodic manipulation of bones or joints, massage therapy, or holistic or alternative medicine. 3. Membership or service fees associated with health clubs, weight loss clinics and fitness programs. 4. Charges and fees for health education classes, smoking cessation programs, stress management and childbirth education. 5. Equipment and supplies to promote health or exercise, including, but not limited to, exercise equipment, videos, software, whirlpools, Jacuzzis, air conditioners, air purifiers, humidifiers, and dehumidifiers. 6. Hearing examinations, except that provided in the Physician’s office or for the treatment and diagnosis of diseases of, or Injury to, the ear or up to a \$150 benefit for hearing aid exam(s) . 7. Vision examinations, except that provided in the Physician’s office or for the treatment and diagnosis of diseases of, or Injury to, the eye. 8. Certain services or diagnostic or screening procedures determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation. 9. Comprehensive preventive clinics or spas.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Primary Care Services</p>	<p>We believe that healthcare works best when it is coordinated by a Primary Care Physician (“PCP”). You are encouraged to designate a PCP. You can select or change your PCP by contacting the Claims Administrator’s Customer Service Department or visiting our website.</p> <p>Covered Service for the following primary care services provided by your PCP or under your PCP’s supervision:</p> <ol style="list-style-type: none"> 1. Office visits for Covered Illness or Injury. 2. Inpatient and outpatient Hospital visits for Covered Services and approved stays. 3. Preventive care services and immunizations (provided in accordance with the Preventive Services section). 4. Covered office diagnostic testing. 5. Surgical procedures for Covered Services. 6. Covered injections and medications administered during an office visit. 7. Hearing and vision screening or testing by your PCP. <p>Ø Note: Your PCP has designated other Physicians that cover for him or her in his or her absence. In the event your PCP is unavailable, you may obtain primary care services from one of your PCP’s designated covering Physicians. You can obtain the name of the designated covering Physician by contacting your PCP’s office or Our Customer Service Department.</p> <p>Ø Note: Co-payments or Coinsurance will apply to office visits when you are seen by your PCP, or a covering Physician, physician assistant, nurse practitioner or nurse.</p>	<p>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.</p> <p>You are not covered for the following primary care services:</p> <ol style="list-style-type: none"> 1. Physical examinations, vaccines, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order. 2. Services or charges for which workers compensation is the primary payor. 3. Services, treatments or supplies that are not Medically Necessary for the treatment of an Injury or Illness or are outside generally accepted health care practice. 4. Services, treatments or supplies that are otherwise not a covered benefit under the Plan. 5. Telephone, computer or Internet consultations between your Provider and you or between your Provider and another Providers; telephone assessments in general. 6. Any appointment you did not attend or failed to cancel on a timely basis.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Prostheses, Prosthetic Devices, Prosthetic Appliances and Implants (PA)</p> <p>(Please refer to other specific subject headings in this Schedule of Covered Services (such as Breast-Related Services) for Coverage of specific items.)</p>	<p>Prostheses, Prosthetic Appliances and Implants (PA) is defined as an appliance or device that replaces all or part of a body organ, or all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The device may be external to, or implanted surgically into, the body. (Examples include, but are not limited to, eyes, post-mastectomy prostheses and bras, pacemakers, surgical implants, and lens implants required as a replacement for natural lenses.)</p> <p>Prosthetic Device is defined as an artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as medically necessary.</p> <p>You are covered for Prostheses, Prosthetic Devices, Prosthetic Appliances and Implants (PA) as follows:</p> <ol style="list-style-type: none"> 1. The prostheses, prosthetic device, and/or PA, or the repair of the same, must be prescribed by a licensed provider. 