

## **Your HMO Plan**

**View plan documents at [YourHealthAlliance.org](http://YourHealthAlliance.org)**

**07/01/2014**





301 S. VINE ST. • URBANA, IL 61801-3347 • 800.851.3379 • 217.337.8100 • TTY: 800.526.0844 • HEALTHALLIANCE.ORG

July 1, 2014

Dear Member:

Thank you for choosing Health Alliance during the State of Illinois Benefit Choice Period. Please take some time to review this letter and the other helpful info here.

**Your Physician Network Is Key to Coverage**

Remember, your plan requires you to choose a Primary Care Physician and to see only in-network doctors. Log in at [YourHealthAlliance.org](http://YourHealthAlliance.org) to use our updated Provider Directory search. You can print or download the listing you need.

On our website, you can also check the status of a claim, view our Drug Formulary, order a new ID card and much more.

**Take a Look**

The info here gives quick, easy answers to your most common questions and explains any changes to your plan. For full details, please see the Policy we sent to you as a new member, as well as any updates we've sent since.

Please call Customer Service at 1-800-851-3379 with questions or if you need us to send you info. We also have interpreters who speak 140 languages. Just call the Customer Service number on the back of your ID card and say which language you need. You may also ask for your member info to be translated.

**Anytime Nurse Line**

When you have a health question, we're here for you—day or night. Call our 24-hour Anytime Nurse Line at 1-855-802-4612 (listed on the back of your ID card) to get help:

- Deciding if you to see a doctor right away or set up a visit.
- Coping with diabetes, asthma, high blood pressure, high cholesterol and more.
- Finding health care resources.

**Medicare Primary Members**

Members with primary Medicare coverage will pay the standard State benefit cost sharing for covered services after the Medicare payment is applied if there are remaining charges. Health Alliance will review the amount of savings the member has “banked” by having Medicare as primary, according to coordination of benefits guidelines. Those savings will be used to offset member responsibility.

**Wellness Services**

Because we know wellness services are key to staying healthy, we cover many of these services at no charge to you. Our *Be Healthy* brochure has a full list of free wellness services, including women's wellness services added this year.

To view the *Be Healthy* brochure, visit [HealthAlliance.org](http://HealthAlliance.org) and click the Health and Wellness tab. Then select "Preventive Care Benefits" under "Health and Prevention." Or call Customer Service to check coverage or have a brochure mailed to you.

We are partnering with Audax Health to create a new wellness tool for you. This tool, Rally, allows you to unlock health recommendations by answering a few simple questions. You can also earn coins for making healthy choices and use them to enter prize drawings. Look for this tool on [YourHealthAlliance.org](http://YourHealthAlliance.org) later this fall.

Thank you for choosing Health Alliance. We look forward to serving you.

Sincerely,



Angela A. Beitelman  
Director of Customer Service

enclosures

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Learn about our suite of health and wellness programs, including our online services to help you access your benefits





State of Illinois FY15

Member Benefits			Member Responsibility	
			In-Network	Out-of-Network (OON)
<b>Plan Year Deductible</b>	Medical	Individual	\$0	Not Applicable
		Family	\$0	Not Applicable
	Pharmacy	Individual	\$100	Not Applicable
		Family	Not Applicable	Not Applicable
<b>Plan Year Out-of-Pocket Maximum (OOPM)</b>				
<i>Combined medical expenses including deductibles, copayments and coinsurance</i>				
	Medical	Individual	\$3,000	Not Applicable
		Family	\$6,000	Not Applicable
<b>Contract Year Maximum Benefits</b>				
	Outpatient Rehabilitation Services		60 visits per condition per plan year	
	Inpatient Rehabilitation Services/Skilled Nursing Facility		120 days per plan year	
<b>Ambulatory Patient Services</b>				
	Vision Exam		Not Covered	Not Applicable
	Primary Care Physician Office Visits		\$20 per visit	Not Applicable
	Specialty Care Physician Office Visits		\$30 per visit	Not Applicable
	Spinal Manipulations		\$30 per visit	Not Applicable
	Urgent Care Visits		\$20 per visit	Not Applicable
	Allergy Treatment and Testing		\$0	Not Applicable
<b>Emergency Services</b>				
	Emergency Department Visits		\$250 per visit	\$250 per visit
	Emergency Ambulance Transportation		\$0	\$0
<b>Hospital Services</b>				
	Outpatient Surgery/Procedures Facility Fees		\$250 per procedure	Not Applicable
	Outpatient Surgery/Procedures Physician/Surgeon Fees		\$0	Not Applicable
	Inpatient Hospitalization Facility Fees		\$350 per stay	Not Applicable
	Inpatient Physician/Surgeon Fees		\$0	Not Applicable
<b>Rehabilitative and Habilitative Services</b>				
	Outpatient Rehabilitation Services		\$30 per visit	Not Applicable
	Inpatient Rehabilitation/Skilled Nursing Facility		\$0 per stay	Not Applicable
	Home Health		\$30 per visit	Not Applicable
<b>Diagnostic Services</b>				
	MRI and CT Scans		\$0 per service	Not Applicable
	Diagnostic Testing		\$0 per service	Not Applicable
<b>Mental Health/Substance Use Treatment</b>				
	Outpatient Office Visits		\$20 per visit	Not Applicable
	Inpatient Services		\$350 per stay	Not Applicable

Member Benefits	Member Responsibility		
		In-Network	Out-of-Network (OON)
<b>Prescription Drugs</b>			
30-day supply	Rxtra	\$0	Not Applicable
	Generic - Tier 1	\$8	Not Applicable
	Brand - Tier 2	\$26	Not Applicable
	Non-Preferred Brand - Tier 3	\$50	Not Applicable
	Preferred Specialty Pharmacy/Medical - Tier 4	\$8	Not Applicable
	Non-Preferred Specialty Pharmacy/Medical - Tier 5	\$26	Not Applicable
	Non-Formulary Specialty Pharmacy/Medical - Tier 6	\$50	Not Applicable
<b>Maternity</b>			
<i>Minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by Caesarean section.</i>	Routine Prenatal Care	\$50 per pregnancy	Not Applicable
	Maternity Inpatient	\$350 per stay	Not Applicable
	Newborn Care	\$350 per stay	Not Applicable
<b>Preventive and Wellness Services</b>			
<i>Immunizations, adult &amp; child annual physical exams, mammograms, PAP smears, prostate screening &amp; more. Age/frequency schedules apply.</i>	Wellness Care	\$0	Not Applicable
<b>Other Services</b>			
<i>Other services covered within your policy and not otherwise specified on this summary or on the SBC.</i>	Other Covered Services	\$0	Not Applicable
	Durable Medical Equipment	20%	Not Applicable

This is a brief statement of Health Alliance HMO benefits, exclusions and limitations, which are subject to change. Please refer to the Health Alliance HMO Policy booklet for more detail about your health plan. This document is in conjunction with the Summary of Benefits and Coverage (SBC). You can view your SBC online at [YourHealthAlliance.org](http://YourHealthAlliance.org) or request a copy by contacting the customer service number on the back of your ID card.



## ***Description of Coverage Text Pages***

### **Service Area**

Listed below are the counties in which Health Alliance is authorized to do business and is offering the Health Alliance HMO Plan. Service Areas is the area or counties where Health Alliance HMO is licensed to accept Members. Your Service Area is determined by the location of the Primary Care Physician you have selected.

Our HMO Service Area is listed below.

Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, DeKalb, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Franklin, Ford, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Kankakee, Knox, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, St. Clair, Saline, Sangamon, Schuyler, Scott, Shelby, Stark, Stephenson, Tazewell, Union, Vermillion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, Woodford

### **Provider Network**

Your provider network is the listing of physicians, health care facilities and other health care professionals that are Participating for your Plan. To obtain a listing of Providers in your Provider Network please log on to [www.healthalliance.org](http://www.healthalliance.org) or contact the Customer Service Department on the back of your Member Identification Card.



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## **MEMBERS' RIGHTS AND RESPONSIBILITIES**

### **Rights:**

- To receive information about Health Alliance, its services, its Providers and Members' rights and responsibilities
- To be treated with respect and recognition of your dignity and right to privacy
- To participate with contracted Providers in making decisions about your health care
- To a candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage
- To voice complaints or appeals about Health Alliance or the care provided
- To make recommendations regarding the Health Alliance Members' rights and responsibilities policies
- To reasonable access to health care

### **Responsibilities:**

- To supply, to the extent possible, information Health Alliance and its contracted practitioners and Providers need to provide care
- To follow the plans and instructions for care you have agreed on with your Providers
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To read and understand your Policy and any attached Riders or Amendments and follow the rules of membership
- To know the Providers in your network
- To notify Health Alliance in a timely manner of any changes in their status as a Member or that of any of your covered Dependents

## **INTRODUCTION**

Health Alliance HMO is a Health Maintenance Organization Plan established as a fully insured product of Health Alliance Medical Plans, Inc. (Health Alliance). The main office of Health Alliance is located at 301 South Vine Street, Urbana, Illinois 61801-3347.

This Policy, along with the Description of Coverage, Amendments and/or Riders describe the health care Plan chosen by your Group. It is important for you to read this Policy as it explains your rights, benefits and responsibilities as a Health Alliance HMO Member. As a Member, you are subject to all terms and conditions of this Policy and payment of Copayments, Coinsurance and Deductible amounts as specified on the Description of Coverage.

Health Alliance Customer Service Representatives are available to help you understand your health care Plan. We encourage you to call the number on the back of your Member Identification Card to speak with one of our representatives about your benefits.

## **HOW THE HEALTH ALLIANCE HMO PLAN WORKS**

The Health Alliance HMO Plan provides coverage for Medically Necessary health care services in exchange for your agreement to certain limitations. You are required to receive all your covered medical care from the Physicians, Hospitals and other Providers within your Provider network, also referred to as Participating Providers. You are also required to have all your medical care coordinated by your Primary Care Physician whom you select from a list of available Primary Care Physicians in your Provider Network. If your Primary Care Physician believes you require care from a specialist or other Provider, your Primary Care Physician will refer you to the appropriate Provider. In addition, Preauthorization from Health Alliance is required for some types of care.

### **Your Relationship with Your Primary Care Physician**

We want you to have an open and honest relationship with your Primary Care Physician because this Physician will direct all your health care needs. Upon enrollment, you must select a Primary Care Physician. Your child's legal representative may designate a Physician (allopathic or osteopathic) who specializes in pediatrics as his or her Primary Care Provider. The Provider Directory for your Plan is available online at [www.healthalliance.org](http://www.healthalliance.org). This Provider Directory lists Participating Providers in your Plan by specialty. If you do not have access to the internet or prefer to have a printed copy of the Provider Directory, one will be provided upon request. You may change your Primary Care Physician by calling the Customer Service Department at the number on the back of your Member Identification Card or writing Health Alliance. Please note that a change in Primary Care Physician may change your Provider network.

Female Members may select a Woman's Principal Health Care Provider, in addition to their Primary Care Physician, to provide covered services within the scope of his or her license without a referral from a Primary Care Physician. A Woman's Principal Health Care Provider must be selected from among the list of Participating Providers in your Provider Network.

### **The Relationship Between Health Alliance and Participating Providers**

Participating Providers are responsible for providing you with the services covered by this Policy. Health Alliance has contracted with Participating Providers to provide you with covered services. Health Alliance does not provide medical services or make medical treatment decisions.

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The Participating Providers are independent contractors and not agents of Health Alliance. We have not given the Participating Providers the authority to act on behalf of Health Alliance in any manner or to make any promises or representations to you on its behalf. Participating Providers are responsible for the services they provide to you, including the health care services covered under this Policy. They are responsible for the manner and skill with which those services are provided or rendered.

### **Specialty Care from Participating Providers**

If your Primary Care Physician believes specialty care is Medically Necessary, he or she will refer you to a Participating Provider in your Provider Network. Physicians, Hospitals, mental health and other health care Providers are listed in the Provider Directory for your Provider Network by specialty with addresses and telephone numbers. Your Primary Care Physician will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, your Primary Care Physician may give you a standing referral. A standing referral will be effective for either the time period or number of visits specified by your Primary Care Physician. If the specialty services needed are not available from a Participating Provider in your Provider Network, a referral from your Primary Care Physician and Preauthorization from Health Alliance are required for coverage of the specialty services. Non-Participating Provider services are covered only when a Participating Provider cannot provide the requested Medically Necessary services. Female Members may obtain services from a Participating Woman's Principal Health Care Provider without a referral from a Primary Care Physician.

### **Non-Participating Providers or Out-of-Network Coverage**

Health Alliance will not cover services rendered by a non-Participating Provider, except for Emergency Services, or otherwise specified in this Policy, unless your Primary Care Physician refers you and you receive Preauthorization from Health Alliance.

### **Continued Care Coverage with Terminating Physicians**

If your treating Physician's contract terminates, you may be eligible for coverage of continued treatment by that Physician during a transitional period if you are in an ongoing course of treatment or if you are pregnant. The following conditions must be met: the Physician termination did not involve potential harm to a patient or disciplinary action by a state licensing board, the Physician remains in your Service Area and the Physician agrees to abide by the terms and conditions of the terminating contract. You must contact the Customer Service Department at the number on the back of your Member Identification Card within 30 days of receiving the termination notice if you want coverage of continued care with a terminating Physician.

- **Ongoing Course of Treatment**

If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your Physician for a period of 90 days. The 90-day period starts on the date you receive notice from Health Alliance that your Physician's contract with Health Alliance is terminating.

- **Maternity Care**

If you are pregnant and have entered the second or third trimester of your pregnancy by the date of your Physician's termination, Health Alliance will cover continued care with that Provider through post-partum care.

### **Continued Care Coverage for New Members**

If your treating Physician is not a Participating Provider in your Service Area, you may be eligible for coverage of continued treatment during a transitional period with that Physician if you are in an ongoing course of treatment or if you are pregnant. Your Physician must agree to accept reimbursement rates similar to other Participating Providers in the Provider Network and comply with Health Alliance quality assurance requirements and policies and procedures. You must contact the Customer Service Department within 15 days of your Effective Date of coverage if you want coverage of continued care with your non-Participating Physician.

- **Ongoing Course of Treatment**

If you are in an ongoing course of treatment, Health Alliance will cover continued treatment with your treating Physician for a period of 90 days from your Effective Date of coverage. Coverage is subject to any applicable Preexisting Condition limitation.

- **Maternity Care**

If you are pregnant and have entered your second or third trimester of your pregnancy on your Effective Date of coverage, Health Alliance will cover continued care with your treating Physician through post-partum care. Pregnancy is not subject to the Preexisting Condition limitation.

## **PREAUTHORIZATION**

Your Primary Care Physician, Participating Provider or Extended Network Provider is responsible for obtaining Preauthorization from Health Alliance on your behalf. If the Preauthorization request is approved, you and the Provider who requested the Preauthorization will be notified of the effective dates and the care and services you are authorized to receive. If the Preauthorization request is denied, your Provider will be notified in writing. If the Preauthorization request is denied, the Plan will not provide coverage for the requested services.

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### **Preauthorization Procedures for Non-Urgent Care (Pre-Service Claims)**

Health Alliance will make a coverage decision and notify you or your authorized representative in writing within 15 days of receipt of the request for Preauthorization.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within five days of the request for Preauthorization. You will have 45 days to provide the requested information. Health Alliance will make a coverage decision within 15 days of receipt of the additional information or within 15 days after the end of the period given to provide the additional information, whichever is earlier.

The determination period may be extended one time for 15 days due to circumstances beyond the control of Health Alliance. Health Alliance will notify you or your authorized representative in writing of the reason for the extension.

If your Preauthorization request is denied, you may request an appeal of the denial (See “Appeal Procedures for Non-Urgent Care Decisions”). If your Preauthorization request is denied on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness and you have exhausted the internal appeals process, you also have the right to request that decision be reviewed by an independent review organization (See “External Review of Appeals”).

### **Preauthorization Procedures for Urgent Care (Pre-Service Claims)**

Health Alliance will make a coverage decision for Urgent Care within 72 hours of the request. Health Alliance will try to reach you or your authorized representative by telephone as soon as a decision has been made. You or your authorized representative will be notified in writing or electronically within three days of the coverage decision.

If additional information is needed, Health Alliance will notify you or your authorized representative within 24 hours of the request specifying what information is needed to make a decision. You will have 48 hours to provide the requested information. Health Alliance will make a decision as soon as possible, and no later than 48 hours, after receipt of the requested information.

If your Preauthorization request for Urgent Care is denied, you have the right to request an expedited internal appeal of the denial (See “Appeal Procedures for Urgent Care Decisions”). If your Physician or other health care Provider believes that the denial of coverage of health care services or the timeframe for completion of an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization.

If your Preauthorization request is denied due to treatment being experimental or investigational and your Physician certifies in writing that treatment would be significantly less effective if not promptly initiated, you may request an expedited external review of the denial at the same time you request an expedited internal appeal of the denial (See “External Review of Appeals,” “Expedited Medical Necessity Reviews”).

### **Notification of Emergency Services**

If you are admitted as an inpatient to a non-Participating Hospital or a Participating Hospital outside your Provider Network for an Emergency Medical Condition, you must notify the Customer Service Department at the number listed on the back of your Member Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

## **COVERAGE DECISIONS**

### **Concurrent Care Decisions**

Any reduction or termination before the end of an approved period of time, length of stay or number of treatments is considered a denial of coverage. You will be notified in writing at a time sufficiently in advance of the reduction or termination to allow you or your authorized representative to request an internal appeal of the concurrent care decision and to obtain a determination on review before the coverage is reduced or terminated (See “Appeal Procedures for Concurrent Care Decisions”).

If your Physician or other health care Provider believes that the denial of coverage of health care services or the timeframe for an expedited internal review would jeopardize your life, your health or your ability to regain maximum function, you have the right to request an expedited review by an independent review organization. If the denial of coverage is based on the determination that the required treatment is experimental or investigational and your health care Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited review by an independent review organization (See “External Review of Appeals,” “Expedited Medical Necessity Review”).

### **Coverage Decisions (Post-Service Claims)**

Health Alliance will make a coverage decision within 30 days of receipt of a claim for payment or reimbursement of health care services that have already been provided. When any services are denied, you or your authorized representative will be notified in writing.

If the Plan needs additional information to make a decision, Health Alliance will advise you or your authorized representative of the specific information needed within 30 days of receipt of the claim. You will have 45 days to provide the requested information. Health Alliance will



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make a decision within 15 days of receipt of the additional information or within 15 days after the end of the period given to provide the additional information, whichever is earlier.

The determination period may be extended one time for 15 days due to circumstances beyond the control of Health Alliance. You or your authorized representative will be notified in writing of the reason for the extension.

If your claim for coverage is denied on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness, you have the right to request an internal review of the denial (See “Appeals Procedures for Coverage Decisions Post-Service Claims”). If you have exhausted the internal appeals process, you have the right to request an external review by an independent review organization. (See “External Review of Appeals”).

**ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE**

Individuals must meet the following requirements to be eligible for coverage under the Plan:

**The Policyholder**

The Policyholder must be a bona fide employee, regularly employed on a permanent basis by the Group, who enrolls under his or her Group’s health Plan with Health Alliance. A Policyholder must live or work in the Service Area of the Group’s Plan and is subject to all terms and conditions of the Group Enrollment Agreement.

**Dependent**

A Dependent may be eligible to enroll under the Group’s Health Alliance Plan for coverage if he or she lives within the Service Area and has one of the following relationships to the Policyholder:

- Your Legal Spouse
- Your natural-born or legally adopted child, or stepchild.
- A child for whom you or your Legal Spouse are the court-appointed legal guardian
- A child placed for adoption with you or your Legal Spouse. Placement or placed for adoption means you assume and retain total or partial support of the child in anticipation of an adoption. If the child’s placement for adoption terminates, upon termination the child will no longer be eligible for benefits under the Plan.

Examples of Dependents who are not eligible for coverage under the Plan, include but are not limited to, foster children, grandchildren (unless you are the legal guardian), parents and other relatives.

A person is not an eligible Dependent if on active duty in the armed forces of any country or if covered under the Plan as an employee.

Any child covered must be under the age of 26. The only exception is if it states otherwise in the Group Enrollment Agreement or the child is under the age of 30, is a veteran and Illinois resident who served in the Armed Forces of the United States (but did not receive dishonorable discharge).

To be able to get coverage, the Dependent must turn in to Health Alliance an approved form by the Illinois Department of Veterans’ Affairs that states the date when he or she was released from service.

For a Dependent to continue being covered by this Plan after his or her 26th, birthday, the Dependent:

- Must have an apparent handicapped condition that does not allow him or her to stay employed
- Be Totally Disabled and dependent on his or her parent (or other care providers) for lifetime care and supervision.

To continue coverage for the Dependent, you must submit documentary proof the disability and dependency when Health Alliance or your employer asks for it. These requests will be made no more than once a year from the date when Health Alliance was first notified of the child’s disability and dependency.

**Initial Enrollment**

If you meet the requirements stated in the “Policyholder” or “Dependent” subsections and you also meet the Group’s eligibility requirements, you may enroll by submitting a completed Group application form to your employer within 31 days of your eligibility date.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in case of a minor is required to reimburse Health Alliance for any and all sums paid on his or her behalf for health care services together with any reasonable attorneys’ fees and expenses incurred in collection of such sums.

**Effective Date**

The Effective Date of coverage under this Plan depends on the Group’s eligibility requirements. The eligibility requirements are specified in the Group Enrollment Agreement between the Group and Health Alliance. Coverage under this Policy begins on the Effective Date shown on the Description of Coverage, and remains in effect for the term specified in the Group Enrollment Agreement,

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unless canceled or terminated at an earlier date by you, your Group or Health Alliance.