2. The item must be custom-fitted for the sole benefit of the Member and must not have any use other than in connection with the use of such device. 3. Coverage for prostheses and PA is limited to the standard model that meets your needs as determined by the Plan. You may decide to purchase a more advanced model, but you will be responsible for any amount in excess of the charge for the standard model, in addition to applicable Co-payments, Coinsurance, and Deductibles. 4. You are Covered for the professional services for the fitting and adjusting your prostheses, prosthetic devices and PA. 5. You are Covered for the repair, refitting, and/or replacement of your prostheses, prosthetic devices and/or PA based on your physical condition as Medically Necessary, so long as it has been properly maintained and not subjected to misuse or loss and when not covered by product warranty. The Plan will determine if the item should be repaired or replaced. 6. The general exclusions, limitations and financial requirements of the policy, including coordination of benefits, participating provider requirements, utilization review of health care services, including medical necessity review, case management, and experimental and investigational treatments, and other terms and conditions. 7. Ostomy supplies in limited quantities for patients that are colostomy or ileostomy status as determined by the Plan. 8. Wigs, hair-pieces, and toupees for hair loss as a direct result of chemotherapy or radiation therapy. A lifetime maximum of \$300 is applied for use at a Provider of Your choice. 	<p>Prior Authorization required for prosthetics over \$10,000. Prosthetic devices are covered under terms and conditions that are no less favorable than those that apply to substantially all medical and surgical benefits provided under the plan.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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. Hearing aids, ear molds, and other equipment intended to improve hearing except for a limited hearing aid benefit of \$600 for hearing aids every three (3) years and up to \$150 for exam(s). 3. Dentures; dental implantology 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 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 and PA when the item being replaced is one that would continue to meet your basic medical needs as determined by the Plan.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Pulmonary Rehabilitation Therapy</p>	<p>Covered Service for pulmonary rehabilitation therapy when delivered in an approved, Hospital-based pulmonary rehabilitation program under the direct supervision of a licensed therapist or pulmonologist, and each of the following conditions has been met:</p> <ol style="list-style-type: none"> 1. The pulmonary rehabilitation must be required and Medically Necessary due to a documented pulmonary (lung) condition; 2. You must have a loss of function as a result of the pulmonary condition; 3. The pulmonary rehabilitation must be significantly likely to substantially improve your functional status and result in either improved symptom control or quality of life within a period of two (2) months; and 4. The pulmonary rehabilitation must not be able to be effectively and/or safely provided in a lesser setting. 	<p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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 (<i>e.g.</i>, massage therapy). 7. 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.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Radiology	Covered Service for diagnostic radiology procedures, such as X-rays, MRI's, CT scans and PET scans.	<p>Prior Authorization required for certain services.</p> <p>You are not covered for the following radiology services:</p> <ol style="list-style-type: none"> 1. Radiology services that are considered Experimental or Investigational in nature. 2. Radiology services that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Radiology services that are not done to evaluate current health problems or symptoms (<i>e.g.</i>, screening for conditions in the absence of symptoms or significant risk factors) unless as part of the preventive health guidelines. 