### **Newborns, Adopted Children or Children Placed for Adoption**

If you are paying premiums for individual coverage (employee only), your newborn child is covered only if you submit a Group application form to your employer within 31 days of the birth. If you are paying premiums for Family Coverage, your newborn child is covered for the first 31 days of life. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed Group application form to your employer within 31 days following the birth. If no additional premium is due, a completed Group application form must be submitted to your employer within 31 days following the birth. Coverage for a newborn will include Medically Necessary care for illness, Injury, congenital defects, birth abnormalities and premature birth. A newborn of a Dependent child is not covered.

If you adopt a child, serve as a child's legal guardian or a child is placed for adoption, coverage is subject to the submission of written documentation, including the signature of the judge on a final order of adoption, guardianship or placement for adoption, accompanied by a completed Group application form within 31 days from the date of the order.

Premiums for coverage of a newborn, adopted child or child placed for adoption will be payable from the date of eligibility and must be paid within 31 days from the date your request for coverage is received. Group application forms are available through your employer.

### **Qualified Medical Child Support Order**

The term "Qualified Medical Child Support Order" means an order that creates or recognizes the Dependent's right to receive benefits under this Plan. A support order may be issued by a state court or through a state administrative process. If the Policyholder has a Dependent child and your Group receives a Medical Child Support Order Notice identifying the child's right to enroll in the Plan, your employer will notify both the Policyholder and the Dependent that the order has been received. The notification will also indicate the procedure for determining whether the Medical Child Support Order is qualified.

Your employer will notify you whether the Dependent is eligible for coverage within 31 days of receipt of the order. If the Group offers more than one Plan option, the Dependent will be enrolled in the same Plan in which the Policyholder is enrolled. The Dependent's eligibility for enrollment will be under the same terms and conditions as other Dependents of the Plan. Your employer does not need approval from you to add a Dependent to the Plan. Children covered under a Qualified Medical Child Support Order and who reside in a Health Alliance Service Area that is different from the Health

Alliance Service Area of the Policyholder will receive the same covered benefits as the Policyholder when utilizing contracted Providers in the Dependent's Health Alliance Service Area and following the Plan's requirements.

The Dependent may designate another person, such as a custodial parent or legal guardian, to receive the Policy, Description of Coverage, reimbursement for claims, explanation of benefit forms and other Plan materials.

If your employer decides that the order is not a Qualified Medical Child Support Order, each Dependent specified in the order as entitled to enroll in the Plan may submit a written appeal to the employer. The employer is required to respond in writing within 31 days of receiving the appeal.

The Group will not disenroll or discontinue coverage for any child until:

- Satisfactory written evidence is provided that the order is no longer effective.
- Comparable coverage through another plan will take effect no later than the disenrollment date.
- The Group eliminates Dependent coverage for all Policyholders.
- The Group terminates the Plan for all Members.

Enrollment of a Dependent in response to a Qualified Medical Child Support Order must be made according to the specifications of the order, without regard for normal enrollment dates.

### **Open Enrollment**

A Group may have an Open Enrollment Period where eligible employees and their eligible Dependents may enroll in the Plan by submitting a completed Group application form to your employer within 31 days of the Group's renewal date. Individuals who enroll under an Open Enrollment Period may be considered Late Entrants if they did not previously enroll when initially eligible. Refer to the "Preexisting Condition Limitation" section of this Policy to see if you are subject to a limitation period.

### **Late Entrant**

A Group may allow employees and their eligible Dependents to enroll as Late Entrants (see "Terms" Late Entrant). Eligible employees and their Dependents may enroll by submitting a completed Group application form to your employer within 31 days of the Group's eligibility date. Coverage is effective the first of the month following the receipt of the Group application form. Refer to the "Preexisting Condition Limitation" section of this Policy to see if you are subject to a limitation period.

### **Special Enrollment**

Federal law describes special enrollment provisions, which establish a period of time in which you have the option to

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enroll in the Plan when you or your Dependents experience a special enrollment event. Individuals who are eligible for special enrollment are not considered Late Entrants.

You and your Dependents are eligible for a special enrollment period of 31 days when one of the following special enrollment events occurs:

- If you acquire a new Dependent through marriage or a civil union partnership you may enroll yourself and/or your new Legal Spouse and eligible Dependents in the Plan.
- If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Legal Spouse, the newborn or newly adopted child and any other eligible Dependent children not currently enrolled in the Plan.
- If you and/or your Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours or termination of employer contributions you and your eligible Dependents may enroll in the Plan.
- If you have other coverage (such as a plan offered by your Legal Spouse's employer) and you lose coverage as a result of a special enrollment qualifying event (such as death, legal separation, divorce), you and your eligible Dependents may enroll in the Plan.
- If you or your eligible Dependents exhaust COBRA continuation or state continuation coverage, you and your eligible Dependents losing coverage may enroll in the Plan.
- If you are enrolled in another plan option offered by your employer and you have reached the Lifetime Maximum on that plan option, you and your eligible Dependents may enroll in the Plan.

To be eligible to enroll under one of these special enrollment events, you must submit a written request to Health Alliance requesting changes in your coverage within 31 days of the event. Any request to add yourself or eligible Dependents after the 31 day period will not be granted. You may be required to provide supporting documentation for the change in enrollment.

The Effective Date of coverage of you and your Dependent added through one of these special enrollment events is the date of the special enrollment event.

You and your Dependents are eligible for a special enrollment period under another employer-sponsored Group health plan if you are no longer eligible for the Plan because you cease to live or work in the Service Area and there is no other benefit plan option available under the Plan.

You and your Dependents are eligible for a special enrollment period of 60 days when one of the following special enrollment events occurs:

- If you are eligible for coverage but not enrolled in this Plan and you or your Dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you and your eligible Dependents may enroll in the Plan.
- If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you and your eligible Dependents may enroll in the Plan.

To be eligible to enroll under one of these special enrollment events, you must submit a written request to Health Alliance requesting changes in your coverage within 60 days of the event. Any request to add yourself or eligible Dependents after the 60-day period will not be granted. You may be required to provide supporting documentation for the change in enrollment.

The Effective Date of coverage for you or your Dependents added through one of these special enrollment events is the first day of the month following receipt of the special enrollment request.

### **Coverage During an Approved Family or Medical Leave of Absence**

If your Plan meets the Group size criteria and your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may, during the continuance of the approved FMLA leave, continue coverage under the Plan for yourself and your eligible Dependents.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contributions and you fail to do so.
- The date the Group determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues.

Coverage for a Dependent will not be continued beyond the date it would otherwise terminate. If your coverage terminates because your approved FMLA leave is deemed terminated by the Group, you may be eligible for continuation coverage under COBRA. If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for continued coverage on the same terms as an employee actively at work.

If you return to work following the date your Group determines the approved FMLA leave is terminated, your

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coverage under this Plan will be in force as though you had continued active employment rather than going on an approved FMLA leave provided you make a request for such coverage within 31 days of the date your Group determines the approved FMLA leave is to be terminated. If you do not make such a request within 31 days, coverage will be effective under this Policy only if and when the Group gives written consent.

### **Coverage During Qualified Military Service**

A Policyholder absent from work due to qualified military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, may elect to continue the type of coverage in effect on the day immediately prior to the start of the leave. This right applies only to employees and their Dependents covered under the Plan before leaving for military service.

- Such coverage will continue until the earlier of the following occurs:
  - (1) The 24-month period beginning on the date the Policyholder's absence begins, or
  - (2) The day after the date on which the Policyholder was required to apply for or return to a position of employment and fails to do so.
- A Policyholder who elects to continue health plan coverage may be required to pay up to 102 percent of the full contribution under the Plan, except a Policyholder on active duty for 30 days or less cannot be required to pay more than the Policyholder's share of the contribution, if any, for the coverage.
- Any exclusion or any waiting period under the Plan may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If a Policyholder decides to waive coverage during the qualified military service and returns to employment following the leave, prior Plan coverage will be reinstated immediately upon re-employment if the Policyholder reports to work within the required timeframes established under USERRA and appropriate documentation is provided upon request.

## **PREEXISTING CONDITION LIMITATION**

If you do not have the necessary Creditable Coverage and health care expenses are incurred in connection with a Preexisting Condition, you may be subject to a Preexisting Condition limitation. Coverage for a Preexisting Condition is limited to 50 percent of covered medical expenses, unless otherwise specified on the Description of Coverage. The Copayment or Coinsurance for such services will not apply to your Out-of-Pocket Maximum. If you are pregnant, your pregnancy is not subject to a Preexisting Condition limitation.

Newborns, adopted children and children placed for adoption and/or Members age 19 and younger are not subject to a Preexisting Condition limitation provided they meet the eligibility requirements stated in the "Eligibility, Enrollment and Effective Date of Coverage" section.

### **The Preexisting Condition Limitation Period**

If you are eligible to enroll in the Plan as a new employee or Dependent during an Open Enrollment period or a special enrollment period and you have a Preexisting Condition you may be subject to the limitation during the first 12 consecutive months after coverage is effective. If you enroll as a Late Entrant and you have a Preexisting Condition you may be subject to the limitation during the first 18 consecutive months after coverage is in effect.

It is your responsibility to supply your employer with documentation of Creditable Coverage for you and any Dependents. If you do not provide documentation or the documentation suggests a break in coverage of 63 days or more, you will be notified in writing of the Preexisting Condition limitation period that has been applied to you and your Dependents. The notification will include steps on how you can provide documentation of Creditable Coverage. Upon receipt of additional Creditable Coverage documentation, the length of the Preexisting Condition limitation period may be reduced or eliminated, depending on the amount of Creditable Coverage you have from another health plan. Health Alliance will send you written notification of any change in the Preexisting Condition limitation period.

You have a right to request a Certificate of Creditable Coverage from the prior Group health plan or health insurance issuer if necessary to properly establish the period of Creditable coverage. You may request a Certificate of Creditable Coverage within 24 months after losing coverage. Your employer will assist you in obtaining this certificate if requested. You will be provided a Certificate of Creditable Coverage from this Plan if you request one either before losing coverage or within 24 months of coverage ceasing.

## **OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS**

### **Copayments, Coinsurance and Deductible**

In no event will any single Copayment or Coinsurance amount exceed 50 percent of the Usual, Customary and Reasonable (UCR) charge determined by Health Alliance for a specific Basic Health Care Service. Copayments and Coinsurance applicable to non-Basic Health Care Services are not subject to this limitation. For purposes of this subsection, a UCR charge is a charge that is not more than the normal level of charges made by Providers for covered medical services in a geographic area. Health Alliance will determine the UCR charges. Basic Health Care Services are: emergency care, inpatient Hospital and Physician care, Outpatient medical services, mental health care and Substance Abuse treatment.

All Copayment, Coinsurance and Deductible amounts are specified on the Description of Coverage. Any Coinsurance for services from Participating Providers is based on the amount the Participating Provider has agreed with Health Alliance to accept as full payment for the service, which is referred to as the discounted or allowed amount.

### **Out-of-Pocket Maximum**

The Out-of-Pocket Maximum amount for an individual and family is specified on the Description of Coverage. This is the maximum amount you are required to pay in Copayments and Coinsurance for Basic Health Care Services during the Plan Year.

Any Copayment or Coinsurance amount for Basic Health Care Services exceeding the Out-of-Pocket Maximum will be waived for the remainder of the Plan Year.

Any Copayments, or Coinsurance for non-Basic Health Care Services that are not applied to your Out-of-Pocket Maximum are specified on the Description of Coverage. Payments for non-covered items or services and amounts over the Usual, Customary and Reasonable do not apply to your Out-of-Pocket Maximum.

### **Plan Year Maximum Benefit**

The Plan Year Maximum Benefit is the total benefit amount for an individual on specific non-Essential Health Benefits and is specified on the Description of Coverage. This is the maximum amount the Plan will pay for the specified medical services during the Plan Year. You must reimburse the Plan for any amounts exceeding the Plan Year Maximum that the Plan pays on your behalf.

### **Lifetime Maximum Benefit**

The Lifetime Maximum Benefit is the total benefit amount for an individual on specific non-Essential Health Benefits and is specified on the Description of Coverage. This is the

maximum amount the Plan will pay for the specified medical services in a Lifetime. You must reimburse the Plan for any amounts exceeding the Lifetime Maximum that the Plan pays on your behalf.

## **PREMIUMS**

### **Payment of Premiums**

Payment of premiums must be made as follows: you, or anyone paying on your behalf, for example your Group, must remit the specified premium to Health Alliance monthly. You are entitled to the benefits of this Policy only if Health Alliance receives the full amount of the premium within the required time period.

### **Premium Rate Revision**

The monthly premium rate will be effective for the balance of the Plan Year and will be subject to change annually upon the Group's renewal date. Rates may also be subject to change during a Plan Year due to a change in age, number of eligible Dependents or Medicare status. Notice of such change in the premium rate will be provided to the Group not less than 31 days prior to the effective date of the change.

Health Alliance reserves the right to change the premium rate for a Group if state or federal laws require a change in benefits or other terms of coverage. Written notice will be provided to the Group not less than 31 days prior to the premium rate change.

### **Premium Due Date**

The first monthly premium must be paid on or before the Effective Date of this Policy and the succeeding premiums must be paid on or before the due date, subject to the grace period provisions.

### **Grace Period**

If you or anyone paying on your behalf fails to pay the premium within 31 days after it becomes due, this Policy is automatically canceled and you will not be entitled to further benefits. During the grace period, the Group will remain liable for the payment of the premium for the time coverage was in effect. The Policyholder will remain liable for the payment of any applicable share of the premium for the time coverage was in effect, as well as for any Copayment or Coinsurance owed because of services received during the grace period.

### **Unpaid Premiums**

Any premium due and unpaid or covered by any note or written order will be deducted from the payment of a claim under this Policy.

### **Reinstatement**

In the event the premiums are not paid within the time granted, including any grace period, and coverage is

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terminated, reinstatement of coverage under this Policy is subject to approval by Health Alliance and advance payment of any overdue premiums.

## WHAT IS COVERED

**The following health care services covered under this Policy subject to the Copayments, Coinsurance, Deductibles and Lifetime Maximum and Plan Year Maximum benefits specified on the Description of Coverage.** Expenses for health care services, including Basic Health Care Services, are covered only if your Primary Care Physician or a Participating Provider considers the service to be Medically Necessary for the treatment, maintenance or improvement of your health. Some health care services are subject to Preauthorization by Health Alliance.

Medical policies have been developed as a guide for determining Medical Necessity. These medical policies provide the criteria to be met before coverage is provided for some health care services covered under this Policy. Medical policies are available on the Health Alliance website, [www.healthalliance.org](http://www.healthalliance.org) under “Medical and Pharmacy Policies,” or you can request a paper copy of a medical policy by contacting the Customer Service Department at the number listed on the back of your Member Identification Card.

Diagnostic and treatment services from non-Participating Providers are covered only when your Primary Care Physician refers you and the services are Preauthorized by Health Alliance, except as stated in the “Emergency Services” subsection.

If you are unsure whether a diagnostic test or treatment will be covered, call the Customer Service Department at the number listed on the back of your Member Identification Card to verify coverage and Preauthorization requirements prior to receiving services.

### **Additional Surgical Opinion**

A consultation with a board certified surgeon is covered after you receive a recommendation for surgery. If a second opinion does not confirm the primary surgeon’s opinion, a third opinion is covered. If your Primary Care Physician or treating specialist recommends a second or third opinion with a Provider outside your Provider Network, a referral and Preauthorization from Health Alliance is required.

### **Ambulance**

**Air Transportation** – Emergency transportation by air ambulance is covered for an Emergency Medical Condition when Medically Necessary. Air ambulance services are not covered when you could be safely transported by ground ambulance or by means other than by ambulance.

**Ground Transportation** – Emergency transportation by ground ambulance is covered for an Emergency Medical Condition when Medically Necessary.

### **Amino-Based Elemental Formulas**

Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome are covered when prescribed by a Physician as Medically Necessary (See also Durable Medical Equipment and Home Infusion Services).

### **Autism Spectrum Disorders**

The Medically Necessary diagnosis and treatment of Autism Spectrum Disorders for Members under the age of 21 are covered. “Autism Spectrum Disorders” means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association, including Autism, Asperger’s disorder, and pervasive developmental disorder.

Treatment includes Medically Necessary direct, consultative or diagnostic psychiatric care, direct or consultative psychological care, habilitative or rehabilitative care and therapeutic care:

- Habilitative or rehabilitative care includes counseling and treatment programs intended to develop, maintain, and restore the functioning of a Member under the age of 21 who has been diagnosed with Autism Spectrum Disorder.
- Therapeutic care for Autism Spectrum Disorders includes behavioral, speech, occupational, and physical therapies addressing self-care and feeding; pragmatic, receptive, and expressive language; cognitive functioning, applied behavioral analysis, intervention, and modification; motor planning, and sensory processing.

Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders 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. Coverage for Medically Necessary early intervention services must be delivered by a certified early intervention specialist.

Services provided that are not directly related to the treatment of autism are not applied to the Autism Spectrum Disorders annual benefit. The Outpatient Rehabilitation Services Plan Year Benefit limit does not apply to the Autism Spectrum Disorders benefit.

### **Bariatric Surgery for Severe Obesity**

Bariatric surgery for severe obesity is covered for select procedures determined by Health Alliance to have significant

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published experience on long-term results for the treatment of severe obesity for patients who have documented failure of Physician supervised, non-surgical weight loss consisting of dietary therapy, appropriate exercise, behavior modification, psychological support and who meet Medical Necessity criteria. The Physician must have documented the Member’s demonstrated knowledge and compliance with lifelong diet, exercise, and behavioral changes necessary for successful maintenance of weight loss surgery.

Subsequent related surgery is covered when Medically Necessary to treat complications from a covered surgery. Subsequent surgery because of failure to achieve or maintain long-term weight loss may not be covered. Coverage is limited to individuals age 18 and older at the time of surgery.

**Blood**

Blood and blood products are covered when determined to be Medically Necessary by your Primary Care Physician. Costs related to the administration and procurement of blood and blood components are also covered, including the processing and storage of blood you donate yourself.

**Cancer Clinical Trials**

During an approved clinical cancer trial, routine patient care that is administered to the Member as defined in this Policy is covered unless the service or item is covered by the clinical trial directly. Each covered service is subject to the Deductibles, Copayments or Coinsurance amounts specified on the Description of Coverage. This coverage includes clinical trials phases II, III and IV. For coverage of a phases II, III, or IV clinical trial, the trial must be approved by one of the follow agencies: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs or the United States Department of Energy as well as be pre-authorized by Health Alliance.

**Contraceptive Drugs, Devices and Services**

Federal Drug Administration (FDA) approved prescription Contraceptive devices, injections, procedures and services are covered.

Devices and the medical fitting and insertion of devices for Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to IUD’s, diaphragms, cervical caps or Implanon®. Additional charges billed will apply to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage.

Injectibles and the injection intended for female Contraceptive purposes only are covered under the wellness benefit. This includes but is not limited to DepoProvera®. Additional charges billed will apply to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage.

Sterilization procedures, intended for female Contraceptive purposes are covered under the wellness benefit. Additional charges billed will apply to the appropriate Deductible, Copayment or Coinsurance as specified on the Description of Coverage. Also see under “What is Covered” Sterilization Procedures.

Prescription Contraceptive Services as specified in this section that are prescribed or recommended to treat medical conditions and are not used for Contraceptive purposes or for unintended pregnancy for females are not considered wellness and are subject to the Prescription Contraceptive Device/Injectible Deductible, Copayment or Coinsurance as specified on Description of Coverage.

Prescription Contraceptives, including but not limited to, Contraceptive pills, patches, the ring, are not covered unless otherwise specified in a Rider attached to this Policy.

**Dental Services**

Hospitalization for dental work will be covered for children age six and under, individuals with a medical condition that requires hospitalization or general anesthesia for dental care or individuals who are disabled when Preauthorized by Health Alliance. (See “Oral Surgery” in this section for other covered services.)

**Diabetic Equipment and Supplies**

Blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices are covered subject to the durable medical equipment Coinsurance amount specified on the Description of Coverage. The diabetic equipment listed in this subsection must be obtained from a Participating Provider and prescribed in writing by a Participating Physician. Diabetic equipment not listed in this subsection requires Preauthorization by Health Alliance.

**Diabetic Self-Management Training and Education**

Outpatient self-management training and education for the treatment of all types of diabetes and gestational diabetes mellitus are covered when Medically Necessary and provided by a qualified Participating Provider.

**Diagnostic Testing**

Diagnostic testing, including but not limited to, X-ray examinations, laboratory tests and pathology services are covered when ordered by a Participating Provider.

**Dressings and Supplies**

Dressings, splints, casts and related supplies are covered when Medically Necessary and when administered by a Participating Provider or by a nurse or other health care professional under the direction of a Participating Provider.

**Durable Medical Equipment and Orthopedic Appliances**

Corrective and orthopedic appliances (such as leg braces and

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knee sleeves) and durable medical equipment for home use (such as wheelchairs, surgical beds and oxygen equipment) are covered when Medically Necessary due to an Injury, illness or medical condition. Items and supplies provided under this subsection must be prescribed by a Participating Physician and Preauthorized by Health Alliance. Health Alliance determines whether the equipment is made available through rental or purchase agreements. A maximum benefit limit may apply. Costs associated with the repair of covered equipment are covered if Health Alliance determines the equipment has been properly maintained. Ostomy supplies are covered, but other disposable supplies are not covered.

To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount under this benefit. Coverage can be verified by calling the Customer Service Department at the number listed on the back of your Member Identification Card.

### **Emergency Services**

Emergency Services received inside or outside your Provider Network for an Emergency Medical Condition are covered. In an emergency, seek immediate care or call 911 if it is available in your area. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The Emergency Services Copayment or Coinsurance is waived if you are admitted to the Hospital when your Plan requires an inpatient Hospital Copayment or Coinsurance. Elective care or care required as a result of circumstances which could reasonably have been foreseen prior to leaving your Provider Network is not covered. Unexpected hospitalization due to complications of pregnancy is covered.