4. Radiology services done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Radiology services determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Reconstructive Surgery</p>	<p>Reconstructive Surgery is surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved body part. (A congenital anomaly is a defective development or formation of a part of the body, which such defect is determined by a Physician to have been presented at the time of birth.)</p> <p>Covered Service is limited to the following types of Reconstructive Surgery:</p> <ol style="list-style-type: none"> 1. Reconstructive Surgery to correct a seriously disfiguring condition resulting from accidental Injury, when: <ol style="list-style-type: none"> a) The disfigurement must have caused an anatomical functional impairment or defect and a major effect on your appearance. b) The Reconstructive Surgery is reasonably expected to correct the functional impairment or defect. c) The Reconstructive Surgery is started within one (1) year of the accidental Injury and is completed within two (2) additional years, unless delay is directly related to Medical Necessity. (For purposes of this section, psychological or emotional conditions do not constitute Medical Necessity.) 2. Reconstructive Surgery to correct a seriously disfiguring condition resulting from surgery when: <ol style="list-style-type: none"> a) The disfigurement must have occurred as a result of a surgical procedure that is otherwise a Covered benefit under the Plan. b) The disfigurement must have caused an anatomical functional impairment or defect and a major effect on your appearance. c) The Reconstructive Surgery is reasonably expected to correct the functional impairment or defect. d) The Reconstructive Surgery is started within one (1) year of the surgery or Illness which results in a seriously disfiguring condition and is completed within five (5) additional years, unless delay is directly related to Medical Necessity. (For purposes of this section, psychological or emotional conditions do not constitute Medical Necessity.) 3. Reconstructive Surgery on a Covered child to correct a seriously disfiguring condition resulting from a congenital disease or anomaly, when: <ol style="list-style-type: none"> a) The disfiguring condition has a major effect on the child's appearance. b) The Reconstructive Surgery is reasonably expected to correct the disfiguring condition. c) The Reconstructive Surgery is started within one (1) year of birth or delayed for medical reasons documented in the first year of life, until a later age. Reconstruction must be completed within five (5) years thereafter. <p>See also Breast Reconstruction for benefits for breast reconstruction surgery following a mastectomy.</p>	<p>Prior Authorization is required.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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. Procedures, services and supplies related to sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation; hormonal support for sex transformation is also excluded. 5. Reconstructive Surgery that occurs after your Coverage is no longer effective under the Plan, whether or not the surgery has been Prior Authorized. 6. The removal of benign skin lesions, growths, or skin tags primarily for Cosmetic purposes. 7. Surgery to remove excess skin, including pannus, and services of a similar nature resulting from morbid obesity surgery or severe weight loss.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Second Surgical Opinion	Covered Service for a second medical opinion from or consultation with another Provider in order to determine if a recommended treatment, surgery, service or supply is Medically Necessary. The second opinion will be at no additional cost to you beyond what you would otherwise pay for an initial medical opinion or consultation.	No Prior Authorization required.
Sexual Assault or Abuse	You are Covered for actual expenses incurred, without offset or reduction for benefit Deductibles or Coinsurance amounts, for Emergency Services sustained because you were the victim of a sexual assault or sexual abuse or an attempt to commit such offense. Covered Services include, but are not limited to, examination and testing to establish whether sexual contact did or did not occur, and to establish the presence or absence of a sexually transmitted disease or infection; and examination and treatment of injury and trauma sustained as a victim of such offense. Co-payments amounts for services received in the emergency room for sexual assault or abuse will be waived if you are a victim of such offense.	No Prior Authorization required.

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SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Skilled Nursing Facility Services</p>	<p>Covered Service for services, including room and board in a semi-private accommodation, provided at an institution operated as a skilled nursing facility to restore the health of a sick or injured Member under the care and supervision of a Physician, but only if the following conditions have been met:</p> <ol style="list-style-type: none"> 1. The services must be provided at a facility licensed by the State of Illinois and approved as a Provider or Skilled Nursing Facility under the Medicare Program and the Plan; and 2. The medical services delivered must be required to be provided by a licensed professional health personnel (<i>i.e.</i>, registered nurse or licensed physical therapist); and 3. The required medical services cannot be consistently and safely provided in a less intense setting (<i>i.e.</i>, at home or in a custodial nursing home); and 4. The medical care is required on a daily basis (at least five (5) days per week); and 5. The medical care is actually received by you; and 6. At least one of the following is a goal of the skilled nursing care: <ol style="list-style-type: none"> a) Your medical condition requires services to be provided or supervised by a professional to meet your needs, promote recovery, and ensure your medical safety following debilitation as a result of a prolonged Acute or chronic Illness. The services must be: <ol style="list-style-type: none"> i. temporary in nature; and ii. lead to rehabilitation and increased ability to function; and iii. not intended only to maintain your current level of functioning; and iv. You must continue to have documented improvement in your function during the course of your stay. b) Your medical condition requires teaching and training from skilled nursing or rehabilitation personnel on how to manage a treatment regimen. c) Even if the prognosis for your medical condition is such that partial recovery is not possible, a skilled service or nursing assessment and intervention is needed to alleviate pain or treat Acute symptoms. 	<p>Prior Authorization is required. Coverage for skilled nursing facility services is limited to services received from Tier I or Tier II providers. There is no coverage for skilled nursing facility services received from Tier III providers.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 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, 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. Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable. 5. Take-home drugs dispensed prior to your release from the skilled nursing facility. 6. Preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services. 7. Personal comfort or convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies. 8. Services and supplies which are otherwise not a Covered Benefit under the Plan. 9. Charges in connection with treatments or medications where you are either non-compliant with or are discharged from a Hospital or skilled nursing facility against medical advice.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Sleep Studies	Covered Service.	Prior Authorization is required. You are not covered for the following: <ol style="list-style-type: none"> 1. Sleep studies provided within the home. 2. Alternative therapies, such as sleep therapies.