If you receive Emergency Services either inside or outside the Provider Network for an Emergency Medical Condition, you or someone acting on your behalf must notify the Customer Service Department at the number listed on the back of your Member Identification Card within 48 hours, or as soon as reasonably possible, after care begins.

### **Erectile Dysfunction**

Treatment is covered for males with documented erectile dysfunction without a correctable cause. A maximum benefit limit may apply. Medications are not covered unless an Outpatient Prescription Drug Rider with an erectile dysfunction benefit is attached to this Policy.

### **Hearing Evaluations**

Hearing evaluations performed by Participating Providers are covered. Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered.

### **Home Health Services**

Intermittent skilled nursing and skilled therapeutic home services are covered when you are homebound and the services are given under the direction of a Participating Physician and Preauthorized by Health Alliance.

### **Home Infusion Services**

Home infusion services, including medication and supplies, are covered when given under the direction of a Participating Physician and Preauthorized by Health Alliance.

### **Hospice Care**

Hospice care program charges are covered when ordered by the Member's Primary Care Physician or treating specialist and Preauthorized by Health Alliance. For purposes of this subsection, hospice care program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Member and the Member's family, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. Hospice refers to a program that meets the following requirements:

- It must be licensed by the laws of the jurisdiction where it is located and must be operated as a Hospice as defined by those laws.
- It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a Physician, are expected to live less than twelve months as a result of that illness.
- It must be administered by a Hospital, home health agency or other licensed facility.

### **Hospital Care**

Hospital services are covered for an unlimited number of days when hospitalization is ordered by and provided by a Participating Provider. Coverage is limited to a semi private (two bed) accommodation, unless a medical condition warrants otherwise. Hospital admissions, including mental health and Substance Abuse, require Preauthorization by Health Alliance.

If you are hospitalized prior to your Effective Date, coverage begins on your Effective Date. Expenses incurred prior to your Effective Date are not covered under this Plan.

### **Human Organ Donor**

If a Member is the recipient of the living human organ donation, coverage at a Health Alliance approved facility is provided for the donor beginning with the evaluation and



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ending one year after surgical removal of the organ even if the donor is not a Member. Coverage includes complications related to the surgical removal of the donated organ. Donor charges are applied to the recipient's benefits.

If the recipient of the living human organ donation is not a Member, there is no coverage for a Health Alliance Member who is the living human organ donor beginning with the transplant evaluation and ending one year after surgical removal of the living human organ including complications related to the surgical removal of the donated organ.

Members will be covered for complications related to the surgical removal of the donated organ beginning one year from the date of surgical removal of the donated organ.

### **Human Organ Transplant**

Human organ transplants are covered for non-experimental organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, upon prior order and written referral of a Member's Primary Care Physician or treating specialist, and upon the findings of a Medical Director that the recommended treatment is Medically Necessary and is not excluded from coverage under any other sections of this Policy. Transplants must be performed at a Health Alliance approved facility. Coverage for benefits under this subsection begins with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and through one year after transplant. Office visit and Hospital Care Copayments, Coinsurance or Deductible applies as specified on the Description of Coverage.

Organ and tissue procurement is covered. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.

The Plan covers transportation, lodging and meals for the transplant recipient and a companion for travel to and from the Health Alliance designated transplant center. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.

### **Mandibular and Maxillary Osteotomy**

A mandibular or maxillary osteotomy is covered only if you have significant functional problems that have not been corrected with dental and/or orthodontic treatment.

### **Maternity Care**

Services rendered by the attending obstetrician or family practitioner during the course of a pregnancy are covered subject to the Routine Prenatal Care Copayment or Coinsurance specified on the Description of Coverage. Medical care, consultation or services rendered by a specialty care Provider, or a Provider other than the

attending Physician during the course of the pregnancy is not considered routine prenatal care and is subject to additional applicable specialty care office visit Copayments or Coinsurance as specified on the Description of Coverage.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section are covered for the Member and the newborn. Your Primary Care Physician, Woman's Principal Health Care Provider or attending Physician, may determine after consultation with you that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of your Physician, 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 is also covered. Routine prenatal care or delivery at 36 weeks or greater are not covered if you are outside your Provider Network unless you are outside of your Provider Network due to circumstances beyond your control.

Coverage for the properly enrolled newborn is provided subject to any applicable newborn care Copayment, Coinsurance and Plan Year Medical Deductible amount specified on the Description of Coverage.

Lactation counseling and/or support and the rental or purchase of a breast pump is covered during pregnancy and through the postpartum period under the Plan's wellness benefit.

### **Medical Social Services**

Medical social services, including Hospital discharge planning and assistance in accessing community service agencies and other related services, are covered when you are coping with a medical condition.

### **Medical Specialty Prescription Drugs**

Specialty Prescription Drugs are defined as any prescription drugs, regardless of dosage form, which require at least one of the following in order to provide optimal patient outcomes, and are identified as a Specialty Prescription Drug on the Health Alliance Drug formulary:

- (1) specialized procurement handling; distribution; or is administered in a specialized fashion;
- (2) complex benefit review to determine coverage;
- (3) complex medical management; or
- (4) FDA-mandated or evidence-based medical guideline determined comprehensive patient and/or Physician education.

Medical Specialty Prescription Drugs are covered under this Policy subject to a prior written order by your Physician and Preauthorization by Health Alliance. Medical Specialty

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Prescription Drugs are those Specialty Prescription Drugs received in the Physician's office and/or are administered by a healthcare professional in an office or other healthcare setting. Coverage for Specialty Prescription Drugs is subject to the Deductibles, Copayments or Coinsurance specified on the Description of Coverage.

Pharmacy Specialty Prescription Drugs are not covered unless otherwise specified in an Outpatient Prescription Drug Rider attached to this Policy.

To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Prescription Drugs and the medical conditions for which they are approved for coverage. Coverage can be verified by calling the Customer Service Department at the phone number listed on the back of your Member Identification Card or at our website [www.healthalliance.org](http://www.healthalliance.org).

### **Mental Health Care**

Mental health care services for short-term Medically Necessary treatment and/or crisis intervention are covered as specified on the Description of Coverage. Care in a day Hospital program or intensive Outpatient program are subject to the Inpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage. Inpatient mental health services require Preauthorization except in emergency situations.

Outpatient mental health care visits including group Outpatient visits are subject to any Outpatient mental health Deductibles, Copayments or Coinsurance as specified on the Description of Coverage.

The services may be provided by a Participating Physician, a registered clinical psychologist, or by an ancillary mental health professional under the supervision of a Physician or registered clinical psychologist.

Services not covered include care provided by a non-Participating Provider for serious mental health conditions or non-licensed mental health professional, care in lieu of detention or correctional placement, care in residential facilities and marriage or social counseling.

Services with a non-Participating Provider are covered for non-serious mental health conditions as described on the Description of Coverage.

Non-serious mental health conditions mean those mental health illnesses that are not one of the following serious mental illnesses as defined in the most current edition of the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association:

- schizophrenia
- paranoid and other psychotic disorders
- bipolar disorders (hypomanic, manic, depressive, and mixed)
- major depressive disorders (single episode or recurrent)
- schizoaffective disorders (bipolar or depressive)
- pervasive developmental disorders
- obsessive-compulsive disorders
- depression in childhood and adolescence
- panic disorder
- post traumatic stress disorders (acute, chronic or with delayed onset)
- anorexia nervosa and bulimia nervosa

### **Oral Surgery**

Oral surgical procedures are covered in connection with the following limited conditions:

- Traumatic Injury to sound natural teeth for Medically Necessary non restorative services within 30 days of Injury.
- Traumatic Injury to the jaw bones or surrounding tissue within 30 days of the Injury.
- Correction of a non dental pathological condition such as cysts and tumors.

### **Orthotics**

Specially molded and custom-made orthotics are covered when prescribed by a Physician and Preauthorized by Health Alliance. The durable medical equipment and orthopedic appliance Copayment or Coinsurance amount as specified on the Description of Coverage applies. Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure are covered.

### **Physician Services**

Diagnostic and treatment services and wellness services provided by a Physician or under the supervision of a Physician are covered.

Physician services are covered if you are hospitalized and they are subject to the provisions of the "Preauthorization" section and "Hospital Care" subsections of this Policy.

### **Podiatry Services**

Services are covered when determined to be Medically Necessary.

**Prostheses**

Prosthetic devices (such as artificial limbs) are covered when Medically Necessary due to an illness or Injury. Devices must be prescribed by a Participating Physician and Preauthorized by Health Alliance.

To be consistent with changes in medical technology, Health Alliance maintains a list of covered and non-covered items and the maximum payable amount. Coverage can be verified by calling the Customer Service Department at the number listed on the back of your Member Identification Card.

**Reconstructive Surgery**

Services are covered to correct a functional defect resulting from an acquired and/or congenital disease or Injury when Preauthorized by Health Alliance. Services are also covered when performed to correct a seriously disfiguring condition resulting from accidental Injury or incident due to surgery. However, coverage is provided only if such condition has a major effect on your appearance and the condition can be reasonably corrected by the surgery. Correction of a congenital defect or birth abnormality of an enrolled newborn is covered.

Coverage is provided for reconstructive surgery or a prosthetic device following a mastectomy when Preauthorized by Health Alliance. Coverage for breast reconstruction includes:

- Reconstruction of the breast on which the mastectomy has been performed.
- Reconstructive surgery of the other breast to produce a symmetrical appearance.
- Prostheses and treatment for all physical complications at all stages of mastectomy including lymphedemas.

Coverage for reconstructive surgery and prosthetic devices for non-malignant mastectomy is limited to within two years after the date of the mastectomy.

**Rehabilitation and Skilled Care—Inpatient**

Inpatient services for rehabilitation and skilled nursing care with ongoing documentation of Medical Necessity are covered subject to any inpatient rehabilitation and skilled nursing coverage limitations specified on the Description of Coverage. Inpatient admissions require Preauthorization by Health Alliance.

**Rehabilitative Therapy Services—Outpatient**

Speech, physical and occupational therapies as well as hot/cold pack therapies, for medical conditions received in the Outpatient or home setting when you are homebound, which are directed at improving your physical functioning and are expected to result in significant improvement within two months of commencement, are covered subject to any Outpatient rehabilitation coverage visit limitations

per condition per Plan Year specified on the Description of Coverage. Therapies are counted by type and date of service.

The Outpatient Rehabilitation Services Plan Year Benefit limit does not apply to the Autism Spectrum Disorders benefit.

**Sexual Assault or Abuse Victims**

Hospital and medical services in connection with sexual abuse or assaults that are of an emergency nature are covered. The Copayment, Coinsurance and Deductible amount will be waived.

**Smoking Cessation Program**

A smoking cessation program is covered through Health Alliance's I Can Quit program. Smoking cessation pharmacological therapy, as defined by the Health Alliance formulary, is covered for Members who are enrolled in the smoking cessation program and who have pharmacy benefits through a Health Alliance Outpatient Prescription Drug Rider.

**Spinal Manipulations**

Spinal manipulation and mobilization are covered for the care of musculoskeletal spinal disorders where significant improvement can be expected within two months of commencement from such treatment when Preauthorized by Health Alliance. Hot/cold pack therapy used in conjunction with approved manipulation and mobilization is also covered (also see "Rehabilitation Therapy Services-Outpatient).

**Sterilization Procedures**

Elective sterilization procedures, such as tubal ligation are covered. Vasectomies performed as an office procedure are covered. Sterilization procedures for women intended for Contraceptive purposes only are covered under the wellness benefit listed on the Description of Coverage. All sterilization procedures for men and procedures for women that are medical in nature and for non Contraceptive purposes are subject to the appropriate Deductible, Copayment and Coinsurance listed on the Description of Coverage. Surgical procedures performed to reverse voluntary sterilization are not covered.

**Substance Abuse Detoxification**

Acute inpatient Substance Abuse detoxification is covered if determined by your Primary Care Physician that Outpatient management is not medically appropriate. Treatment is considered medical and does not apply to the Substance Abuse Treatment benefit until the patient is discharged from the Hospital or transferred to a Substance Abuse unit. Inpatient admissions require Preauthorization by Health Alliance.

**Substance Abuse Treatment**

Substance Abuse rehabilitation services or treatment is covered for Medically Necessary short-term treatment,

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subject to any coverage limitations specified on the Description of Coverage.

Inpatient benefits include acute inpatient short-term Medically Necessary residential care, and care in a Day-Hospital program or intensive Outpatient treatment program. Inpatient admissions require Preauthorization by Health Alliance. Outpatient benefits include individual counseling sessions or group Outpatient visits.

Inpatient and Outpatient Substance Abuse treatment coverage does not include services in a long-term residential facility, care in lieu of detention or correctional placement or family retreats.

### **Urgent Care**

Services obtained at a Participating Urgent Care Center are covered. These services are intended for immediate Outpatient treatment of an unforeseen illness, Injury or condition to prevent serious deterioration. Urgent Care Centers also may be referred to as convenient care, prompt care or express care centers, and treat patients on a walk in basis without a scheduled appointment. You will be subject to the Deductible, Copayment or Coinsurance as listed on the Description of Coverage.

### **Vision Care**

Vision screenings and examinations for prescribing glasses or for determining the refractive state of the eyes are covered, unless otherwise specified on the Description of Coverage.

One pair of eyeglasses or one contact lens per affected eye is covered following cataract surgery. The maximum allowable benefit for frames and lenses is the standard allowable established by the Centers for Medicare and Medicaid Services (CMS).

Health Alliance maintains a list of covered and non-covered items and services and the maximum payable amount under this benefit. Coverage can be verified by calling the Customer Service Department at the number listed on the back of your Member Identification Card.

### **Wellness Care**

Well-child care, annual physicals and annual well women visits are covered as wellness visits. Additional visits are subject to the office visit Copayments or Coinsurance and/or Deductible on the Description of Coverage.

Other preventive health services include, but are not limited to:

- **Injections and Immunizations**

Medically Necessary injections and immunizations, including but not limited to human papillomavirus vaccine, are covered. Drugs that can be safely administered without the supervision of health

care professionals will be administered at the most appropriate level of care. Unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups are not covered.

- **Clinical Breast Exams**

A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer at least every three years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older is covered.

- **Mammograms**

A screening mammogram and/or breast ultrasound is covered annually under the wellness benefit for women age 35 and over. Screenings other than what is listed are subject to the diagnostic testing and/or office visit Deductibles, Copayments or Coinsurance listed on the Description of Coverage.

- **PAP Smear**

One cervical smear or PAP smear test each year is covered for females. Additional PAP smear tests are subject to the appropriate Copayment or Coinsurance listed on the Description of Coverage.

- **Prostate-specific Antigen Tests**

Annual digital rectal exams and prostate-specific antigen tests are covered for asymptomatic men age 50 and over, African-American men age 40 and over and men with a family history prostate cancer age 40 and over when authorized by your Primary Care Physician. Additional Prostate tests are subject to the appropriate Copayment or Coinsurance listed on the Description of Coverage.

- **Colorectal Cancer Screening**

A screening for colorectal cancer for Members aged 50-75, by means of a colonoscopy every ten years or sigmoidoscopy once every five years is covered under the wellness benefit as specified on the Description of Coverage. Colonoscopies and sigmoidoscopies done other than what is listed under wellness are subject to the office visit and/or Outpatient Surgery/procedure (when there is an associated facility fee) Deductibles, Copayments and Coinsurance as specified on the Description of Coverage.

- **Bone Mass Measurement**

A onetime bone mass measurement screening for osteoporosis is covered as wellness for Members age 65 and over. Additional osteoporosis screenings or for screenings done under the age of 65, are subject to the office visit and/or diagnostic testing

Deductibles, Copayments and Coinsurance as specified on the Description of Coverage.

- **Cholesterol/Lipid Screening**  
Cholesterol or lipid screenings are covered under the wellness benefit once every five years for Members age 20 and over. Cholesterol screenings done, other than the wellness screenings listed here or additional charges, will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **Sexually Transmitted Infection Counseling and Screening**  
Counseling and screenings for sexually transmitted infections including but not limited to the human immune-deficiency virus (HIV) and human papillomavirus (HPV) are covered annually under wellness. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **High Risk HPV(human papillomavirus) testing**  
DNA testing in women age 30 and over, once every three years is covered for women under the wellness benefit. Additional charges or testing will be subject to the appropriate Copayments or Coinsurance on the Description of Coverage.
- **Domestic Violence Counseling and Screening**  
Annual screening and counseling for interpersonal and domestic violence is covered for women under the wellness benefit. Additional charges or visits will be subject to the appropriate Deductibles, Copayments or Coinsurance on the Description of Coverage.
- **United States Preventative Services Task Force (USPSTF)**  
In addition to the Wellness Care listed here, coverage will also include any other preventative services approved by the United States Preventative Service Task Force (USPSTF) Graded A or B.

## **WHAT IS NOT COVERED (Exclusions & Limitations)**

The following services are excluded from coverage under this Policy unless specifically agreed upon by the Group and Health Alliance and documented in any Amendments and/or Riders.

Care from Physicians or Providers other than Participating Providers or in Hospitals not associated with Health Alliance, other than Emergency Services, is not covered.

### **Abortion**

Services, drugs or supplies related to abortions, except when the life of the mother would be endangered if the fetus was carried to term or when the fetus has a condition incompatible with life outside the uterus, are not covered.

### **Acupuncture, Acupressure and Hypnotherapy**

Charges for treatment and services related to acupuncture, acupressure and hypnotherapy are not covered.

### **Blood Processing**

Costs related to the processing and storage of blood and its components from a person designated as a donor are not covered.

### **Circumstances Beyond the Control of Health Alliance**

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Health Alliance results in the facilities, personnel or financial resources of Health Alliance and/or any of its Participating Providers being unavailable to provide or arrange for the provision of a covered service in accordance with the requirements of this subsection, Health Alliance is required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event.

### **Convenience or Comfort Items**

Convenience or comfort items are not covered. These items include, but are not limited to, grab bars, tub transfers, seat lifts, raised toilet seats, telephones and televisions.

### **Cosmetic Surgery**

Surgery for cosmetic purposes and not primarily for reasons of Medical Necessity is not covered. This includes, but is not limited to, rhinoplasties, breast reductions, blepharoplasties, liposuction, and removal of skin tags and lipomas when not done primarily because of Medical Necessity.

### **Counseling**

Charges for social counseling or marital counseling are not covered.

### **Custodial or Convalescent Care**

Custodial or convalescent care in an acute general Hospital, skilled care facility or home is not covered.

### **Dental Services**

Dental services are not covered. Surgical removal of wisdom teeth and services related to Injuries caused by or arising out of the act of chewing are also not covered. Hospitalizations for dental work are not covered unless the hospitalization is necessary due to a medical condition and Preauthorized by Health Alliance. (See "What Is Covered" under Dental Services and Oral Surgery.)

**Disposable Items**

Self-administered dressings and other disposable supplies are not covered. (See “What Is Covered” under Durable Medical Equipment.)

**Durable Medical Equipment, Orthopedic Appliances and Devices**

The following corrective and orthopedic appliances and devices are not covered: hearing aids, earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not covered unless you would be bed or chair confined without such equipment. This includes any dispensing fees incurred in obtaining these items.

**Experimental Treatments/Procedures/Drugs/Devices/Transplants**

Unless otherwise stated in this Policy, such as coverage for “Cancer Clinical Trials,” the Plan does not pay benefits for any charges incurred for or related to any medical treatment, procedure, drug, device or transplant that is determined by a Medical Director to meet one or more of the following standards or conditions:

- The medical treatment, procedure, drug, device or transplant is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for your condition, disease or illness.
- The drug or device cannot be lawfully marketed for your condition, disease or illness without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness is determined by a Medical Director to be experimental or investigational.

In making his or her determination that a medical treatment, procedure, drug, device or transplant for the treatment or

diagnosis of your condition, disease or illness is excluded from coverage under this subsection, a Medical Director will use current medical literature, discussion with medical experts and other technological assessment bodies designated by Health Alliance. Each review will be on a case-by-case basis regarding coverage of a requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of your condition, disease or illness.

**Eyeglasses, Contacts and Refractory Treatment**

Eyeglasses, contact lenses, contact lens evaluations and fittings are not covered, unless there is a diagnosis of cataract. (See “What Is Covered” under Vision Care) Lens tinting, scratch protection coating, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses are not covered. Refractive eye surgery is not covered including, but not limited to, refractive keratectomy, radial keratotomy and laser in-situ keratomileusis (LASIK) surgery.

**Fitness**

Any program designed for overall physical fitness or membership to fitness facilities for the same purpose is not covered. Not included in this exclusion is rehabilitative therapy.

**Governmental Responsibility**

Services for disabilities connected to military service for which you are legally entitled to and for which facilities are reasonably available to you, or for conditions that state or local laws require be treated in a public facility, unless legal liability exists, are not covered.

**Hearing Aids**

Hearing aids, their fittings or testing for the purpose of using a hearing aid are not covered. Any service, supply or treatment for the rehabilitation of hearing impairment is also not covered.

**Illegal Activities**

Charges for any service, supply or treatment that arose out of or occurred while you were engaged in an illegal occupation or in the commission of or attempt to commit a felony are not covered.

Emergency or other medical, Hospital, or surgical expenses incurred as a result of and related to an Injury acquired while intoxicated or under the influence of any narcotic is covered.

**Infertility Services**

Infertility services are not covered, unless otherwise specified in an Amendment and/or Rider attached to this Policy.

**Institutional Care**

Institutional care that is for the primary purpose of controlling or changing your environment, or is maintenance care, Custodial Care, domiciliary care, convalescent care or rest cures is not covered.