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WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Specialty Care Services</p>	<p>Covered Service for the following specialty care services which are beyond the scope of services provided by your Primary Care Physician:</p> <ol style="list-style-type: none"> 1. Office visits for Covered Illness or Injury. 2. Inpatient and outpatient Hospital visits for Covered Services and approved stays. 3. Preventive care services and immunizations (provided in accordance with the Preventive Services section) 4. Covered office diagnostic testing. 5. Surgical procedures for Covered Services. 6. Covered injections and medications administered during an office visit. <p>Ø Note: Co-payments or Coinsurance will apply to office visits when you are seen by a Specialty Care Physician, or a covering Physician, physician assistant, nurse practitioner or nurse.</p>	<p>Some procedures performed in a Specialist's office may require Prior Authorization. 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.</p> <p>You are not covered for the following specialty care services:</p> <ol style="list-style-type: none"> 1. Specialty care services that are redundant or duplicative. 2. Specialty services, treatments or supplies that are not Medically Necessary for the treatment of an Injury or Illness or are outside generally accepted health care practice. 3. Specialty services, treatments or supplies that are otherwise not a Covered Benefit under other sections of this Plan Document. 4. Physical examinations, vaccines, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order. 5. Services or charges for which workers compensation is the primary payor. 6. Telephone, computer or Internet consultations between your Provider and you or between your Provider and another Providers; telephone assessments in general. 7. Any appointment you did not attend or failed to cancel on a timely basis.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Substance Abuse Services</p>	<p>Covered Service for reasonable and necessary treatment of alcoholism and substance or drug abuse. Covered Service for diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or an outpatient basis. Coverage for these services are the same as Coverage for any other Illness, condition or disorder.</p> <p>Covered Service for rehabilitation services on an inpatient basis.</p> <p>Covered Service for individual outpatient care visits per Member per year as appropriate for evaluation, short-term treatment and crisis intervention services with a Provider for the treatment of alcoholism and substance abuse under the same terms and conditions as Coverage for outpatient visits for the treatment of physical Illness.</p>	<p>Prior Authorization is required for inpatient substance abuse services.</p> <p>You are not covered for the following substance abuse services:</p> <ol style="list-style-type: none"> 1. Long-term or prolonged rehabilitation services in a specialized inpatient or residential facility. 2. Care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats. 3. 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. 4. 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. 5. Care in lieu of detention or correctional placement or that is required to be treated in a public facility. 6. Institutional care which is for the primary purpose of controlling or changing your environment. 7. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis. 8. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine habits or addictions. 9. An addiction to a controlled substance or cannabis that is used in violation of law.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Transplants	<p>Covered Service for Physician, Hospital, surgical and medical services for evaluation for organ and tissue transplant as well as organ or tissue procurement, acquisition, harvesting, transplantation and storage, under the following conditions:</p> <ol style="list-style-type: none"> 1. The organ or tissue transplant must be Medically Necessary and the most appropriate treatment for your medical condition. 2. The transplant must be needed to aid the function of a body organ or replace tissue lost due to Illness or Injury. 3. The transplant must be provided from a human donor to living human recipient. 4. The organ or tissue transplant must not be Experimental or Investigational in nature. 5. The organ or tissue transplant must have a high likelihood of success in treating your medical condition long term. 6. The organ or tissue transplant must be performed at a Coventry Transplant Network Participating facility approved by the Plan to perform that specific organ or tissue transplant. <p>Donor screening tests are also Covered, subject to a Lifetime benefit maximum of \$10,000 when performed at a Coventry Transplant Network Participating facility approved by the Plan.</p> <p>Ø Note: when both the donor and recipient are Covered by the Plan, each is entitled to benefits.</p> <p>Ø Note: when only the recipient is Covered by the Plan, the donor's benefits for care and complications will be limited to those not available to the donor from any other source, be charged against the recipient's Coverage under the Plan and will last only for the duration of the Coverage of the recipient when approved by the Plan.</p> <p>Ø Note: when only the donor is Covered by the Plan, the cost of any care, including complications, arising from an organ donation is excluded for both donor and recipient.</p>	<p>Prior Authorization is required. Transplant services must be performed at a Coventry Transplant Network Participating facility. There is no coverage for transplantation services received from Tier III providers.</p> <p>You are not covered for the following:</p> <ol style="list-style-type: none"> 1. Animal transplants or transplants that involve artificial or mechanical devices designed to replace human organs. 2. Organ or tissue transplants which are considered to be Experimental or Investigational or not considered to be clinically acceptable. 3. 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. 4. Organ and tissue procurement, evaluation and transplantation provided by a Provider not Participating in the Coventry Transplant Network.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
<p>Transplant Travel and Other Related Services</p>	<p>Covered Service for lodging, meal charges, and transportation of Members and living donors to and from a facility for evaluation and transplant services when the Plan is the primary insurer, an approved Coventry National Network Participating facility is used, and the Member and living donor live greater than 50 miles one way from the approved facility. The Plan complex case manager will assist the Member in coordinating travel arrangements through the corporate travel agency. Although the exact amounts of each benefit are set forth in the Plan's transplant travel policy, the transplant travel benefit includes:</p> <ul style="list-style-type: none"> ◇ Lodging ◇ Meals ◇ Air travel when the Member and living donor live greater than 150 miles one way from the approved facility ◇ Auto mileage reimbursed according to the current IRS medical mileage rates. ◇ Reasonable expenses for parking, taxi, or shuttle buses ◇ Ambulance charges otherwise Covered under the Plan ◇ Ongoing travel to the approved facility where the transplant was performed for all transplant-related services required for 12 months following discharge of the Member from the approved facility. <p>Any State or Federal regulations regarding transplants or travel benefits for transplants will supersede this benefit.</p>	<p>Prior Authorization is required.</p> <p>Limited to a Lifetime maximum of \$10,000 to be used by the Member and living donor</p> <p>You are not covered for:</p> <ol style="list-style-type: none"> 1. Car rental. 2. Travel and other related expenses incurred outside of the United States 3. Personal comfort or convenience items or services such as movies, television, telephone, barber or beauty service, guest services and similar incidental services and supplies. 4. Any other expenses not specifically outlined in the Plan's transplant travel policy.

**SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED.	AUTHORIZATION REQUIREMENTS AND LIMITATIONS.
Urgent Care	<p>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, after hours facility or convenient care clinic.</p> <p>Some examples of cases involving Urgent Care include but are not limited to:</p> <ul style="list-style-type: none"> ◇ High fever; ◇ Non-severe bleeding; ◇ Sprains <p>Your Primary Care Physician can help you determine whether your condition is urgent and/or whether you need to receive care at an alternate facility.</p> <p>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 Medically Necessary 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.</p>	

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 ayurvedic

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, ADD, ADHD, 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 trials** – any product, service or supply that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically Covered herein.
12. **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.

13. **Counseling** – services and treatment related to religious counseling or relationship counseling, vocational or employment counseling and sex counseling or therapy.
14. **Court-ordered services** – court-ordered services or services that are a condition of probation or parole.
15. **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.
16. **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 periodontitis 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.
17. **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.
18. **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.

19. **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).
20. **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 baths; 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 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.
21. **Education** – educational materials, books, videotapes; educational testing or training; vocational testing or training; educational services for remedial education, such as evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training; health education classes, such as risk-factor modification, smoking cessation, stress management and childbirth education classes.
22. **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);
23. **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.
24. **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.
25. **Experimental or Investigational** – any procedure or treatment that are determined to be Experimental or Investigational as that term is defined herein.
26. **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.

27. **Family planning** – outpatient contraceptive drugs and devices not approved by the FDA; over-the-counter contraceptives, such as foams, condoms, and spermicidal creams; 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).
28. **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.
29. **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.
30. **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.
31. **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.
32. **Hearing** – hearing aids, 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.
33. **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.
34. **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.
35. **Illegal acts** – Any expenses for medical services or supplies for the treatment of Illness or

Injury arising out of the commission or attempt to commit a Serious Illegal Act. For purposes of this section, a Serious Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed. It is not necessary that criminal charges be filed or that a sentence of imprisonment for a term in excess of one (1) year actually be imposed. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a Covered medical (including both physical and mental health) condition. It also does not apply if the expenses were incurred as a result of and related to an Injury or Illness acquired while the Member is intoxicated or under the influence of any narcotics, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.

36. **Immunizations** – immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entity whose role it is to establish eligibility guidelines and recommend preventive guidelines; immunizations where the recommended eligibility guidelines are not met; immunizations for non-health related reasons, such as for travel, education or employment; immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups; preventive services received from Tier III providers.
37. **Infertility** – non-medical costs of an egg or sperm donor; selected termination of an embryo or fetus; provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, said termination shall be Covered; costs associated with cryo preservation and storage of sperm, eggs and embryos; provided however, that subsequent procedures of a medical nature necessary to make use of the cryo preserved substance shall not be similarly excluded if deemed non-experimental and non-investigational; reversal of voluntary sterilization; (however, if voluntary sterilization is successfully reversed, Infertility benefits shall be available if the Covered Member's diagnosis meets the definition of Infertility); payment for services rendered to a surrogate; (however, costs for procedures to obtain eggs, sperm or embryos from a Covered individual shall be Covered if the individual chooses to use a surrogate); travel costs for travel within 100 miles of the Member's home address; which are not Medically Necessary; or not mandated or required by the Plan; Infertility treatments deemed Experimental or Investigational; and Infertility treatments rendered to Dependents under the age of 18 or women who are post-menopausal .
38. **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.
39. **Learning disabilities** – treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions, such as autism, except as otherwise specifically provided for herein.
40. **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.
41. **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.
42. **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.
43. **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. (This includes, but is not limited to, treatment for pervasive developmental disorders, and chronic organic brain syndrome, except that there is limited Coverage for additional outpatient visits for speech therapy for the treatment of pervasive developmental disorder up to the visit limits as set forth in your Schedule of Benefits, Coverage for psychiatric, psychological and habilitative and rehabilitative care for the treatment of persons diagnosed with autism spectrum disorder, and Coverage for habilitative services for children); 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.
44. **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.
45. **Miscellaneous charges** – telephone, computer or Internet consultations between Provider and

Member or between Provider and another Provider; telephone assessments in general.

46. **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.
47. **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.
48. **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.
49. **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.
50. **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.
51. **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.
52. **Prohibited services** -- charges for services or supplies that are prohibited by federal, state or local law.
53. **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.
54. **Replacement items** – replacement items, such as batteries, tires and light bulbs.
55. **Sex transformation** -- services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation; hormonal support for sex transformation; any changes for, related to or resulting from sex change operations; sex transformation procedures, treatments or studies.
56. **Sleep studies** – sleep studies provided within the home.
57. **Smoking cessation** – services and supplies for smoking cessation programs and treatment of nicotine addiction.
58. **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.