**Medicare Benefits**

Health care items and services furnished to a Medicare-Eligible Beneficiary are not covered to the extent that benefits or payment for items or services are provided by or available from Medicare, whether or not those benefits or payment are received.

**Obesity**

Charges for special formulas, food supplements, special diets, minerals, vitamins or Physician and non-Physician supervised weight loss programs are not covered. Treatment or products for obesity, food addiction or weight reduction are not covered (See Bariatric Surgery for Severe Obesity under “What is Covered”).

**Outpatient Prescription Drugs**

Outpatient prescription drugs are not covered, unless otherwise specified in a Rider attached to this Policy.

**Reversal of Sterilization**

A surgical procedure to reverse voluntary sterilization is not covered..

**Services that are Not Medically Necessary**

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not covered.

Vocational rehabilitation services or other services or supplies, other than Basic Health Care Services, which are not Medically Necessary for the treatment, maintenance or improvement of your health are not covered.

Care ordered or directed by individuals other than a Physician or registered clinical psychologist, care in lieu of detention or correctional placement, family retreats or marriage counseling are not covered.

Services that are not primarily medical in nature, including but not limited to traditional mattresses, air filters, Jacuzzis/spas, swimming pools, exercise equipment, gym memberships, air conditioners, adaptive devices/filters for residential heating and air conditioning systems, car seats, and educational services unless specified elsewhere in the Policy, are not covered.

**Sex Changes and Sex Therapy**

Charges for any service, supply or treatment for a sex change or sex therapy are not covered.

**Skin Lesions**

Skin lesion removal primarily for cosmetic reasons rather than for Medical Necessity is not covered.

**Supplemental Drinks/Vitamins/Weight Gain Products**

Over-the-counter supplies or products taken to supplement

caloric intake, not primarily medical in nature and not used as the sole source of nutrition, are not covered.

**Temporomandibular Joint Syndrome (TMJ)**

Any service, supply or treatment connected with TMJ pain dysfunction syndrome (TMJ-PDS) is not covered.

**Other Non-Covered Items**

- Any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.
- Any service, supply, treatment, diagnosis or advice for which you are not legally required to pay.
- Any service, supply or treatment prohibited by the laws of the United States or the state where the expense was incurred.
- Any care, treatment, service or supply furnished by a facility owned or operated by a state or national government. Charges are covered if you have a legal obligation to pay for the care or treatment or if the United States has the authority to recover or collect the reasonable cost of such care or service.
- Any Injury or illness arising out of or occurring in the course of your job for wage or profit and which is covered by Worker’s Compensation or similar law.
- Charges for appointments scheduled and not kept (missed appointments).
- Charges incurred before you became covered under the Plan or after you terminate from the Plan.
- Complications arising directly from rightfully excluded conditions.
- Services provided by a non-licensed professional.
- Services furnished or billed by a Provider that has been excluded or debarred by the federal government.
- Any service, supply or treatment received outside of the United States of America, other than Emergency Services or Urgent Care.

**APPEALS**

Appeals are divided into two categories: administrative decisions or denials of coverage based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness. You or any person you have chosen as your authorized representative, including your Physician or other health care Provider or attorney may request an appeal of either category. The party filing the appeal may send us written comments, documents, records, or other information regarding your appeal. All available information relevant to your appeal will be considered when reviewing your appeal. A Clinical Peer not involved in the initial denial will review appeals made on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. A review committee or an individual not involved in the initial denial and who does not work

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under the authority of the initial decision maker will review administrative appeals.

You, your authorized representative, Physician or other health care Provider may request an appeal within 180 days of receiving the initial denial notice by calling the Member Relations Department at 1-800-500-3373 or writing to the Member Relations Department, Health Alliance Medical Plans, 301 S. Vine Street, Urbana, Illinois, 61801-3347.

### **Appeal Procedures for Non-Urgent Care Decisions (Pre-Service Claims)**

You or your authorized representative, Physician or other health care Provider may request an appeal for denial of requested health care services that require Preauthorization. Health Alliance will notify the party filing the appeal within three business days of all information required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and any health care Provider who recommended services in writing within 15 days of receipt of all requested information, but no later than 30 calendar days after receipt of the request for an appeal.

If the appeal of your Preauthorization request is denied on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness and you have exhausted the internal appeals process, you have the right to request that decision be reviewed by an independent review organization (See “External Review of Appeals”)

### **Appeal Procedures for Urgent Care Decisions (Pre-Service Claims)**

You, your authorized representative, Physician or other health care Provider may request an appeal for denial of requested health care services that require Preauthorization. Health Alliance will make a decision and notify you, your authorized representative, Physician and any health care Provider who recommended services by telephone within 24 hours of receipt of all requested information, but no later than 48 hours after receipt of the request for an appeal. You, your authorized representative, Physician and any health care Provider who recommended services will receive written notice within three days of the decision.

If the appeal of your Preauthorization request is denied and you have exhausted the internal appeals process, you have the right to request that decision be reviewed by an independent review organization (See “External Review of Appeals”). If you have a medical condition where the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the requested health care services are denied and the denial concerns an emergency admission, availability of care, continued stay, or health care service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based

on the determination that the requested service or treatment is experimental or investigational and your health care Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review (See “External Review of Appeals,” “Expedited Medical Necessity Review”).

### **Appeal Procedures for Concurrent Care Decisions**

You, your authorized representative, Physician or other health care Provider may request an appeal when coverage will be reduced or terminated for ongoing treatment. The appeal must be made at least 24 hours before the scheduled reduction or termination of coverage for treatment. Health Alliance will make a decision and notify you, your authorized representative, Physician and any health care Provider who recommended services by telephone within 24 hours of the request for an appeal. You, your authorized representative, Physician and any health care Provider who recommended services will receive written notice within three days of the decision.

If the appeal for coverage of health care services is denied and you have exhausted the internal appeals process, you have the right to request that decision be reviewed by an independent review organization (See “External Review of Appeals”). If you have a medical condition where the timeframe for completion of a standard external review would jeopardize your life, your health or your ability to regain maximum function, an expedited external review may be requested. If the request for health care services are denied and the denial concerns an emergency admission, availability of care, continued stay or health care service and you have not been discharged from the facility, you may request an expedited external review. If the denial of coverage is based on the determination that the requested service or treatment is experimental or investigational and your health care Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, you may request an expedited external review (See “External Review of Appeals,” “Expedited Medical Necessity Review”).

### **Appeal Procedures for Coverage Decisions (Post-Service Claims)**

You, your authorized representative, Physician or other health care Provider may request an appeal for denial to pay or reimburse health care services that have already been provided. Health Alliance will notify the party filing the appeal within three business days of all information required to evaluate the appeal. Health Alliance will make a decision and notify you, your authorized representative, Physician and/or other health care Provider in writing within 15 days of receipt of all requested information, but no later than 60 calendar days after receipt of the request for an appeal.

If your claim for coverage is denied on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness and you have exhausted the internal



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appeals process, you have the right to request that decision be reviewed by an independent review organization. (See “External Review of Appeals”).

### **Civil Action under ERISA**

You have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if your appeal has not been approved after all reviews have been completed.

### **External Review of Appeals**

For denials made on the basis of Medical Necessity, appropriateness, health care setting, level of care or effectiveness, you, your authorized representative, your Physician, other health care Provider, attorney or any other authorized representative may request an external review by an independent review organization if you are not satisfied with the Health Alliance resolution of the denial of coverage for health care services. The party requesting the review may contact the Illinois Department of Insurance at 1-877-850-4740, by facsimile at 217-557-8495, via their website at [www.insurance.illinois.gov/externalreview](http://www.insurance.illinois.gov/externalreview) or write to them at 320 S. Washington Street, Springfield, Illinois, 62767.

Except in the case of an expedited review at an initial Urgent Care Pre-Service Claim denial (See “Preauthorization Procedures for Urgent Care Pre-Service Claims”), you must exhaust the internal review process before a request for an external review can be made.

You will also be considered to have exhausted the internal review process if:

- You have not received our written decision on your Pre-Service Claim appeal within 30 days (See “Appeal Procedures for Non-Urgent Care Decisions Pre-Service Claims”);
- You have not received our decision on your Urgent Pre-Service Claim appeal within 48 hours (See “Appeal Procedures for Urgent Care Decisions Pre-Service Claims”); or
- Health Alliance agrees to waive the internal review exhaustion requirement.
- **Medical Necessity, Appropriateness, Health Care Setting, Level of Care or Effectiveness Review**  
A written request for external review may be submitted within four months after receipt of notification that your Preauthorization request for the appeal for approval of coverage of health care services has been denied.
- **Expedited Medical Necessity Review**  
An expedited review may be requested orally or in writing if you, your Physician, other health care Provider or authorized representative involved in the

appeal believe that the denial of coverage of health care services could significantly increase risk to your health. You can contact the Department of Insurance at 1-877-850-4740.

## **COMPLAINTS**

If you have a complaint about any medical or administrative matter connected with Health Alliance services that is not resolved by your Physician, or clinic or Hospital personnel, call the Customer Service Department at the number listed on the back of your Member Identification Card, or write to the Customer Service Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois, 61801-3347.

You may file a complaint with the Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767 or with the Illinois Department of Insurance, 122 S. Michigan Ave., 19th Floor, Chicago, IL 60603. You may also contact the Department of Insurance directly at [www.insurance.illinois.gov](http://www.insurance.illinois.gov).

## **TERMINATION**

In the event the Group terminates this Policy, all rights to benefits and services will cease on the effective date of termination. The Group will be responsible for notifying you of termination of this Policy under this subsection and your right to elect coverage under an individual conversion plan subject to the provision in the “Conversion of Coverage” section of this Policy.

If you terminate employment with your Group, coverage under this Policy will terminate the last day of the month in which employment ends or as otherwise specified in the Group Enrollment Agreement. If you become ineligible for continued membership in the Group while the Group Enrollment Agreement between Health Alliance and the Group is in effect, you may be eligible for continuation of coverage subject to the provisions stated in the “Continuation of Group Coverage” section or you may convert coverage. To convert coverage, see the “Conversion of Coverage” section of this Policy.

Health Alliance may terminate your benefits and cancel this Policy immediately for any of the following reasons:

- You no longer live or work within the Service Area. The Service Area is specified on the Description of Coverage.
- Failure to pay the required premium under the “Premiums” section of this Policy, subject to the grace period.

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- The Health Alliance Member Identification Card is provided for use by any person not eligible for covered services under this Policy.

Health Alliance may terminate your rights and the rights of any covered Dependent and cancel this Policy as of your Effective Date if any material information has been withheld or omitted and thereafter such information is discovered by Health Alliance. Any such Member, or responsible parent or guardian in the case of a minor, shall be required to reimburse Health Alliance for any and all sums expended on his or her behalf for health care services from the Effective Date of coverage to the date of termination, together with reasonable attorneys' fees and expenses in collection of such sums. You will be provided at least 30 days written advanced notice before Your Policy is rescinded. You have the right to appeal any such rescission.

Coverage of a Dependent child will terminate on the last day of the month in which the child reaches the limiting age as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self sustaining employment by an apparent handicapped condition and the child is dependent upon his or her parent or other care providers for lifetime care and supervision, the child will continue to be covered as a Dependent child for the duration of the disability and dependency.

Coverage for health care services under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy. The obligation of Health Alliance under this Policy is limited to arranging for the provision of the health care services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered health care services after the effective date of termination. "Effective date of termination," for the purposes of this section, will mean that date on which Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date the Group Enrollment Agreement terminates, or the date you no longer meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

## **COORDINATION OF BENEFITS**

This coordination of benefits (COB) provision applies when you or your covered Dependent have health care coverage under more than one plan. When you are covered by two or more health plans, benefits provided by the other plan will be coordinated with those provided by this Plan.

### **Definitions**

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment.

However, if separate contracts are used to provide coordinated coverages for Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- "Plan" includes: Group insurance, closed panel or other forms of Group or Group-type coverage (whether insured or uninsured), medical care components of Group long-term care contracts, such as skilled nursing care; medical benefits under Group or individual automobile contracts, no-fault automobile insurance (by whatever name it is called) and Medicare or other governmental benefits, as permitted by law.
  - "Plan" does not include: individual or family insurance, closed panel or other individual coverage (except for Group-type coverage), Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of Group long-term care policies, and Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
2. The "Order of Benefit Determination Rules" determine whether this Plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
    - When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
    - When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
    - When there are more than 2 health plans covering the person, the Plan may be primary as to one or more of the other health plans and secondary to different health plan(s).
  3. "Allowable Expense" means a health care service or expense of a similar service or expense to which COB applies, including Copayments, Coinsurance and Deductibles, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
    - If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one

of the plans provides coverage for Hospital private rooms).

- If a person is covered under two or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable fees, any amount in excess of the highest of the Usual, Customary and Reasonable fee for a specific benefit is not an allowable expense.
  - If a person is covered under two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
  - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable fees and another plan that provides its benefits or services on the basis of a negotiated fee, the primary plan's payment arrangement shall be the allowable expense for all plans.
  - The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, Preauthorization or when the covered person has a lower benefit because he or she did not use a Participating Provider.
4. "Claim Determination Period" means a Plan Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.
  5. "Closed Panel Plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with Health Alliance, and that limits or excludes benefits for services provided by other Providers, except in cases of an Emergency Medical Condition or referral by a Provider on the panel.
  6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

#### **Order of Benefit Determination Rules**

This Plan determines its order of benefits using the first of the following rules that applies:

1. A plan with no provision for coordination with other benefits is considered to pay its benefits before a plan that contains such a provision.
2. **Non-Dependent/Dependent.** The benefits of the plan that covers the person as an employee or Member (that

is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent.

3. **Dependent Child/Parent not Separated or Divorced.** Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":
  - 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 the year.
  - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in the first bullet 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.
4. **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:
  - The plan of the parent with custody of the child.
  - The plan of the Legal Spouse of the parent with custody of the child.
  - The plan of the parent who does not have custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for health care expenses 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 will be the secondary plan. This paragraph does not apply to any claim determination period or Plan Year when any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Dependent Child/Joint Custody.** If the specific terms of a court decree state that the parents will 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 will follow the order of benefit determination rules outlined in (3) above.
6. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as the employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired (or as that employee's Dependent).

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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 requirement will be ignored.

7. **Continuation Coverage.** If a person whose coverage is provided by a federal or state law right of continuation is also covered by another plan, the following will be the order of benefit determination:

- The benefits of the plan covering the person as a Member, or as that person's Dependent, will pay first.
- The benefits of the plan providing continuation coverage will pay second.

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 will be ignored.

8. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee or Member longer are determined before those of the plan that covered that person for the shorter term. Benefits by this Policy will not be increased by virtue of this coordination of benefits limitation. It will be the obligation of any Member claiming benefits by this Policy to notify Health Alliance of the existence of all other Group contracts, as well as the benefits payable by any other Group contract. Health Alliance will have the right to release and obtain from any Physician, other medical professional, insurance company or other person or organization, any claim information (including copies of records) to pay to any other organization any amount determined to be warranted by this Policy. Health Alliance may recover any overpayment, which may have been made to any person, insurance company, or organization under the provisions of this section. Each Member claiming benefits by this Policy must give Health Alliance any information it needs to pay the claim.
9. **Network.** If the primary plan has a network of Providers and the secondary plan does not have such a network, the secondary plan must pay benefits as if it were primary when a covered individual uses a Non- Participating Provider, unless the services are rendered on an emergency basis or are authorized and paid for by the primary plan.
10. If none of the previously discussed rules apply, then the plans are to share the allowable expense equally.

### **Effect on the Benefits of This Plan**

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total

allowable expenses. Each benefit is reduced in proportion and then charged against any applicable benefit limit of this Plan.

### **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Health Alliance may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Health Alliance need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Health Alliance any facts it needs to apply those rules and determine benefits payable.

Health Alliance may also request updated information from you annually or when information is received that indicates a change from the information we have on file to verify or update your Coordination of Benefits information. You may fill out and return the request via mail or you may contact the Customer Service Department listed on the back of your Member Identification Card to respond to these requests. If no response is received within one year from the request, claims will not be considered for payment.

### **Facility of Payment**

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Health Alliance may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. Health Alliance 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.

### **Right of Reimbursement**

If a covered person recovers expenses for sickness or Injury that occurred due to the negligence of a third party the Plan shall have the right to first reimbursement for all benefits paid by the Plan 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 or 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 the Plan may reasonably require in order to exercise its rights under this provision. This provision applies whether or not the third party admits liability.

### **Subrogation**

The Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Plan for that sickness or Injury. You are required to furnish any information or assistance or provide any documents that

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the Plan may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

### **LIABLE THIRD PARTY**

If you and/or any of your covered Dependents incur a claim for medical expenses as a result of Injuries caused by someone else's negligence, wrongful act or omission, this Plan is not responsible to pay these expenses. This Plan also does not provide benefits to the extent that there is other coverage under non-Group medical payments including auto or medical expense type coverage. However, this Plan will provide benefits, otherwise payable under this Plan, only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of your and/or your Dependent's rights of recovery against any person or organization to the extent of the benefits provided. Subrogation is a legal right allowing the Plan to recover medical expenses paid by the Plan on behalf of a Member from another party if the Member's Injuries are caused by the other party's negligence. You and/or your covered Dependents agree to do whatever is necessary to secure the rights of the Plan. You and/or your covered Dependents agree not to do anything after loss to prejudice the rights of the Plan. You and/or your covered Dependents agree to cooperate with the Plan and/or any representatives of the Plan in completing forms and in giving information surrounding any accident the Plan or its representatives believe necessary to fully investigate the incident.
2. The Plan is also granted a right of reimbursement from the proceeds of any recovery by settlement, judgment or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.
3. The Plan, by payment of any benefits, is granted a lien on the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents. You and/or your covered Dependents consent to the lien and agree to take whatever steps are necessary to assist the Plan to secure a lien.
4. The Plan, by payment of any benefits, is granted an assignment of the proceeds of any settlement, judgment or other payment received by you and/or your covered Dependents to the extent of the benefits paid. By accepting benefits, you and/or your covered Dependents consent to assignment and authorize and direct his and/or her attorney, personal representative or any insurance company to directly reimburse the Plan or its designee to the extent of the benefits paid. This assignment becomes effective and is binding upon any attorney, personal representative or any insurance company upon service of a copy of this provision upon them by the Plan or its designee.
5. The subrogation and reimbursement rights, assignments and liens apply to any recoveries made by or on behalf of you and/or your covered Dependents as a result of the Injuries sustained, including but not limited to the following:
  - Payments made directly by the third party responsible for Injuries or any insurance company on behalf of the third party responsible for Injuries or any other payments on behalf of the third party responsible for Injuries.
  - Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of you and/or your covered Dependents or other person.
  - Any other payments from any source designed or intended to compensate you and/or your covered Dependents for Injuries sustained as the result of negligence or alleged negligence of a third party.
  - Any workers' compensation award or settlement.
6. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents, minors and incompetent or disabled persons settlements or recoveries.
7. You and/or your covered Dependents shall not make any settlement that specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.
8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by you and/or your covered Dependents, which right shall not be defeated or reduced by the application of any so-called Made-Whole Doctrine, or any other such doctrine that intends to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
9. You and/or your covered Dependents shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, no court costs or attorneys fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called Fund Doctrine or Common Fund Doctrine, or Attorney's Fund Doctrine.
10. The Plan shall recover the full amount of benefits without regard to any claim of fault on the part of you and/or

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your covered Dependents, whether under comparative negligence or otherwise.

11. The benefits under this Plan are secondary to any coverage under no-fault of similar insurance.
12. In the event that you and/or your covered Dependents fails or refuses to comply with the terms of this agreement, you and/or your covered Dependents shall reimburse the Plan for any and all costs and expenses including attorneys' fees, incurred by the Plan in enforcing its rights.

Health Alliance may also request information from you based on claims or other information received to verify Third Party Liability information or to verify if a Third Party is involved. You must fill out the requested form in writing and return via mail or fax to Health Alliance Medical Plans 301 South Vine Street, Urbana, IL 61801 or to our Recovery Department at 217-365-7488. If no response is received within one year from the request, claims will not be considered for payment.

## **CONVERSION OF COVERAGE**

### **Health Alliance HMO Conversion Plan**

You may be eligible for the Health Alliance HMO Individual Conversion Plan if one of the following qualifying events occurs:

- Cancellation of eligibility for coverage under this Policy
- Cancellation of the Group Enrollment Agreement
- Non-renewal of the Group Enrollment Agreement

To convert your coverage, you must submit a completed Group application form and applicable premium payment to Health Alliance within 31 days after the date coverage under this Policy is terminated.

Coverage under the Health Alliance HMO Conversion Plan will not be available to you if one or more of the following occur:

- Cancellation of your coverage under a Group plan for failure to make timely premium payments; for fraud or material misrepresentation in enrollment or in the use of services or facilities; or for material violation of the terms of this Policy.
- You have not been continuously covered under this Policy during the three months prior to the termination date.
- You are covered by any other insured or uninsured plan, which provides Hospital, surgical or medical coverage.
- You are covered by or entitled to Medicare.
- You have moved outside of the Service Area.

- The Group Enrollment Agreement has been terminated in its entirety, and there is a succeeding carrier providing coverage to the Group in its entirety.
- Your coverage under this Policy terminates because of Health Alliance being placed in rehabilitation or liquidation proceedings pursuant to section 5-6 of the Illinois Health Maintenance Organization Act.