59. **Substance abuse** – long-term or prolonged rehabilitation services in a specialized inpatient or residential facility; 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.
60. **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.
61. **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 Coventry Transplant Network.
62. **Travel** – travel or transportation expenses, even if prescribed by a Provider, except as specifically provided for herein.
63. **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 jejunioileal bypass, biliopancreatic bypass, gastric balloon, duodenal switch, stomach stapling, wiring of the jaw and the like.
64. **Work** – work-hardening or work-conditioning programs; vocational therapy.
65. **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. Coventry Health Care 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:

- Ø Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- Ø 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 health 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:

- Ø The other plan has rules coordinating its benefits with those of This Plan; and
- Ø 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:

- Ø The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- Ø 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:

- Ø The persons it has paid or for whom it has paid;
- Ø Insurance companies; or
- Ø 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 Coventry Health Care of Illinois, 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 by telephone within one (1) business day and in writing no later than forty-eight (48) 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 has forty-eight (48) hours to provide the requested information. The Plan will make the decision within forty-eight (48) hours after the earlier of:

- 1 the receipt of the additional information; or

the end of the forty-eight (48) 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, 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 two (2) business days after the request and all necessary information are received by the Plan; and, 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-five (45) 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-five (45) 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-five (45) 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 follow the Urgent Care Claims process above.

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 Customer Service Department Monday through Friday from 8:00 a.m. to 6:00 p.m. C.S.T. at the following telephone numbers: (866) 557-8751.

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 all available levels before the Plan Participant may seek external review or other available appeal levels. **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 pre-service claims: within 15 calendar days.
- For post-service claims: within 30 calendar days.

- For Urgent Care claims: within 72 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 every level of 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.

4.Final Review by DCMS Appeal Committee

For Medical Appeals, if a Plan Participant is not in agreement with the decision made by the external reviewer, the Plan Participant may initiate one additional level of the appeal process. The Plan Administrator and DCMS are not permitted to appeal a decision by the external reviewer. An Appeal Committee appointed by the Director will review whether the external reviewer's decision is in accordance with the requirements of the Group Insurance Act and all applicable Plan guidelines.

- The Plan Participant must submit a written request to the Appeal Committee within 30 days of the decision by the external reviewer.
- The appeal committee will review the documentation presented in the appeal as well as the decision of the external reviewer.
- The Appeal Committee will consider the merits of each individual case. Information that was not presented to the plan administrator and/or the external reviewer will not be considered in the Appeal Committee's review.
- A bargaining unit employee covered under AFSCME has the option to request or decline that a designated union representative be a member of the Appeal Committee. AFSCME

shall provide the DCMS with prior notification, if applicable, of the representative who will serve as a member of the committee.

- The Appeal Committee shall issue a written decision within 30 days of the Committee's next scheduled quarterly meeting. The Plan Participant will be notified in writing of the outcome of the Appeal Committee's review. Whether or not the Appeal Committee decides in favor of the Plan Participant, the decision of the Appeal Committee shall be final and binding on all parties.

Submit Appeal Documentation to:
DCMS Benefits Deputy Director
Group Insurance Division
201 E. Madison Street, Suite 3A
P.O. Box 19208
Springfield, IL 62794-9208

For questions regarding appeal rights and/or assistance with the appeal process, a Plan Participant may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). A consumer assistance program may also be able to assist the Plan Participant. Requests for assistance from the consumer assistance program should be sent to:

Illinois Department of Insurance
100 W. Randolph St, 9th Floor
Chicago, IL 60601
(877) 527-9431

or

Illinois Department of Insurance
320 W. Washington St, 4th Floor
Springfield, IL 62727

11. HIPAA Privacy

In fulfillment of the requirements of Section 504(f)(2) of the privacy rule found in 45 C.F.R. Part 164 (the "Privacy Rule") promulgated pursuant to the federal Health Insurance Portability and Accountability Portability Act of 1996, Public Law 104-191 ("HIPAA"), the Plan provides as follows:

- 11.1** Consistent with the HIPAA Privacy Rule, persons holding positions with the Plan Sponsor or its affiliates and who have access to individually identifiable health information deemed "protected health information" ("PHI") under the Privacy Rule are identified in Section 11.2, below, and are restricted to using and disclosing PHI for Plan administrative purposes such as those described as "payment" and "health care operations" under the Privacy Rule. More particularly, such uses and disclosures may include: evaluating the Plan's claims experience; seeking proposals for insurance or reinsurance of Plan benefits; reporting to stop-loss carriers; administering case, quality and utilization management programs; determining the application of Plan provisions to

particular claims; and assisting participants and beneficiaries with the filing of claims.