Benefits under the Conversion Plan will be terminated upon any of the following:

- You fail to make timely payments
- You become eligible under another health plan or become entitled to Medicare
- You no longer live or work within the Service Area

### **Comprehensive Health Insurance Plan**

A Member who is losing coverage under this Policy may be eligible to convert coverage to the CHIP-HIPAA Plan, which is a comprehensive medical benefit plan offered under Section 15 of the Illinois Comprehensive Health Insurance Plan (CHIP) Act. This plan is available only to federally eligible individuals who qualify. You have 60 days from the date of the qualifying event to convert coverage. For more information on the CHIP-HIPAA Plan, you should call 1-800-962-8384. If you enroll in a Health Alliance individual plan, you will lose eligibility to enroll under the CHIP-HIPAA Plan.

## **MEDICARE-ELIGIBLE BENEFICIARIES**

The federal "Medicare Secondary Payor" (MSP) laws regulate how certain employers may offer Group health coverage to Medicare-Eligible employees and Dependents. Under the MSP laws, Medicare generally pays secondary to the Group health coverage provided under this Policy for the following Medicare-Eligible Beneficiaries:

- Members with end-stage renal disease, during the first 30 months of Medicare eligibility or entitlement.
- Members age 65 or over who are covered under this Policy due to their or their Legal Spouse's current employment status with the Group, if the Group has 20 or more employees.
- Disabled Members under age 65 who are covered under this Policy due to their or a family member's current employment status with the Group, if the Group employs more than 100 employees.

To assist your Group and Health Alliance in complying with the MSP laws, you must notify your Group promptly if you or any of your covered Dependents becomes eligible for Medicare or has Medicare eligibility terminated or changed.

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You must also promptly and accurately complete any requests for information from your Group or Health Alliance concerning your or any of your covered Dependents' Medicare eligibility.

Medicare is the primary coverage for those Medicare-Eligible Beneficiaries to whom the MSP laws do not apply (for example, Retired Employees and their Legal Spouses who are age 65 or older). Health Alliance benefits for such Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available if the Medicare-Eligible Beneficiary enrolled in Medicare and made a proper claim for Medicare payment.

For a Medicare-Eligible Beneficiary to obtain the greatest level of benefit, a Medicare-Eligible Beneficiary to whom the MSP laws do not apply should:

- enroll in Part A and Part B of Medicare.
- obtain needed health care services and items from Participating Providers according to the terms and conditions of this Policy.
- assign his or her claim for Medicare benefits to the Provider. Health Alliance HMO benefits will then cover any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "What is Covered" section that Medicare does not cover.

If you do not enroll in Part B of Medicare, you will be responsible for the portion of the bills that Medicare would have allowed under Part B coverage.

We encourage you to call the number on the back of your Member Identification Card to speak with one of our Customer Service Representatives with any questions about the benefits available and how to obtain them.

**PAYMENT OF CLAIMS**

The Plan pays benefits to the health care Provider unless you advise Health Alliance otherwise by the time the claim is submitted for payment. Any claim for reimbursement or bills for covered health care services must be submitted within 60 days of the service or as soon thereafter as reasonably possible. All claims should be submitted to:

Claims Department  
 Health Alliance Medical Plans  
 301 S. Vine St.  
 Urbana, Illinois 61801-3347

The Plan is not responsible for claims or bills submitted more than one year after the provision or initiation of the service to which the claim or bill relates.

Unless Health Alliance receives prior written instruction from you, any health care benefits unpaid at your death will be paid to the health care Provider rendering the service for which benefits are due or reimbursement to your estate. If benefits payable are \$1,000 or less, Health Alliance may pay someone related to you by blood or marriage whom Health Alliance considers to be entitled to the benefits. Health Alliance will be relieved of further obligation as to this benefit payment when made by Health Alliance in good faith.

**FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and or civil penalties.

**PRIVACY AND CONFIDENTIALITY**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) together with the Standards for Privacy of Individually Identifiable Health Information aim to safeguard the confidentiality of private information and protect the integrity of health care data.

**Use of Information**

Protected Health Information is used in the normal course of business for underwriting and establishing premiums, processing claims, informing you of your benefits and encouraging participation in health promotion programs. Other ways this information is used includes:

- Providing membership rosters to health care Providers
- Corresponding with you
- Participating in accreditation, auditing and quality improvement activities
- Participating in disease management studies to improve health care
- Providing you with health care reminders
- Conducting utilization review, reporting and other medical management activities
- Investigating complaints and appeals
- Establishing and maintaining proper records
- Billing and collection activities
- Fulfilling requests for information about services and benefits
- Coordination of Benefits with other plans

**Disclosure of Information**

Nonpublic personal and Protected Health Information is disclosed under the following circumstances:

- To you or your authorized representative
- To another party with your signed authorization

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- For Plan administration (health care operations and payment)
- To persons or companies that perform health care operations on behalf of Health Alliance
- Specific information that you agree to disclose (you will be given the opportunity to object)
- Information that has been de-identified (you cannot be identified in the information disclosed)
- Sharing information with government agencies as required by applicable state and federal laws

Health Alliance has policies and procedures in place to protect the confidentiality of your information. All persons or companies acting with Health Alliance or on the behalf of Health Alliance are contractually obligated to keep the information confidential and use it only to carry out the services they are contracted to provide. Health Alliance also shares information with its affiliate, Carle.

### **Your Rights**

Under the privacy regulations, you are granted the following rights with respect to your Protected Health Information:

- Right to access your own Protected Health Information
- Right to amend or correct Protected Health Information that is inaccurate or incomplete
- Right to obtain an accounting of disclosures of your Protected Health Information
- Right to request additional restrictions on the use and disclosure of your Protected Health Information
- Right to complain about our privacy practices
- Right to receive a written privacy notice that explains your rights in further detail

## **GENERAL PROVISIONS**

### **Clerical Error**

Clerical error, whether of the Group or Health Alliance, in quoting benefits or in processing or maintaining any record pertaining to the coverage under this Policy, will not invalidate coverage otherwise validly in force or reinstate coverage otherwise validly terminated.

### **ERISA**

If you have questions about your rights under the Employee Retirement Income Security Act (ERISA), you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

### **Entire Contract and Changes**

This Policy, the Description of Coverage, Amendments, Riders, and other papers attached, if any, in combination with the Group Enrollment Agreement and the Group application form, constitute the entire contract between you and Health Alliance. No change in this contract will be valid until approved by an executive officer of Health Alliance. No agent has the authority to change this contract or to waive any of its provisions. Any provision, term, benefit or condition of coverage and this Policy may be amended, revised or deleted in accordance with the terms of the Group Enrollment Agreement between the Group and Health Alliance, or in accordance with changes in State and/or Federal law. This may be done without your consent.

### **Extension of Benefits in the Case of Total Disability**

If this Plan is terminated for reasons other than those specified in the Eligibility, Termination and Guaranteed Renewability sections of this Policy and replacement coverage is not available or the succeeding insurer has an allowable Preexisting Condition limitation, this Plan will continue to provide benefits according to the Policy and the benefit levels specified on the Description of Coverage until the first one of the following occurs: satisfaction of the succeeding insurer's Preexisting Condition limitation; twelve months following the effective date of termination; the date the maximum benefit is reached or the end of Total Disability.

### **Financial Information**

You may request in writing from Health Alliance a statement of the financial arrangements between Health Alliance and a Participating Provider. If requested, Health Alliance will provide the percentage of Copayments, Coinsurance and total premiums spent by Health Alliance HMO on health care related expenses and other expenses including administrative expenses. This description of financial arrangements will not include specific Provider reimbursement levels or premium contributions paid by the Group.

### **Guaranteed Renewability**

Health Alliance will renew benefits under this Policy at the option of the Group. Health Alliance reserves the right to not renew or to discontinue coverage under this Policy and under the Group Enrollment Agreement for one or more of the following reasons:

- Non-payment of premium by the Group, which includes payments not made in a timely manner
- Acts of fraud or any material misrepresentation by the Group
- Violation of participation or contribution rules under the Group Enrollment Agreement
- Health Alliance ceases to offer coverage in the market
- Movement outside the Service Area by either the Member, Group or Health Alliance



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### **Hospitalized on Effective Date**

If on your Effective Date under the Plan, you or any of your covered Dependents are inpatients in a Hospital, you are required to notify the Plan at the number on the back of your Member Identification Card within 48 hours of the Effective Date or as soon as reasonably possible. Medically Necessary charges incurred on or after your Effective Date will be covered by the Plan. Charges incurred prior to 12:01 a.m. of your Effective Date will not be covered by the Plan.

### **Legal Action**

No legal action shall be brought to recover on this Policy before 60 days after written proof of loss has been furnished. No legal action shall be brought to recover on this Policy more than three years after the time written proof of loss was furnished.

### **Member Identification Card**

The Member Identification Cards issued to you pursuant to this Policy are for identification only. Possession of a Health Alliance Member Identification Card confers no right to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Policy have actually been paid.

### **New Medical Technologies**

To keep pace with technology changes and your equitable access to safe and effective care, Health Alliance has established policies and procedures to evaluate new developments in medical technology and its applicability to benefit changes. Professionals with the expertise related to new medical procedures, pharmacological treatments and devices participate in the evaluation of each new technology and the creation of criteria for its applications.

### **Notices**

Any notice to be given under the terms of this Policy by Health Alliance to the Group will be in writing and may be affected by deposit in any post office in the United States addressed to the Group at the most recent address of the Group shown in the records of Health Alliance. Any notice to be given under the terms of this Policy by Health Alliance to a Member will be in writing and may be affected by deposit in any post office in the United States addressed to the Member at the address shown on the Description of Coverage attached to this Policy, unless notice of change of such address has been given by the Member in the manner as specified below. Any notice to be given under the terms of this Policy to Health Alliance will be in writing and may be affected by deposit in any post office in the United States addressed to Health Alliance Medical Plans, Inc., 301 S. Vine St., Urbana, Illinois 61801-3347. All notices given in the manner provided for in this section will be deemed to have been received by the party to whom addressed five business days after deposit in said post office.

You may notify us of a change of address by calling the Customer Service Department number on the back of your Member Identification Card or by sending the change of address information to the Membership Department, Health Alliance Medical Plans, 301 S. Vine St., Urbana, Illinois 61801-3347.

### **Time Limit on Certain Defenses**

No misstatements made in the application for this Policy will be used to void this contract or to deny a claim for loss incurred after two years from the Effective Date of coverage. This provision does not include fraudulent misstatements.

### **Timely Payment of Claims**

All benefits due will be paid upon receipt of proof of loss. We will notify you within 30 days if additional information is needed. If payment is delayed more than 30 days after all necessary information regarding the claim has been received, we will pay interest on benefits due.

### **Other Provisions**

The obligation of Health Alliance is limited to furnishing health care coverage to Members through contracts with such Providers of care. Health Alliance is not liable, in any event, for any act or omission of the professional personnel of any medical Group, Hospital or other Provider of services to Members.

The health care coverage provided for in this Policy is not transferable to another party by any Member.

Through the Group Enrollment Agreement, the Group makes Health Alliance HMO coverage available to people who are eligible under the provisions of this Policy. However, the Group Enrollment Agreement is subject to amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between Health Alliance and the Group without the consent of the Members. By electing medical or Hospital coverage under the Group Enrollment Agreement or accepting benefits of this Policy, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting agree to all terms, conditions and provisions hereof.

This Policy is not intended to meet the requirements of a Federally Qualified HMO.

## **CONTINUATION OF GROUP COVERAGE**

This is a summary of your rights under the Illinois and the federally mandated continuation coverage laws, then in effect. You may be eligible to continue your health care coverage under this Policy provided you meet the requirements stated below and the terms and conditions of the Group Enrollment Agreement. It is the responsibility of

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your employer to notify you of your rights to continuation of coverage. You should contact your employer for more detailed information on your rights to continuation of coverage.

## STATE CONTINUATION

### Eligibility

You, your covered Legal Spouse and Dependent children may be eligible for twelve months of continuation coverage if you are a Member whose coverage under this Policy would otherwise terminate due to termination of the Policyholder's employment (termination of employment cannot be due to a felony or theft at work), termination of membership, or the reduction of the Policyholder's hours and if you:

- Have been continuously enrolled under the Group contract during the entire three-month period ending with the termination date
- Are not covered under another Group health insurance policy or entitled to Medicare
- Have not exercised your conversion coverage rights
- Have not moved outside the Service Area

### Election

To elect continuation coverage, you must submit a completed Group application form and applicable premium payment to Health Alliance within 30 days (but no later than 60 days following the date your coverage under this Policy ended) after you receive notification of your right to choose continuation coverage.

### Termination of Coverage

Continuation coverage under this Policy will terminate if one of the following occurs:

- You have exhausted the maximum twelve-month period
- You have failed to make timely premium payments
- The Group Enrollment Agreement is terminated
- You become covered under another Group health insurance policy
- You become eligible for Medicare
- You have moved outside the Service Area

Upon termination, you may be eligible to enroll in a conversion plan, subject to the requirements stated in the "Conversion of Coverage" section of this Policy.

## SPOUSAL CONTINUATION

### Eligibility

Health Alliance will provide continuation coverage if you are a Legal Spouse or Dependent whose coverage under this Policy would otherwise terminate due to one of the following

qualifying events and you were covered under this Plan on the day before the qualifying event:

- Divorce from the Policyholder
- Death of the Policyholder
- Retirement of the Policyholder and the Legal Spouse is age 55 or older
- You are not covered under another Group health insurance policy or eligible for Medicare
- You have not moved outside the Service Area
- You have not exercised your conversion coverage rights

For purposes of this section the term "Legal Spouse" means the Retired Employee's Legal Spouse or a former Legal Spouse due to death or divorce of the employee.

Within 30 days from the date of the divorce, death or retirement of the employee, the Legal Spouse of the employee must provide written notice to the employer or Health Alliance. The employer has 15 days to notify Health Alliance of the divorce, death or retirement of the employee.

### Election

Upon the receipt of written notice by the employer Group of the divorce, death or retirement of the employee, Health Alliance will notify the Legal Spouse of the employee of his or her rights to spousal continuation coverage. To elect continuation coverage, you must submit the completed Group application form and applicable premium payment to Health Alliance within 31 days after receipt of the notice.

### Termination of Coverage

Continuation coverage under this Policy will terminate for the Legal Spouse and any Dependents if one of the following occurs:

- The Legal Spouse is under 55 years of age and has exhausted the maximum 2 year period
- The Legal Spouse is age 55 or older and becomes eligible for Medicare
- The Legal Spouse remarries
- The Legal Spouse has failed to make timely premium payments
- The Group Enrollment Agreement is terminated
- The Legal Spouse becomes covered as an employee under another Group health insurance policy
- The Legal Spouse moves outside the Service Area

Upon termination, the Member may be eligible to enroll in a conversion plan, subject to the requirements stated in the "Conversion of Coverage" section of this Policy.

## DEPENDENT CONTINUATION

### Eligibility

Health Alliance will provide continuation coverage if you are a Dependent whose coverage under this Policy would otherwise terminate due to the death of the Policyholder or your attainment of the limiting age under the terms of this Policy if you:

- Were a covered Dependent under the terms of the Policy on the day before the qualifying event
- Are not eligible for coverage under Spousal Continuation
- Are not covered under another Group health insurance policy
- Have not exercised your conversion coverage rights
- Have not moved outside the Service Area

Within 30 days of the date your coverage would terminate due to the death of the Policyholder or your attainment of the limiting age, you or a responsible adult acting on your behalf must provide written notice of the death of the Policyholder or your attainment of the limiting age to the employer or Health Alliance. The employer has 15 days to notify Health Alliance.

### Election

Upon receipt of written notice from you, a responsible adult acting on your behalf or the employer Group of the death of the Policyholder or your attainment of the limiting age, Health Alliance will notify you or the responsible adult acting on your behalf of your rights to Dependent continuation coverage. To elect continuation coverage, you or a responsible adult acting on your behalf must submit a completed Group application form and applicable premium payment to Health Alliance within 31 days after receipt of the notice.

### Termination of Coverage

Your Dependent continuation coverage under this Policy will terminate upon the earliest of the following:

- You or a responsible adult fails to make timely premium payments
- Coverage would terminate under the terms of the existing Policy if you were still an eligible Dependent of the Policyholder
- The date you become covered as an employee under another health insurance policy
- Two years from the date Dependent continuation coverage began
- The Group Enrollment Agreement is terminated
- You move outside the Service Area

Upon termination, you may be eligible to enroll in a conversion plan, subject to the requirements stated in the “Conversion of Coverage” section of this Policy.

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

**This section applies only to Members of a Group with 20 or more employees.**

### Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families Dependents covered under the Plan will be entitled to elect a temporary extension of health coverage (called “COBRA continuation coverage”) where coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of their your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

### What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of Group health plan coverage that must be offered to certain Policyholders and their eligible Dependents (called “Qualified Beneficiaries”) at Group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the “Qualifying Event”). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

### Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered employee, the Legal Spouse of a covered employee, or a Dependent child of a covered employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure

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to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (iii) A covered Retired Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the Legal Spouse, surviving Legal Spouse or Dependent child of such a covered employee if, on the day before the bankruptcy Qualifying Event, the Legal Spouse, surviving Legal Spouse or Dependent child was a beneficiary under the Plan.

The term “covered employee” includes not only common law employees (whether part time or full time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self employed individuals, independent contractor or corporate director).

An individual is not a Qualified Beneficiary if the individual’s status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual’s employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Legal Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Dependent who does not qualify as a **Policyholder’s** tax Dependent under IRS rules is not considered a Qualified Beneficiary. However, per the Group Enrollment Agreement, civil union partners may be eligible for COBRA

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other Group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another Group health plan (but only after any applicable Preexisting condition exclusions of that other plan have been satisfied).

### **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provided that the Member would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect

immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered employee.
- (ii) The termination (other than by reason of the employee’s gross misconduct), or reduction of hours, of a covered employee’s employment.
- (iii) The divorce or legal separation of a covered employee from the employee’s Legal Spouse.
- (iv) A covered employee’s enrollment in any part of the Medicare program.
- (v) A Dependent child’s ceasing to satisfy the Plan’s requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (vi) The employer files for bankruptcy under Title 11 of the U.S. Code and you are a Retired Employee.

If the Qualifying Event causes the covered employee, or the covered Legal Spouse or a Dependent child of the covered employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered employee, or the Legal Spouse or a Dependent child of the covered employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

If a covered employee discontinues coverage for his or her Legal Spouse in anticipation of divorce or other Qualifying Event prior to the actual event, when the divorce or other Qualifying Event becomes final, the employer must be notified so the notification can be sent.

If your employer is subject to the Family and Medical Leave Act of 1993 (FMLA), the taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note: that

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the covered employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

### **What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

### **What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Qualified Beneficiaries should take into account that a failure to elect COBRA will affect future rights under federal law. First, the right to avoid having Preexisting condition exclusions applied to you by other Group health plans can be lost if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, the guaranteed right to purchase individual health insurance policies that do not impose such Preexisting condition exclusions can be lost if you do not get COBRA coverage for the maximum time available to you. Finally, Qualified Beneficiaries should take into account the special enrollment rights available under federal law. Qualified Beneficiaries have the right to request special enrollment in another Group health plan for which you are otherwise eligible (such as a plan sponsored by your Legal Spouse's employer) within 30 days after your Group health coverage under the Plan ends because of a Qualifying Event. Qualified Beneficiaries will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their Group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for

assistance under this special provision should contact the employer for further information.

### **Is a covered employee or Qualified Beneficiary responsible for informing the employer of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the employer has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the employee,
- commencement of a proceeding in bankruptcy with respect to the employer, or
- enrollment of the employee in any part of Medicare.

### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and Legal Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify your employer in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to your employer during the 60-day notice period, any Legal Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to your employer.**

**NOTICE PROCEDURES:**

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to your employer. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the Plan or Plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the Plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, “*Duration of COBRA Coverage*.” That explanation describes other situations where notice from you or the Qualified Beneficiary is required in order to gain the right to COBRA coverage.

Once your employer receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their Legal Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying Event. If you or your Legal Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary’s election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, as applicable.

**When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the employer ceases to provide any Group health plan (including a successor plan) to any employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any Preexisting condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) 29-months after the date of the Qualifying Event, or
  - (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary’s entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual’s relationship to a Qualified Beneficiary, if the Plan’s obligation to make COBRA

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continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

### **What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18-months after the Qualifying Event, if there is not a disability extension and 29-months after the Qualifying Event, if there is a disability extension.
- (ii) In the case of a covered employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:
  - (a) 36-months after the date the covered employee becomes enrolled in the Medicare program; or
  - (b) 18-months (or 29-months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the Retired Employee ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Legal Spouse, surviving Legal Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36-months after the death of the retiree.
- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36-months after the Qualifying Event.

### **Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within

that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The employer must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the employer.

### **How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the employer with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the employer.

### **Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102 percent of the applicable premium and up to 150 percent of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

### **Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

### **What is Timely Payment for payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the employer and the entity that provides Plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10 percent of the required amount.

### **Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a Group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

### **IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact your employer. For more information on ERISA, including COBRA, HIPAA and other laws affecting Group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **KEEP YOUR EMPLOYER INFORMED OF ADDRESS CHANGES**

To protect your family's rights, you should keep your employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the employer.

## **TERMS**

Capitalized terms used throughout the Policy are defined in this section.

### **Amendment**

A separate document attached to this Policy that adds, modifies or deletes existing provisions of the Policy.

### **Basic Health Care Services**

Emergency care, inpatient Hospital and Physician care, Outpatient medical services, mental health care and Substance Abuse treatment.

### **Clinical Peer**

A health care professional who is in the same profession and the same or similar specialty as the health care Provider who typically manages the medical condition, procedures or treatment under review.

### **Coinsurance**

A percentage of a charge you must pay directly to the Provider for services rendered to you by the Provider.

### **Contraceptives**

Devices, drugs, procedures or other methods which are used with intention to prevent pregnancy or conception.

### **Copayment**

A specific dollar amount you must pay for certain covered services at the time and place you receive such services.

### **Creditable Coverage**

Coverage you have had prior to enrolling in this Plan under any of the following:

- A Group health plan
- Health insurance coverage
- Part A or Part B of Title XVIII of the Social Security Act (Medicare)
- Title XIX of the Social Security Act (Public Aid/Medicaid)
- Chapter 55 of Title 10, United States Code (armed forces personnel)
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefit risk pool
- A health plan offered under Chapter 89 of Title 5, United States Code (government organization and employees)
- A public health plan
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))
- S-CHIP (State Children's Health Insurance Program)
- Any health coverage provided by a government entity, whether or not it qualifies as insurance coverage
- Coverage provided under a plan established or maintained by a foreign country or political subdivision



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If you or your covered Dependent(s) have a 63-day period where you or your covered Dependent(s) were not covered under any of the above, the period proceeding the 63-day period will not count as Creditable Coverage.

**Custodial Care**

Care furnished for the purpose of meeting non-Medically Necessary personal needs that can be provided by persons without professional skills or training, such as assistance in walking, positioning, dressing, bathing, eating, preparation of special diets and taking medications.

**Deductible**

The amount you must pay before the Plan benefits begin. A new Deductible will apply each Plan Year.

**Dependent**

A child or Legal Spouse of a Policyholder who meets the eligibility requirements of the Group.

**Description of Coverage**

A Description of Coverage attached to this Policy that includes, but is not limited to, Copayment, Coinsurance, Deductible amounts, benefit limitations and Out-of-Pocket Maximums.

**Effective Date**

The date you and your covered Dependents are eligible for benefits under this Policy.

**Emergency Medical Condition**

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing your health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Emergency Services**

The covered inpatient and Outpatient services furnished by a Provider qualified to provide such services and needed to evaluate or stabilize an Emergency Medical Condition.

**ERISA (Employee Retirement Income Security Act of 1974)**

A federal law that regulates the majority of private pension and welfare Group benefit plans in the United States.

**Essential Health Benefits**

Essential Health Benefits means benefits covered under the Policy in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness

services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

**Extended Network Provider**

A Physician or Provider that has entered into a valid contract with Health Alliance through a leased network arrangement to provide health care services to Members.

**Family Coverage**

The health care services arranged for and provided to you and any of your Dependents under the terms and conditions of this Policy and for which the applicable premium has been paid to and received by Health Alliance.

**Group**

An employer, association, union or other Group who has contracted with Health Alliance to offer health care benefits to its employees.

**Group Enrollment Agreement**

A contract, which this Policy is a part of, between Health Alliance and the Group to offer Group health care benefits to its employees.

**Hospital**

An institution that meets the following requirements:

- It must provide medical and surgical care and treatment for acutely sick or injured persons on an inpatient basis.
- It must have diagnostic and therapeutic facilities.
- Care and treatment must be given by or supervised by Physicians. Day and night nursing services must also be given and must be supervised by a licensed nurse.
- It must not be operated by a national, provincial or state government.
- It must not be primarily a place of rest, a place for the aged or a nursing home.
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a Hospital as defined by those laws.

**Injury**

An accidental physical Injury to the body caused by unexpected external means.

**Late Entrant**

An individual who enrolls under Health Alliance at a time other than during the first period in which the individual is eligible to enroll under his or her Group plan. An individual who enrolls under a Special Enrollment Period will not be considered a Late Entrant.

## Illinois Group HMO

### **Legal Spouse**

The adult person whom the Policyholder is legally married to or in a legally recognized civil union partnership with.

### **Medical Director**

Medical Director means a licensed Physician employed or under contract with Health Alliance to provide services including, but not limited to, utilization management and quality assurance reviews.

### **Medically Necessary (Medical Necessity)**

A service or supply that is required to identify or treat your condition and is:

- Appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or Injury.
- Adequate and essential for the evaluation or treatment of a disease, condition or illness.
- Can reasonably be expected to improve your condition or level of functioning.
- Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Not mainly for the convenience of you, a Physician or other Provider.
- The most appropriate medical service, supply or level of care that can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an Outpatient.

### **Medicare-Eligible Beneficiary**

A Member who is eligible for Medicare due to age, disability or end-stage renal disease, whether or not the Member enrolls in Medicare. Medicare is the program established by Parts A and B of Title XVIII of the Social Security Act, as amended (42 U.S.C. 1395 et eq.).

### **Member (Also referred to as “you” or “your” within this Policy)**

A Policyholder or a covered family Dependent who is entitled to benefits under the Plan.

### **Member Identification Card**

A card that is provided by Health Alliance to each Member upon enrollment. Replacement cards may be requested by contacting the Customer Service Department.

### **Open Enrollment**

A period of time determined by the Group during which eligible employees and their Dependents may enroll in the Plan.

### **Out-of-Pocket Maximum**

The maximum dollar amount you and/or your family will pay in accumulated Copayments, Coinsurance and/or Deductible amounts for Basic Health Care Services during a Plan Year. Amounts paid for non-covered health care services and certain other expenses will not apply to the Out-of-Pocket Maximum.

### **Outpatient**

The care you or a Dependent receives in a Physician’s office, the home, the Outpatient department of a Hospital or freestanding surgical center.

### **Outpatient Surgery**

Surgery or procedure that is performed in the Outpatient department of a Hospital, freestanding surgical center or freestanding medical clinic. Outpatient Surgery Copayments, Coinsurance and Deductibles apply to any associated facility fee for a surgery or procedure.

### **Participating**

A Physician or Provider who has entered into a valid contract with Health Alliance to provide health care services to Health Alliance HMO Members.

### **Physician**

A person licensed to practice medicine in all of its branches under the applicable laws of the state within the United States of America where the services are provided.

### **Plan**

The program of health care benefits adopted by the Group for its eligible employees.

### **Plan Year**

The calendar, Policy or fiscal year on which the records of the Plan are kept.

### **Plan Year Maximum Benefit**

The total benefits available for certain covered services during a Plan Year for each Member.

### **Policy**

Policy means this booklet and any attached Amendments and Riders issued to a Policyholder that describe the coverage provided under the Plan.

### **Policyholder (Also referred to as “you” or “your” within this Policy)**

A person who is a bona fide employee, regularly employed on a permanent basis by the Group and enrolled in Health Alliance. A Policyholder must live or work in the Service Area of the Group’s plan and is subject to the terms and conditions of the Group Enrollment Agreement.

Illinois Group HMO

**Preauthorization (Preauthorized)**

A review by Health Alliance prior to receipt of services to determine and authorize the coverage level of Medically Necessary services for which the Plan will pay.

**Preexisting Condition**

A condition, for which medical advice, diagnosis, care or treatment, including prescribed drugs or medicine, was recommended or received within a six-month period preceding the Effective Date.

**Primary Care Physician**

A Participating Physician trained in who spends a majority of clinical time engaged in general practice or in the practice of family practice, internal medicine or pediatrics. These Physicians are designated in the Provider Directory.

**Protected Health Information**

All individually identifiable health information maintained or transmitted by the Plan.

**Provider**

A health care Provider, health care facility and/or corporation licensed under the applicable laws of the state within the United States of America where the services are provided.

**Provider Directory**

A list of Participating Providers for your Plan and the area they serve.

**Provider Network**

The Participating Providers that are associated with your Plan.

**Retired Employee**

A former active employee of the employer who was retired while employed by the employer and who is covered under the Group's health care Plan.

**Rider**

A separate document that provides specific additional benefits not included in this Policy.

**Service Area**

The geographic region listed on the Description of Coverage of this Policy that contains the counties within which the Plan is authorized to do business.

**Skilled Nursing Care**

Services that can only be performed by or under the supervision of a licensed nurse, physical, occupational or speech therapist.

**Skilled Nursing Facility**

A facility that is primarily engaged in providing to its resident's skilled nursing or rehabilitation (physical, occupational or speech therapy) services. Skilled facilities

do not include convalescent nursing homes, rest facilities, or facilities for the aged that primarily furnish Custodial Care.

**Small Employer**

An employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the Plan Year.

**Specialty Prescription Drugs**

Any agent that is obtained from a specialty drug Provider because of special handling, storage, administration, monitoring and/or financial requirements.

**Substance Abuse**

The uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency that develops with continued use and for which treatment is Medically Necessary. The addictive substances included under Substance Abuse are limited to alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

**Urgent Care**

Care that requires immediate attention for an unforeseen illness, injury or condition to prevent serious deterioration of a condition. May also be referred to a facility known as convenient care, prompt care or express care.

**Usual, Customary and Reasonable**

A charge that is not more than the normal level of charges made by Providers of covered services in a geographic area. Health Alliance contracts with a national database for charges by geographic zip code. Charges from Participating Providers are not subject to Usual, Customary and Reasonable charge limitations because of contractual provisions with Health Alliance.

**Woman's Principal Health Care Provider**

A person licensed to practice medicine in all of its branches under the applicable laws of the state where they provide services, specializing in Obstetrics and/or Gynecology or Family Practice.



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**Regarding: 1. Termination**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended as follows:

*Under **TERMINATION**, the sixth paragraph is revised to read as follows:*

Coverage for health care services under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy. The obligation of Health Alliance under this Policy is limited to arranging for the provision of the health care services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered health care services after the effective date of termination. If you are confined in a hospital or extended care facility on the effective date of termination, Health Alliance will cover all costs associated with the hospitalization until you are discharged. "Effective date of termination," for the purposes of this section, will mean that date on which Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date the Group Enrollment Agreement terminates, or the date you no longer meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.



Health Alliance



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**Regarding: 1. HIPAA Privacy Standards**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended to add Attachment A as follows:

**ATTACHMENT A  
HIPAA PRIVACY STANDARDS**

The Health Insurance Portability and Accountability Act of 1996, Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), allows certain members of the employer's workforce to perform services in connection with administration of the group health plan ("Plan"). In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Privacy Standards, these employees are permitted to have such access when the conditions set forth in the Privacy Standards have been met (specifically 45 CFR 164.504(f)).

Therefore, the following provisions apply:

- (1) General.** The Plan shall not disclose Protected Health Information to any member of the employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the employer's workforce shall be used or disclosed by them only for the purpose of the Plan administrative function of submitting to The Centers for Medicare and Medicaid Services (CMS) the Protected Health Information required by 42 CFR 423.884 for the retiree drug subsidy.
- (3) Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the employer's workforce" shall refer to all employees and other persons under the control of the employer.



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- (a) Updates Required.** The employer shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- (b) Use and Disclosure Restricted.** An authorized member of the employer’s workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) Resolution of Issues of Noncompliance.** In the event that any member of the employer’s workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

  - (i)** Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
  - (ii)** Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
  - (iii)** Mitigating any harm caused by the breach, to the extent practicable; and
  - (iv)** Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) Certification of Employer.** The employer must provide certification to the Plan that it agrees to:

  - (a)** Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
  - (b)** Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the employer with respect to such information;
  - (c)** Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer;
  - (d)** Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
  - (e)** Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - (f)** Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  - (g)** Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;



- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and members of the employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the State of Illinois workforce are designated as authorized to receive Protected Health Information from Health Alliance ("the Plan") in order to perform their duties with respect to the Plan: Illinois Department of Central Management Services staff assigned to the Benefits Information Systems Division and the Group Insurance Division; Illinois Department of Healthcare and Family Services staff assigned to the Healthcare Purchasing Unit.

In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.



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**Regarding: Pervasive Developmental Disorders**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended as follows:

*Under **WHAT IS COVERED**, the **Rehabilitative Therapy Services—Outpatient** subsection is amended by adding the following paragraph:*

Speech therapy for the treatment of a Pervasive Developmental Disorder as defined by the American Psychological Association is covered up to 20 additional speech therapy visits per Plan year.

*Under **TERMS**, the following definition is added to read as follows:*

**Pervasive Developmental Disorders** - The diagnostic category of pervasive developmental disorders (PDD) refers to a group of disorders characterized by delays in the development of socialization and communication skills, such as Autism, Asperger's Syndrome, Childhood Disintegrative Disorder, and Rett's Syndrome.

In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.



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**Regarding: Infertility Services**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended as follows:

*Under "WHAT IS COVERED," the following new subsection is added:*

**Infertility Services**

Definitions:

Artificial Insemination (AI). The introduction of sperm into a woman's vagina or uterus by noncoital methods, for the purpose of conception.

Assisted Reproductive Technologies (ART). The treatments and/or procedures in which the human oocytes and/or sperm are retrieved and the human oocytes and/or embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an oocyte retrieval is performed.

Donor. An oocyte donor or sperm donor.

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

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

Gamete. A reproductive cell. In a man the gametes are sperm. In a woman the gametes are eggs or ova.

Gamete intrafallopian tube transfer (GIFT). The direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

Infertility. The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. In the event a Physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments, the one year requirement shall be waived.

In vitro fertilization (IVF). A process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and divided egg is then transferred into the woman's uterus.



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

Mid-level provider. A healthcare professional, other than a physician, that provides patient care in a collaborative practice under the supervision of a physician.

Oocyte. The female egg or ovum formed in an ovary.

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

Oocyte retrieval. The procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. This procedure is also called ova aspiration.

Successful reversal of sterilization. For a male it means there is a minimum of 20 million sperm per milliliter of semen. For a female it means that the fallopian tube is patent and free from obstruction as evidenced by hysterosalpingogram.

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

Unprotected sexual intercourse. Sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

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

Zygote. A fertilized egg before cell division begins.

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

#### Covered Benefit:

Infertility services benefits for the diagnosis and treatment of infertility will be covered subject to the following terms, conditions and limitations. Infertility services benefits are covered upon prior order and written referral from a Member's Primary Care Physician or Woman's Principal Health Care Provider and upon prior written approval of a Medical Director that the Member meets all Health Alliance criteria for coverage. Prescribed and approved services must be received at an infertility center or other provider designated by and under contract with Health Alliance. The following infertility services are covered:

- Infertility evaluation by a Participating Physician or mid-level provider.
- Office visits related to the initial evaluation or follow-up appointments.
- Lab and x-ray, Huhner test (post-coital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, artificial insemination, semen analysis, acrosome reaction test, urological evaluation, testicular biopsy.
- In vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer.
- Assisted reproductive technologies (ART), meaning the treatments and/or procedures in which the human oocytes and/or sperm are retrieved and the human oocytes and/or embryos are manipulated in the laboratory. ART includes prescription drug therapy used during the cycle where an oocyte retrieval is performed.
- Outpatient prescription drugs and specialty prescription drugs for the treatment of infertility as

outlined on the attached Infertility Prescription Drug Rider.

- Infertility services after reversal of sterilization are covered if there is a successful reversal of sterilization and if the Member's diagnosis meets the definition of infertility.

**Benefit Limitation/Oocyte Retrieval Limitation:**

- For treatments that include oocyte retrievals, coverage for such treatments will be provided only if the Member has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments. This requirement shall be waived in the event that the Member or partner has a medical condition that renders such treatment useless.
- For treatments that include oocyte retrievals, coverage for such treatments is not required if the Member has already undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then coverage shall be required for a maximum of two additional completed oocyte retrievals. Such coverage applies to the individual per lifetime of that individual, for treatment of infertility, regardless of the source of payment.
  - 1) following the final completed oocyte retrieval for which coverage is available, coverage for one subsequent procedure used to transfer the oocytes or sperm to the covered recipient shall be provided.
  - 2) the maximum number of completed oocyte retrievals that shall be eligible for coverage is six.
- When the maximum number of completed oocyte retrievals has been achieved, except as provided above, infertility benefits will be exhausted.

**Donor Expenses:**

- The medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the covered recipient will be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, will also be covered if established as prerequisites to donation by the insurer.
- Coverage for a known donor is provided. In the event the Member does not have arrangements with a known donor, the use of a contracted facility is required. If the Member uses a known donor, use of contracted Providers by the donor for all medical treatment, including but not limited to testing, prescription drug therapy and ART procedures, is required.
- If an oocyte donor is used, then the completed oocyte retrieval performed on the donor will count against the Member as one completed oocyte retrieval.

In the "**WHAT IS NOT COVERED**" section, the "**Infertility Services**" subsection is replaced with the following new subsection:

**Infertility Services**

The following services are not covered:

- Reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, infertility benefits will be available if the Member's diagnosis meets the definition of infertility. Coverage is not provided for the diagnostic services needed to confirm a successful reversal.
- Payment for services rendered to a surrogate; however, costs for procedures to obtain eggs, sperm or embryos from a Member will be covered if the individual chooses to use a surrogate.
- Costs associated with cryopreservation and storage of sperm, eggs and embryos. Health Alliance will cover the costs associated with subsequent procedures of a medical nature necessary to make use of the cryopreserved substance if the procedures are not deemed to be experimental and/or investigational.
- Selective termination of an embryo. Health Alliance will cover abortions that are Medically Necessary for the life of the mother.

- Non-medical costs of an egg or sperm donor.
- Travel costs for travel within 100 miles of the Member's home address as filed with Health Alliance, and/or travel costs not Medically Necessary, or mandated, or required by Health Alliance. Health Alliance will cover reasonable travel costs as deemed appropriate.
- Health Alliance will not provide coverage for infertility services that are deemed to be experimental or investigational as supported by the written determination of the American Society for Reproductive Medicine or the American College of Obstetrics. Health Alliance will cover infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from infertility treatment considered experimental.
- Infertility treatments rendered to Dependents under the age of 18.
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- Donor embryos.

In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.



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### Regarding: Dependents

#### HEALTH ALLIANCE HMO GROUP POLICY AMENDMENT

Health Alliance HMO (IL HAMIHMO 2005) is amended as follows:

*Under the **ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section, the **Dependent** subsection, is revised as follows:*

#### **Dependent**

A Dependent may be able to get coverage under the Group's Health Alliance Plan if he or she lives within the Service Area and has one of the following relationships to you:

- Your Legal Spouse
- Your natural-born, legally adopted child or stepchild. It doesn't matter if the child lives with you or not.
- A child who you or your Legal Spouse are the court-appointed guardian of.
- A child placed for adoption or your Legal Spouse. This means that you are partially supporting the child in the anticipation of adopting that child. If the adoption falls through, that child will no longer be eligible for benefits under the Plan.

Examples of some dependents who would not be eligible for coverage under the Plan are foster children, grandchildren (unless you are the legal guardian), parents or other relatives.

A person is not an eligible Dependent if on active duty in the armed forces of any country or if covered under the Plan as an employee.

Any child covered must be under the age of 26. The only exception is if it states otherwise in the Group Enrollment Agreement or the child is under the age of 30, is a veteran and Illinois resident who served in the Armed Forces of the United States (but did not receive dishonorable discharge).

To be able to get coverage, the Dependent must turn in to Health Alliance an approved form by the Illinois Department of Veterans' Affairs that states the date when he or she was released from service.

For a Dependent to continue being covered by this Plan after his or her 26<sup>th</sup> birthday, the Dependent:

- Must have an apparent handicapped condition that does not allow him or her to stay employed
- Be Totally Disabled and dependent on his or her parent (or other care providers) for lifetime care and supervision.

To continue coverage for the Dependent, you must submit documentary proof the disability and dependency when Health Alliance or your employer asks for it. These requests will be made no more than once a year from the date when Health Alliance was first notified of the child's disability and dependency.

If a Member is not eligible for coverage under the Plan and the information has been withheld or omitted, whether intentionally or not, and Providers have been reimbursed for services and supplies on behalf of the Member, any such Member or responsible parent or guardian in case of a minor is required to reimburse Health Alliance for any and all sums paid on his or her behalf for health care services together with any reasonable attorneys' fees and expenses incurred in collection of such sums.

*Under the **ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section, the **Special Enrollment** subsection, the second paragraph is revised as follows:*

You and your Dependents are eligible for a special enrollment period of 31 days when one of the following special enrollment events occurs:

- If you acquire a new Dependent through marriage, or a civil union partnership you may enroll yourself and/or your new Legal Spouse and eligible Dependents in the Plan.
- If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Legal Spouse, the newborn or newly adopted child and any other eligible dependent children not currently enrolled in the Plan.
- If you and/or your Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours, a significant reduction in or termination of employer contributions, or a significant increase in the cost of coverage, you and your eligible Dependents may enroll in the Plan.
- If you have other coverage (such as a plan offered by your Legal Spouse's employer) and you lose coverage as a result of a special enrollment-qualifying event (such as death, legal separation, divorce), you and your eligible Dependents may enroll in the Plan.
- If you or your eligible Dependents exhaust COBRA continuation or state continuation coverage, you and your eligible Dependents losing coverage may enroll in the Plan.

If you are enrolled in another plan option offered by your employer and you have reached the Lifetime Maximum on that plan option, you and your eligible Dependents may enroll in the Plan.

*The **TERMINATION** section is revised as follows:*

In the event, the Group terminates this Policy, all rights to benefits and services will cease on the effective date of termination. The Group will be responsible for notifying you of termination of this Policy under this subsection and your right to elect coverage under an individual conversion plan subject to the provision in the "Conversion of Coverage" section of this Policy.

If you terminate employment with your Group, coverage under this Policy will terminate the last day of the month in which employment ends or as otherwise specified in the Group Enrollment Agreement. If you become ineligible for continued membership in the Group while the Group Enrollment Agreement between Health Alliance and the Group is in effect, you may be eligible for continuation of coverage subject to the provisions stated in the "Continuation of Group Coverage" section or you may convert coverage. To convert coverage, see the "Conversion of Coverage" section of this Policy.

Health Alliance may terminate your benefits and cancel this Policy immediately for any of the following reasons:

- You no longer live or work within the Service Area. The Service Area is specified on the Description of Coverage.
- Failure to pay the required premium under the "Premiums" section of this Policy, subject to the grace period.
- The Health Alliance Member Identification Card is provided for use by any person not eligible for covered services under this Policy.