11.2 The class of position within the workforce of the Plan Sponsor that may receive, use or disclose PHI for the purposes set forth in Section 11.1 is: Senior Benefit Analyst, Office of Healthcare Purchasing (OHP), Department of Healthcare and Family Services, State of Illinois.

11.3 Employees in the job functions described in Section 11.2 will have access to Plan Participants' PHI only for the purposes described in Section 11.1 (i.e., administrative functions performed for the Plan).

11.4 Participants or beneficiaries of the Plan with knowledge that:

11.4.1 employees of the Plan Sponsor, other than employees in the positions identified in Section 11.2, have used or disclosed Plan PHI;

11.4.2 employees in the positions identified in Section 11.2 have used or disclosed the PHI outside the scope of Plan administration (as more fully described in Section 11.1); or

11.4.3 employees of the Plan Sponsor have acted contrary to the Plan Sponsor covenants described in Section 11.5, below, may report such non-conforming activity to the Central Management Services Privacy Officer at the Office of the Chief Counsel, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669, the Plan's privacy contact person, who will work with appropriate Plan and Plan Sponsor personnel to correct the breach or deficiency, mitigate the effect of the breach or deficiency, and impose appropriate disciplinary sanctions.

11.5 The Plan will not disclose PHI to employees of the Plan Sponsor for the administrative purposes described herein without obtaining a certification (the "Certification") from the Plan Sponsor to the effect that the Plan Sponsor will:

11.5.1 not use or further disclose individually identifiable health information created in connection with the Plan except as required by law or for Plan administrative purposes as described in Section 11.1, above, as such administrative purposes may be amended from time to time;

11.5.2 arrange for any agents or subcontractors of the Plan Sponsor that receive PHI to use and disclose PHI consistent with the Certification;

11.5.3 not use or disclose the PHI for employment related actions or in connection with any other benefits or benefit plans;

11.5.4 report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in Section 11.1, which it becomes aware of;

11.5.5 make available to the Plan any PHI in any "designated record

set” (as such term is defined in the Privacy Rule) related to Plan participants or beneficiaries that the Plan Sponsor has control of in accordance with the access requirements of the Privacy Rule;

11.5.6 make available for amendment, to the extent required by the Privacy Rule, the PHI in a designated record set which is related to Plan participants or beneficiaries and incorporate any amendment as required by the Privacy Rule;

11.5.7 make information available to the Plan for, or provide the Plan with, an accounting of PHI disclosures (to the extent required by the Privacy Rule, e.g., other than for treatment, payment, health care operations or other exempt purposes) related to Plan participants or beneficiaries in response to such person’s exercise of his/her rights under such section;

11.5.8 make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services to assist the Secretary in determining the Plan’s compliance with the Privacy Rule;

11.5.9 where feasible, return to the Plan or destroy any PHI received from the Plan when such PHI is no longer needed by the Plan Sponsor for the purpose which permitted the Plan to make the disclosure and, where such return or destruction of PHI is not feasible, to limit its future use of the PHI to the situations that make the return or destruction of the PHI not feasible; and

11.5.10 limit access of its employees to the Plan’s PHI (other than as subjects of the PHI or subscribers to the payment), except where such employees are in job classifications which have been designated above as assisting in Plan administration and thus engaging in the use or disclosure of PHI for treatment, payment and health care operations purposes.

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 Customer Service Department 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 Customer Service Department 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”

Coventry Health Care of Illinois, 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 “Coventry 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 Coventry Health Care 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 Coventry Health Care National 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.chcillinois.com or by contacting our Customer Service Department. 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.