Health Alliance may terminate your rights and the rights of any covered Dependent and cancel this Policy as of your Effective Date if any material information has been withheld or omitted and thereafter such information is discovered by Health Alliance. Any such Member, or responsible parent or guardian in the case of a minor, shall be required to reimburse Health Alliance for any and all sums expended on his or her behalf for health care services from the Effective Date of coverage to the date of termination, together with reasonable attorneys' fees and expenses in collection of such sums.

Coverage of a Dependent child will terminate on the last day of the month in which the child reaches the limiting age as stated in this Policy, or as otherwise specified in the Group Enrollment Agreement. If the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon you for support and maintenance, the child will continue to be included under Family Coverage for the duration of the disability and dependency.

Coverage for health care services under this Policy will terminate at 11:59 p.m. on the effective date of termination of this Policy. The obligation of Health Alliance under this Policy is limited to arranging for the provision of the health care services stated in this Policy up to the effective date of termination. Health Alliance will not be liable for arranging for the provision of, or reimbursement for the provision of, covered health care services after the effective date of termination. "Effective date of termination," for the purposes of this section, will mean that date on which Health Alliance has the right to terminate this Policy according to the terms and conditions of this Policy or the date the Group Enrollment Agreement terminates, or the date you no longer meet the eligibility requirements set forth in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy.

*The **PAYMENT OF CLAIMS** section is revised to add the following:*

**FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and or civil penalties.

*Under the **COBRA** section, the fifth paragraph in the subsection, **Who can become a Qualified Beneficiary?** is revised as follows:*

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A civil union partner who does not qualify as a Subscribers tax dependent under IRS rules is not considered a Qualified Beneficiary. However, per the Group Enrollment Agreement, civil union partners may be eligible for COBRA.

*Under **CONTINUATION OF GROUP COVERAGE**, the **State Continuation** subsection is revised as follows:*

#### **Am I eligible for State Continuation?**

You (and your covered Legal Spouse, Dependent children) may be eligible for 12 months of continuation coverage if your benefits under this Policy end because your employment ended, hours were reduced (unless it ended because of a felony or theft at work), or your membership is terminated and if you:

- Have been continuously enrolled under the Group contract during the entire three-month period ending with the termination date
- Are not covered under another group health insurance policy or entitled to Medicare
- Have not exercised your conversion coverage rights
- Have not moved outside the Service area

**How do I choose this coverage?**

Send a completed application and premium payment to Health Alliance within 30 days (but no later than 60 days following the date your coverage under this Policy ended) after you receive notification of your right to choose continuation coverage.

**How long does continuation coverage last?**

You will have continuation coverage under this Policy until:

- The end of the maximum 12 month period
- You fail to make timely premium payments
- The Group Enrollment Agreement ends
- You become covered under another group health insurance policy
- You become eligible for Medicare
- You move outside the Service Area

Once coverage ends, you may be eligible to enroll in a conversion plan. See the “Conversion of Coverage” section in this policy to learn more.

*The **TERMS** section is amended as follows:*

The definition of “Dependent” is revised as follows:

**Dependent**

A child or Legal Spouse who meets the eligibility requirements of the Group.

The definition of “Spouse” is revised to Legal Spouse as follows:

**Legal Spouse**

The adult person whom the Policyholder is legally married to or in a legally recognized civil union partnership with.

*In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.*

**This document is an Amendment to your Plan's policy.**

An amendment adds, modifies, deletes or otherwise changes a benefit listed in your Policy. You can make the most of your coverage with Health Alliance by reading your Amendments and keeping them with your Policy for future reference.

- Regarding:**
- 1. Hearing Evaluations**
  - 2. Hearing Aids**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended as follows:

*Under **WHAT IS COVERED**, the **Hearing Evaluations** subsection is revised to read as follows:*

Hearing evaluations performed by Participating Providers are covered. Hearing aid evaluations and hearing aids are covered. The hearing aid evaluation benefit is limited to a maximum benefit of \$150 every three years. The hearing aid benefit is limited to a maximum benefit of \$600 every three years.

*The **WHAT IS NOT COVERED** section is revised by deleting the **Hearing Aids** subsection.*

*Under **WHAT IS NOT COVERED**, the **Durable Medical Equipment, Orthopedic Appliances and Devices** subsection is revised to read as follows:*

The following corrective and orthopedic appliances and devices are not covered: earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not covered unless you would be bed or chair confined without such equipment. This includes any dispensing fees incurred in obtaining these items.

*In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.*



**Health Alliance**



**This document is an Amendment to your Plan's policy.**

**An amendment adds, modifies, deletes or otherwise changes a benefit listed in your Policy. You can make the most of your coverage with Health Alliance by reading your Amendments and keeping them with your Policy for future reference.**



**Regarding: Mental Health Care**

**HEALTH ALLIANCE HMO  
GROUP POLICY AMENDMENT**

Health Alliance HMO Group Policy IL GRPHMO 2005 is amended as follows:

*Under **WHAT IS COVERED**, the **Mental Health Care** subsection is amended to read as follows:*

**Mental Health Care**

Mental health care services for short-term treatment and/or crisis intervention are covered as specified on the Description of Coverage. Care in a day Hospital program or intensive Outpatient program may be substituted on a two-to-one basis for inpatient Hospital services subject to any inpatient mental health coverage limitations specified on the Description of Coverage. Inpatient admissions require Preauthorization by Health Alliance.

Group Outpatient mental health care visits may be substituted on a two-to-one basis for individual mental health care visits subject to any Outpatient limitations specified on the Description of Coverage. The services may be provided by a Participating Physician, a registered clinical psychologist, or by an ancillary mental health professional under the supervision of a Physician or registered clinical psychologist.

Services not covered include care provided by a non-Participating Provider or non-licensed mental health professional, court-ordered evaluations or treatment, care in lieu of detention or correctional placement, care in long-term or residential facilities and marriage or social counseling.

*In the event of conflict or inconsistency between this Amendment and the Policy, together with any previous Riders and Amendments, the provisions of this Amendment will control in all respects.*

Amendments





## **This document is a Rider to your Plan.**

**A Rider is a separate document that provides specific additional benefits not included in your Plan's Policy or Summary Plan Description.**



### **HEALTH ALLIANCE HMO PRESCRIPTION DRUG RIDER**

#### **BENEFIT**

Health Alliance administers pharmacy benefits through a national pharmacy benefit manager. Many independent pharmacies and most national chains are Participating pharmacies. To find out if a pharmacy is a Participating pharmacy, call the Customer Service Department at the number listed on the back of your Member Identification Card. You must present your Member Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Copayment or Coinsurance at the time it is filled. If you do not present your Member Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement you may submit your itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager's address noted on the back of your Member Identification Card.

Prescription drugs obtained at a Participating pharmacy when prescribed by a Participating Physician, hereinafter referred to as Physician for purposes of this Rider, in connection with Medically Necessary services are covered for Members subject to the following terms, conditions and limitations.

Prescription Drugs obtained from a non-participating pharmacy in conjunction with emergency services are covered subject to the terms, conditions and limitations listed below.

#### **PREAUTHORIZATION**

Some prescription drugs require Preauthorization from Health Alliance and certain criteria to be met by you. Drugs that require Preauthorization are noted on the prescription drug formulary.

Newly released prescription drugs require Preauthorization for at least six months from the date of launch until the drugs have undergone review by the Health Alliance Pharmacy and Therapeutics Committee.

Therapeutic classes of prescription drugs and injectables that require Preauthorization include, but are not limited to: antifungals, NSAID analgesics (COX 2 inhibitors), proton pump inhibitors (gastroesophageal reflux disease/ulcers), gastrointestinal agents (irritable bowel syndrome), antilipidemics (liver disease), ophthalmics and drugs for the treatment of diabetes, rosacea acne, depression and emesis. Some prescription drugs require Preauthorization after the trial and failure of other medications in the same therapeutic class.

Your Physician must contact Health Alliance to obtain Preauthorization. Preauthorization can be verified by calling Customer Service at the number listed on the back of your Member Identification Card. If Preauthorization is not obtained, Health Alliance will not provide coverage and you will be required to pay the full cost of the drug.

#### **PRESCRIPTION DRUG FORMULARY**

Health Alliance has entered into an agreement with a third party to provide certain pharmaceutical benefit services. This third party may contract with certain manufacturers for rebate programs. A prescription drug formulary, which is a list of covered Value-based drugs, Tier 1, Tier 2 and Tier 3 drugs and specialty prescription drugs, has been developed by Health Alliance. Value Based Drugs are available at lower cost than the regular Tier drugs for those who may be taking certain drugs for common chronic conditions. Tier 1 drugs are the generally the lowest cost drugs, which includes most, but not all, generics. Tier 2 is drugs that are formulary drugs. Most of these drugs are brand name. Tier 3 drugs are Non Formulary drugs. The three-tier system helps manage costs, but

provides flexibility and coverage for Members who choose a higher tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of prescription drugs. The drugs listed in the Health Alliance formulary are reviewed and revised periodically by the Health Alliance Pharmacy and Therapeutics Committee. Prescription drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Plan Year. If a drug moves to a higher tier then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any lower tier alternatives available to you.

To access the most up-to-date version of our Standard Drug list, visit the Our Plans section of our website [www.healthalliance.org](http://www.healthalliance.org) and choose “Standard Drug List” under Pharmacy Options or call the Customer Service Department listed on the back of your Member Identification card. Some plan’s pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a prescription drug is included in the formulary and whether the drug will be covered at the Value-based, Tier 1, Tier 2 or Tier 3 or specialty prescription drug Copayment or Coinsurance.

## **OUTPATIENT PRESCRIPTION DRUGS COVERAGE AND DISPENSING LIMITATIONS**

- Outpatient prescription drugs and diabetic supplies are subject to any applicable limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage. Copayments or Coinsurance for Outpatient prescription drugs and diabetic supplies apply to any applicable Plan Year Outpatient Prescription Drug Out-of-Pocket Maximum limit specified on the Description of Coverage. Initial prescriptions and prescription refills are limited to the maximum supply specified in the Outpatient Prescription Drugs section on the Description of Coverage.
- You pay the lesser of the Participating pharmacy’s regular charge for the drug or the Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage for each initial prescription or prescription refill.
- The following diabetic supplies are covered and will be subject to the Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage: glucagon emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors.
- Coverage will be provided for prescription Contraceptives prescribed for the purpose of preventing conception, and which are approved by the United States Food and Drug Administration (FDA), or generic equivalents of Contraceptives approved as substitutable by the FDA. Prescription contraceptives will be subject to the Deductible and/or Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage or that may be listed in this Rider.
- Value-Based drugs consist of certain maintenance drugs as determined by the Health Alliance Pharmacy and Therapeutics Committee. Value-Based drugs are subject to the Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage.
- Most, but not all, generic drugs (as defined by a National Drug Information Provider) will be dispensed under the Tier 1 or Value-Based Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law.
- If you or your Physician requests a brand-name drug when a generic exists, you pay the Tier 1 Copayment or Coinsurance, plus the difference in cost between the brand-name drug and the generic drug.
- If a Tier 2 or Tier 3 drug is prescribed and a generic does not exist, you pay the Tier 2 or Tier 3 Copayment or Coinsurance.
- Injectable syringes are covered when the injectable drug is covered.
- Prescription drugs for the treatment of male erectile dysfunction that are approved by the Health Alliance Pharmacy and Therapeutics Committee are covered. Examples of covered drugs include, but are not limited to: Viagra<sup>®</sup>, intracavernous vasoactive drug injections (Caverject<sup>®</sup> and Edex<sup>®</sup>) and intraurethral treatment (MUSE<sup>®</sup>). Treatment is limited to four doses of one drug per month.
- Includes medically necessary pain medication for the treatment of breast cancer.
- A limited number of over-the-counter (OTC) medications are covered. A prescription is required from your Physician for covered OTC products and either the Tier 1, Value-Based or Tier 2 Copayment or Coinsurance applies.

- If you are enrolled in the smoking cessation program, smoking cessation pharmacological therapy, as defined by the Health Alliance formulary is covered.
- For a 90-day supply of maintenance medications obtained through the mail-order pharmacy service you pay 2.5 Copayments instead of the three Copayments you would pay for a 90-day supply indicated on the Description of Coverage. For mail-order prescription drugs, the prescription, an order form and the Copayment or Coinsurance must be mailed to the mail-order pharmacy service. The mail-order pharmacy is required by law to fill the prescription with the amount ordered only, however your mail-order Copayment or Coinsurance still applies regardless of the amount dispensed. It is recommended that prescriptions for less than a 90-day supply be filled at an Outpatient Participating pharmacy.
- A 90-day supply of maintenance medications at the rate of 2.5 Copayments instead of three Copayments may also be obtained at certain Participating retail pharmacies. For a list of these Participating retail pharmacies, please call our Pharmacy Department at 1-800-851-3379, extension 8078.

*If a Tier 3 drug is determined to be Medically Necessary by your Physician and Health Alliance, you pay the Tier 2 Copayment or Coinsurance.*

## **OUTPATIENT PRESCRIPTION PHARMACY CONTRACEPTIVES**

Medically Necessary, Federal Drug Administration (FDA) approved prescription pharmacy Contraceptive methods are covered under this Rider when prescribed by a Physician. This includes contraceptive pills, patches, ring and over the counter methods.

- Tier 1 Prescription contraceptive pills, patches and ring will be covered under this Prescription Drug rider at a Preferred Pharmacy with \$0 Copayment as part of the wellness benefit.
- Tier 2 and/or Tier 3 Prescription contraceptive pills, patches, and ring will be subject to the Tier 2 and/or Tier 3 Deductible, Copayments and/or Coinsurance listed on the Description of Coverage.
- FDA-approved over-the-counter contraceptive products (including but not limited to condoms, sponges, and spermicide) are also covered for women with a prescription at a Preferred Pharmacy with \$0 Copayment as part of the wellness benefit. Coverage is limited to one package per month.
- One type of contraceptive product is covered per month under this Pharmacy Rider.

## **SPECIALTY PRESCRIPTION DRUGS**

Pharmacy Specialty Prescription Drugs are defined as any prescription drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty Prescription Drug on the Health Alliance drug formulary: (1) Specialized procurement handling; distribution, or is administered in a specialized fashion; (2) Complex benefit review to determine coverage; (3) Complex medical management; or (4) FDA-mandated or evidence-based medical-guideline determined comprehensive patient and/or physician education.

Pharmacy Specialty Prescription Drugs are available from a specialty pharmacy vendor. Coverage is subject to a prior written order by your Physician and Preauthorization by Health Alliance.

You pay the Specialty Prescription Drugs Copayment or Coinsurance amount specified in the Specialty Prescription Drugs section of the Description of Coverage. A specialty drug listing, which has a list of covered Tier 4, Tier 5 and Tier 6 Specialty Pharmacy Prescription Drugs, has been developed by Health Alliance. Tier 4 Specialty Drugs are the most clinically and cost-effective, these are also known as Preferred Specialty Drugs. Tier 5 Specialty Pharmacy Prescription Drugs are at a higher cost than Tier 4 and usually have clinically comparable alternatives available at the Tier 4 level. These are also known as Non-Preferred Specialty Drugs. Tier 6 Specialty Pharmacy Prescription Drugs are the highest cost specialty drugs or drugs that may not have the clinical advantages of Tier 4 or Tier 5 Specialty Drugs. The three-tier system helps manage costs, but provides flexibility and some coverage for Members who choose a higher-tier drug. This system of cost-sharing also helps Health Alliance continue to cover the majority of Specialty Prescription Drugs. The drugs listed in the Health Alliance formulary are reviewed and revised periodically by the Health Alliance Pharmacy and Therapeutics Committee. Specialty Prescription Drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug

may be removed from a tier during the Plan Year. If a drug moves to a higher tier then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any lower-tier alternatives available to you.

To access the most up-to-date version of our Standard Drug list visit the Our Plans section of our website [www.healthalliance.org](http://www.healthalliance.org) and choose “Standard Drug List” under Pharmacy Options or call the Customer Service Department listed on the back of your Member Identification card. Some plan’s pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a specialty prescription drug is included in the formulary and whether the drug will be covered at the Tier 4, or Tier 5 or Tier 6 specialty drug tier Copayment or Coinsurance.

Specialty Prescription Drugs are subject to any applicable Specialty Prescription Drug limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage. Copayments or Coinsurance for Specialty Prescription Drugs apply to any applicable Plan Year Specialty Prescription Drug Out-of-Pocket Maximum limit specified in the Maximums/Deductibles/Limitations section on the Description of Coverage.

Most, but not all, generic drugs (as defined by a National Drug Information Provider) will be dispensed under the Tier 4 Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law. If you or your Physician request a brand name drug when a generic exists, you pay the Tier 4 Copayment or Coinsurance, plus the difference in cost between the Tier 5 or Tier 6 drug, whichever is dispensed, and the generic drug.

If a Tier 5 or Tier 6 drug is prescribed and a generic does not exist, you pay the Tier 5 or Tier 6 Copayment or Coinsurance.

## **PRESCRIPTION DRUGS NOT COVERED**

- Prescription drugs prescribed by a non-participating Physician or obtained at a non-participating pharmacy, unless obtained for treatment of an Emergency Medical Condition.
- Prescription drugs for the treatment of a dental condition.
- Prescription drugs for the treatment of infertility, unless otherwise covered under an Infertility Prescription Drug Rider attached to the Policy.
- Non-prescription drugs or medicines are not covered, except for covered diabetic supplies, injectable syringes for covered injectable drugs and a limited number of over-the-counter (OTC) medications as stated above.
- When a medication is available both by prescription only (federal legend) and as an OTC product, the prescription drug is not covered unless otherwise stated in this Rider.
- Prescription drugs which are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by Health Alliance, including but not limited to: BOTOX®, psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiant or weight loss medications, anabolic steroids, oral fluoride preparations and hair removal or hair growth promoting medications.
- Growth hormones for idiopathic short stature.
- Devices of any type, other than prescription contraceptive devices, even if such devices may require a prescription, including but not limited to: therapeutic devices, artificial appliances, support garments, bandages, etc.
- Any drug labeled, “Caution - Limited by Federal Law to Investigational Use,” or experimental or other drugs which are prescribed for unapproved uses. Prescription Drugs for cancer treatment are covered if the drug is approved by the FDA and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
- the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network’s Drugs & Biologics Compendium; (3) the Thomson Micromedex’s Drug Dex; (4) the Elsevier Gold Standard’s Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health And Human Services, or 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 medical journals published in the United States or Great Britain.

- Prescription drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or any medication furnished by any other Drug or Medical Service for which there is no charge to you.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Any drug determined to be abused or otherwise misused by you.
- Any prescription drug purchased or imported from outside of the United States of America.
- Any prescription drug received outside of the United States of America, unless received as part of Emergency Services or Urgent Care.

## **DRUG LIMITATIONS**

Certain prescription drugs may be subject to drug limitations based on FDA-approved dosage recommendations and the drug manufacturer's package size. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

*Except as amended by this Rider, all terms and conditions of the Health Alliance HMO Policy to which this Rider is attached shall remain in full force and effect.*



## This document is a Rider to your Plan.

A Rider is a separate document that provides specific additional benefits not included in your Plan's Policy or Summary Plan Description.



### INFERTILITY PRESCRIPTION DRUG RIDER HEALTH ALLIANCE HMO

#### **BENEFIT**

Health Alliance administers pharmacy benefits through a national pharmacy benefit manager. Many independent pharmacies and most national chains are Participating pharmacies. To find out if a pharmacy is a Participating pharmacy, call the Customer Service Department at the number listed on the back of your Member Identification Card. You must present your Member Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Copayment or Coinsurance and/or Deductible at the time it is filled. If you do not present your Member Identification Card, you may be asked to pay the full retail price of your prescription. To request reimbursement you may submit your itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager's address noted on the back of your Member Identification Card.

Infertility prescription drugs obtained at a Participating pharmacy when prescribed by a Participating Physician, hereinafter referred to as Physician for purposes of this Rider, in connection with Infertility Services are covered for Members, subject to the following terms, conditions and limitations.

Infertility prescription drugs obtained from a Non-Participating pharmacy in conjunction with emergency services are covered subject to the terms, conditions and limitations listed below.

#### **PREAUTHORIZATION**

Some prescription drugs require Preauthorization from Health Alliance and certain criteria to be met by you. Drugs that require Preauthorization are noted on the prescription drug formulary.

Newly released prescription drugs require Preauthorization for at least six months from the date of launch until the drugs have undergone review by the Health Alliance Pharmacy and Therapeutics Committee.

Your Physician must contact Health Alliance to obtain Preauthorization. Preauthorization can be verified by calling Customer Service at the number listed on the back of your Member Identification Card. If Preauthorization is not obtained, Health Alliance will not provide coverage and you will be required to pay the full cost of the drug.

#### **PRESCRIPTION DRUG FORMULARY**

Health Alliance has entered into an agreement with a third party to provide certain pharmaceutical benefit services. This third party may contract with certain manufacturers for rebate programs. A prescription drug formulary, which is a list of covered Tier 1, Tier 2 and Tier 3 drugs and specialty prescription drugs, has been developed by Health Alliance. The drugs listed in the Health Alliance formulary are reviewed and revised periodically by the Health Alliance Pharmacy and Therapeutics Committee. Tier 1 drugs are the generally the lowest cost drugs, which includes most, but not all, generics. Tier 2 is drugs that are formulary drugs. Most of these drugs are brand name. Tier 3 drugs are Non Formulary drugs. The three-tier system helps manage costs, but provides flexibility and coverage for Members who choose a higher tier drug. This system of cost sharing also helps Health Alliance continue to cover the majority of prescription drugs. Prescription drugs may be moved between tiers, as new drugs may be added to a tier or an existing drug may be removed from a tier during the Plan Year. If a drug moves to a higher tier then you will be notified at least 30 days prior to the change so that you can discuss with your Physician any lower tier alternatives available to you.

To access the most up-to-date version of our Standard Drug list, visit the Our Plans section of our website [www.healthalliance.org](http://www.healthalliance.org) and choose “Standard Drug List” from the under Pharmacy Options or call the Customer Service Department listed on the back of your Member Identification card. Some plan’s pharmacy benefits may differ from this list. Upon request, Health Alliance will provide you with information as to whether a prescription drug is included in the formulary and whether the drug will be covered at the Tier 1, Tier 2 or Tier 3 or specialty prescription drug Copayment or Coinsurance.

## **OUTPATIENT INFERTILITY PRESCRIPTION DRUGS COVERAGE AND DISPENSING LIMITATIONS**

- Infertility prescription drugs are subject to any applicable limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage. Copayments or Coinsurance for infertility prescription drugs apply to any applicable Plan Year Prescription Drug Out-of-Pocket Maximum limit specified on the Description of Coverage. Initial prescriptions and prescription refills are limited to the manufacturer’s standard package as noted in the Outpatient Prescription Drugs section on the Description of Coverage.
- You pay the lesser of the Participating pharmacy’s regular charge for the drug or the Copayment or Coinsurance specified in the Outpatient Prescription Drugs section on the Description of Coverage for each initial infertility prescription or infertility prescription refill.
- Most, but not all, generic infertility drugs (as defined by a National Drug Information Provider) will be dispensed under the Tier 1 infertility drug Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law.
- If you or your Physician request a brand name infertility drug when a generic infertility drug exists, you pay the Tier 1 infertility drug Copayment or Coinsurance, plus the difference in cost between the brand name infertility drug and the generic infertility drug.
- If a Tier 2 or Tier 3 infertility drug is prescribed and a generic infertility drug does not exist, you pay the Tier 2 or Tier 3 infertility drug Copayment or Coinsurance.
- Injectable syringes are covered when the injectable drug is covered.

## **SPECIALTY PRESCRIPTION DRUGS**

Pharmacy Specialty Prescription Drugs are defined as any prescription drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and is identified as a Specialty Prescription Drug on the Health Alliance drug formulary: (1) Specialized procurement handling; distribution, or is administered in a specialized fashion; (2) Complex benefit review to determine coverage; (3) Complex medical management; or (4) FDA mandated or evidence-based medical-guideline determined comprehensive patient and/or physician education.

Pharmacy Specialty Prescription Drugs are available from a specialty pharmacy vendor. Coverage is subject to a prior written order by your Physician and Preauthorization by Health Alliance. You pay the Infertility Specialty Prescription Drugs Copayment or Coinsurance amount specified in the Specialty Prescription Drugs section of the Description of Coverage. Infertility Pharmacy Specialty Prescription Drugs are subject to any applicable Specialty Prescription Drug limitations specified in the Maximums/Deductibles/Limitations section on the Description of Coverage. Copayments or Coinsurance for infertility Pharmacy Specialty Prescription Drugs apply to any applicable Plan Year Specialty Prescription Drug Out-of-Pocket Maximum limit specified on the Description of Coverage.

Most, but not all, generic infertility Specialty Prescription Drugs (as defined by a National Drug Information will be dispensed under the Tier 4 infertility drug Copayment or Coinsurance when they exist and are available and allowable by applicable State or federal law. If you or your Physician request a brand name infertility drug when a generic infertility drug exists, you pay the Tier 4 infertility drug Copayment or Coinsurance, plus the difference in cost between the Tier 5 or Tier 6 infertility drug, whichever is dispensed, and the generic infertility drug.



If a Tier 5 or Tier 6 infertility drug is prescribed and a generic infertility drug does not exist, you pay the Tier 5 or Tier 6 infertility drug Copayment or Coinsurance.

### **INFERTILITY PRESCRIPTION DRUGS NOT COVERED**

- Non-prescription infertility drugs or medicine.
- Infertility prescription drugs prescribed by a non-participating Physician or obtained at a non-participating pharmacy, unless approved by Health Alliance.
- Infertility prescription drugs which are not approved by the United States Food and Drug Administration (FDA) for the treatment of infertility.
- Any infertility prescription drug labeled, “Caution –Limited by Federal Law to Investigational Use”, or experimental or other drugs which are prescribed for unapproved uses.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Infertility prescription drugs refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Any infertility prescription drug determined to be abused or otherwise misused by you.
- Any prescription drug purchased or imported from outside of the United States of America.
- Any prescription drug received outside of the United States of America, unless received as part of Emergency Services or Urgent Care.

### **DRUG LIMITATIONS**

Certain infertility prescription drugs may be subject to drug limitations based on FDA-approved dosage recommendations and the drug manufacturer’s package size. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

Except as amended by this Rider, all terms and conditions of the Health Alliance HMO Policy to which this Rider is attached shall remain in full force and effect.



# HEALTH ALLIANCE

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# HMO

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in- and out-of-network) can be accessed.
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

We encourage you to review and familiarize yourself with these subjects and the other benefit information in the attached document. For full benefit information, please refer to your Policy, or contact Health Alliance at the number listed on your ID card for information.

For general assistance and information, please call the Illinois Department of Insurance Office of Consumer Health Insurance at 877-527-9431. (Please be aware that the Office of Consumer Health Insurance is not able to provide specific plan information. For this type of information, contact Health Alliance directly.)





301 S. Vine St. • Urbana, Illinois 61801

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective date of this notice: April 14, 2003

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health.

This notice describes the way we may use and disclose information about your health to carry out treatment, payment and health care operations and for other purposes as permitted or required by law. It also describes your rights and duties regarding the use and disclosure of medical information.

**INFORMATION THAT THIS NOTICE APPLIES TO**

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that could only be used to identify you.

We collect such personal information as name, address, telephone number, Social Security number, age, sex and medical diagnosis to coordinate medical care. This information is obtained from member enrollment forms, member surveys and claims.

**OUR LEGAL RESPONSIBILITIES**

- We are required to maintain the privacy of your medical information.
- We are required to provide this notice of privacy practices and legal duties regarding medical information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.
- We will not sell your protected health information.
- We will not use or disclose genetic information for underwriting purposes.

**USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION**

The following categories describe different ways we may use and disclose protected health information without your authorization. For each category, we give some examples of uses and disclosures. Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of these categories.

**Treatment:** We do not provide medical treatment or services. We may disclose information about your health to a physician or health care professional involved in making a decision that could affect your care. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription contradicts prior prescriptions.

**Payment:** We use and disclose information about your health to determine eligibility for benefits and payment of claims for medical treatment or services. For example, we may disclose information to your health care provider to verify coverage for medical treatment or services. Likewise, we may share medical information with a health care provider to assist in billing or filing claims for payment of treatment and services, including third party liability claims and coordination of benefits. We may also send you information about claims we pay and claims we do not pay (called an “explanation of benefits”) for you and your covered dependents. Under certain circumstances, you may request to receive this information confidentially.

**Health Care Operations:** We may use and disclose your medical information for activities that are necessary for our HMO and health insurance operations. These uses and disclosures are necessary for our business and to make sure you are receiving quality services. Some examples of how we may use and disclose information about your health include: case management and care coordination; conducting quality assessment and improvement activities such as outcomes evaluation and development of clinical guidelines; underwriting, premium rating and other activities relating to coverage; submitting claims for stop-loss or reinsurance coverage; conducting or arranging for medical review; fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. Some examples of business associates are our lawyers, auditors, accrediting agencies, consultants, pharmacy benefit managers, collection agencies and printing and mail service vendors. Our business associates are required to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

#### **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT**

We may use or disclose your protected health information in the following situations without your authorization or without allowing you to object or agree to the use or disclosure.

**Legal Requirements:** We may use and disclose your medical information when we are required to do so by law. This includes disclosing your protected health information to a government health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure. For example, we may be required to disclose your medical information, and the information of others, if we are audited by the Illinois Department of Insurance. We will also disclose your medical information when we are required to do so by a court order or other judicial or administrative process.

**To Report Abuse:** We may disclose your medical information when the information relates to abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting or with your permission.

**Law Enforcement:** We may disclose your medical information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness, missing person or in connection with suspected criminal activity. We may disclose protected health information in response to court orders or in emergency circumstances related to a crime. We may also disclose your medical information to a federal agency investigating our compliance with federal privacy regulations.

**Family and Friends:** Unless you object or law prohibits it, we may disclose your medical information to a member of your family or to someone else involved in your medical care or payment for care. This may include telling a family member about the status of a claim or what benefits you are eligible to receive.

**To Avert a Serious Threat:** We may disclose your medical information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

**Health Benefits and Services:** We may use your medical information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Workers' Compensation:** We may disclose medical information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries and illnesses.

**Your Employer or Organization Sponsoring your Group Health Plan (Plan Sponsor):** We may disclose eligibility, enrollment and disenrollment information about you to the Plan Sponsor. We may also disclose summary health information to the Plan Sponsor for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan.

In addition, we may disclose other health information to the Plan Sponsor for plan administration upon certification from the Plan Sponsor that they have agreed to special restrictions on the use and disclosure of this information. Refer to your group health plan documents on additional health information the Plan Sponsor may receive.

## **ORGANIZED HEALTH CARE ARRANGEMENTS**

We may share information that we have about you within our organization and with Carle and its affiliates; and with Springfield Clinic, Memorial Medical Center and their affiliates for purposes of health care operations under an organized health care arrangement. Sharing information enables us to:

- Determine our financial risk
- Resolve quality of care complaints
- Arrange for medical and clinical peer review
- Improve our methods of payment or coverage policies
- Arrange for legal services
- Perform utilization management services

## **YOUR RIGHTS**

The following describes your rights regarding the protected health information we maintain about you. If you want to exercise your rights, please contact a member of our Customer Service Department, who will give you the necessary information and forms for you to return to the address listed under “Whom to Contact” at the end of this notice.

**Authorization:** We may use and disclose your medical information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your medical information for any other reason without your authorization. If you authorize us to use or disclose your medical information, you have the right to revoke the authorization at any time. You may not revoke an authorization for us to use and disclose your medical information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization. We will receive your authorization to use or disclose your information for certain marketing activities.

**Request Restrictions:** You have the right to request that we restrict uses and disclosures of your medical information that we use for treatment, payment and health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment of your care, like a family member. We will consider your request, however, we are not required to agree to a restriction. We cannot agree to restrict disclosures that are required by law.

**Receive Confidential Communications:** If our normal communication channels could endanger you, you have the right to request that we send communications that contain your medical information by alternative means or to an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests to the extent the request specifies an alternative location and allows us to continue to pay claims.

**Inspect and Copy:** You have the right to inspect the medical information we maintain about you in our records and to receive a copy of it. This right is limited to information about you that is used to make decisions such as claims, payment and enrollment records. Under state and federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceedings. To inspect your records or to receive a copy, send your written request to the address listed under “Whom to Contact” at the end of this notice. We may charge a fee for the cost of copying and mailing the records. We will respond to your request within 30 days.

We may deny you access to certain information if it would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, we will explain how you may appeal the decision.

**Amend:** You have the right to request that we amend your medical information for as long as we maintain such information if you believe the information is incorrect or incomplete. This right is limited to information about you that is used to make decisions such as claims, payment and medical case management records. Your written request must include the reason or reasons that support your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if we determine the record that is the subject of the request was not created by us, is not available for inspection as specified by law or is accurate and complete.

**Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures of your medical information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; disclosures made with your authorization; communications with family and friends; disclosures made for national security or intelligence purposes; disclosures to correctional institutions or law enforcement officials; or disclosures made prior to April 14, 2003. We will provide the first list of disclosures you request at no charge. A reasonable, cost-based fee may be imposed for each subsequent request. You must tell us the time period you want the list to cover. If a breach of your information occurs, we will notify you within 60 days.

**Receive a Paper Copy:** You have the right to obtain a paper copy of this notice at any time.

**Complaints:** You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with our Customer Service Department. (See “Whom to Contact” at the end of this notice.) You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services. We will not take any retaliation against you if you file a complaint.

**Maintaining Confidentiality of Member Information:** The security of our members’ personal information is very important to us. Member information is never sold to anyone, for any purpose. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your privacy.

All Health Alliance employees are educated on our standards and are required to sign a confidentiality and security agreement annually. Any employee found to be in violation of our privacy practices is subject to disciplinary action. Employees are encouraged to report violations of confidentiality using the Health Alliance compliance hotline.

## **CHANGES TO THIS NOTICE**

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any medical information we already have, as well as to medical information we receive in the future. Before we make any change in the privacy practices described in this notice, we will mail a revised notice to you within 60 days of the effective date.

## **WHOM TO CONTACT**

You may contact a member of our Customer Service Department by calling the number listed on the back of your Member Identification Card (TTY 1-800-526-0844 for the hearing impaired) or in writing at 301 S. Vine Street, Urbana, IL, 61801:

- For more information about this notice and/or our privacy policies
- To exercise your rights as described in this notice
- To request a copy of the current notice

Representatives are available from 8 a.m. to 5 p.m. Monday through Friday.

This notice is also available on our website at: [HealthAlliance.org](http://HealthAlliance.org)





## Medical Loss Ratio Information

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2013, health insurers must send any rebates due for 2012 and information to employers and individuals regarding any rebates due for 2012.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2012 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit [www.HealthCare.gov](http://www.HealthCare.gov).





# PRESCRIPTION BENEFITS GUIDE

For the  
State of Illinois



Inside you'll learn about:

- Benefit basics
- Cost-saving tools
- Tips to get the most from your coverage
- Answers to common questions

## BENEFIT BASICS

### Understand a Tiered Plan

Think of tiers like steps: the lower the “step” (or tier), the less you pay for your medicine. Before filling a prescription, it’s smart to check the Health Alliance Drug Formulary for your medicine’s tier. The plan you’re on will affect your copayments or coinsurance. You’ll always pay the lowest amount for a Tier 1 drug.

If you or your doctor requests a brand-name drug when the generic is available on a lower tier, you will usually pay the copayment or coinsurance for the generic drug, plus the difference in cost between the brand-name drug you requested and the generic drug.

## GET THE MOST FROM YOUR COVERAGE

### Retail 90

#### At the Store

Do you prefer to pick up your drugs from a neighborhood pharmacy? Below is a list of chain retail pharmacies that participate in the Retail 90 program, which lets you get a 90-day supply of many medications. This list may change.

CVS	Target	Walmart
Meijer	Kmart	
Hy-vee	Walgreens	

Please call the Health Alliance Pharmacy Department for more pharmacies. There are about 50 independent pharmacies who also participate.

### Mail Order

#### At your Door

Our mail-order program brings savings to your doorstep. You get a 90-day supply of your drugs – delivered from a trusted pharmacy – for a discounted price.

To enroll in our mail-order program, please contact Catamaran, our pharmacy benefits manager. They can be reached at 1-866-814-7105. You can also enroll through [YourHealthAlliance.org](http://YourHealthAlliance.org).

### DailyMed

#### Get Peace of Mind

For members who take multiple medications, DailyMed delivers clearly labeled, pre-sorted packages to your home. DailyMed does the pill sorting for you and gives you peace of mind, knowing you’ve taken the right drugs at the right time. Find out more by calling 1-855-793-2459 (1-855-RX-DAILY), or visit [DailyMedRx.com](http://DailyMedRx.com).

### Get Online Help

#### YourHealthAlliance.org

Visit [YourHealthAlliance.org](http://YourHealthAlliance.org) and log in as a member. If you don’t have a member login, you can sign up for one. Directions are on our website.

Once you’ve logged in, click “My Drug Benefit” near the center of your screen. Then choose from the purple tabs along the top. You can:

- see which pharmacies are in your network.
- find out the retail price of your drug and what other drugs like it may cost.
- learn about hundreds of drugs and if there are any side effects or any possible interactions between a new drug and one you are already taking.
- view a history of drugs prescribed to you by your doctor(s).
- print a temporary ID card if you have lost yours.

# ANSWERS TO COMMON QUESTIONS

## Will my doctor always prescribe a drug on the lowest tier?

Not always. Your doctor sees patients on many different health plans and probably doesn't know the details of everyone's specific pharmacy coverage.

Before your doctor writes your prescription:

- Tell your doctor you have a tiered pharmacy plan.
- Ask if there is a low-tier or generic drug that is right for you.
- Remember, to be covered, most Health Alliance plans require prescriptions to be filled at an in-network pharmacy. Visit [YourHealthAlliance.org](http://YourHealthAlliance.org) for in-network pharmacies.

## Can I get a refill of my prescription before I go on vacation if I know I'll run out before I get back?

Each year, you can ask for two early refills per 30-day supply of each of your maintenance drugs (except schedule II controlled substances) from your local pharmacy to take with you on a trip.

If you will be staying in the United States, you could also fill your prescriptions at an in-network pharmacy like Walmart or CVS while on your trip.

Specialty drugs are excluded from vacation supply requests. Our Specialty drug vendor will ship your drugs to your destination within the U.S. Please refer to your formulary to learn more.

For travel outside the U.S., check that country's drug restrictions before you go. Some countries have strict rules on which drugs you can bring with you. Please note, we do not cover routine medical care and maintenance drugs provided outside the U.S.

## What else do I need to get a prescription?

You'll need to show the pharmacist your member ID card to make sure you pay the right copayment amount and to make sure the drug is covered by your plan.

## When can I get a refill?

You can refill your prescription after you've taken  $\frac{3}{4}$  (75%) of your last prescription as prescribed. (For instance, if you have a 30-day prescription, you can get your next month's drugs after you have taken 23 days' worth of the drugs you have.)

## Why do I need preauthorization to take a drug my doctor prescribed?

We have two kinds of preauthorization.

- Step-therapy is a tool to control costs for certain drug groups. If you have a new prescription for a certain type of drug, you have to first try the most cost-effective drug in that group before another one is covered. In most cases, the cost-effective drug will work for you. If it doesn't, your doctor will need to request preauthorization for another drug in the same group.
- We also have preauthorization for other drugs to make sure they are being used for the right medical diagnosis.

Visit [HealthAlliance.org](http://HealthAlliance.org) to see our preauthorization drug list.

Please call the Pharmacy Department at 1-800-851-3379, option 4, for more information.



## COST-SAVING TOOLS



### Get Generics and Save Big

Generic drugs are just as good as the brand-name version. The FDA reviews, approves and regulates them the same way it does the brand-name drugs. Switching to a generic saves you money without giving up quality.

So the next time you are at the doctor, ask, “Can I get a generic?”

To learn more, visit [AskForGenerics.org](http://AskForGenerics.org)

### R<sub>x</sub>tra Benefits

If you have drug coverage through Health Alliance, you can save money on many generic drugs at certain pharmacies.

Here is how R<sub>x</sub>tra works:

- Primary – When you visit these pharmacies, you’ll pay the standard copayment for your plan.
- Preferred – When you use Preferred pharmacies, you’ll pay nothing out-of-pocket on hundreds of the most-used prescriptions.
- Preferred Plus – In addition to the discounts of Preferred pharmacies, you also pay nothing for simvastatin, pravastatin and Ventolin HFA. These cholesterol and asthma medications help keep you healthy – our ultimate goal.

For a full list of R<sub>x</sub>tra pharmacies and drugs, visit [YourHealthAlliance.org](http://YourHealthAlliance.org)

Around every corner you’ll find a participating Preferred Plus chain pharmacy:

Dierbergs	Kroger
Oscor	Sam’s Club
Shop ‘n Save	Walmart



# Customer Service

## We Have People For That

“We have people for that” isn’t just a slogan—it’s a promise to meet your needs, answer questions and find solutions. Our helpful, friendly Customer Service reps are some of our “people” who put this promise into action every day.

They can help with a range of topics about your coverage.

- Copayment/coinsurance and deductible amounts
- Claims
- Preauthorization
- Coverage and eligibility
- Updating your personal information
- See if your meds are covered (and at what cost to you)
- ID cards
- Appeals
- Finding a doctor or hospital in your provider network

## Get Help After Hours

For help after 5 p.m., call the Customer Service number above, which will transfer you to our Member Self-Service system. Here, you can:

- See the date your coverage started.
- Check that your account is active.
- Order a new ID card.
- Leave a message—we’ll return your call the next business day.

## Access Plan Info at [YourHealthAlliance.org](http://YourHealthAlliance.org)

Register on our secure member website, and you can view your plan materials and manage your coverage in these ways.

- Order a new ID card.
- See which doctors and hospitals are in your network with our Provider Directory.
- View the status of current claims and look through past claims.
- Learn about preauthorization, Explanation of Benefits and more.
- Find answers to common questions in our FAQ.

Sign-up is simple. Just go to [YourHealthAlliance.org](http://YourHealthAlliance.org) and click “Register” to create an account.

## Translation Services / Servicios de Traducción

If you or your dependents need help in another language, we give you free access to interpreters who speak more than 140 languages. Just call our regular Customer Service number and ask for “Language Line.”

Si usted necesita ayuda para interpretar la información sobre sus beneficios, por favor llame al teléfono gratis 1-800-851-3379 y pregunte por la “Language Line.”







# Get more at [YourHealthAlliance.org](http://YourHealthAlliance.org)

YourHealthAlliance.org is your interactive, secure member website. After logging in, you'll have all the information you need right at your fingertips.

## Benefit Information

### Customer Service

Bypass the hold line by going online to order ID cards (and print temporary cards while you wait for the new ones to arrive in the mail). You can also ask a question through the website, and a Customer Service rep will respond.

### Important plan documents

View your plan's Summary of Benefits and Coverage (SBC), policy, amendments and all the documents that explain how your coverage works.

### Claims and Explanation of Benefits (EOB)

Check on the status of a claim or view your full EOB, which tells you who paid what and how much.

### Pharmacy Coverage

Review your Drug List for covered drugs, use pricing tools to determine your true drug costs and find in-network pharmacies.

### Medical and Pharmacy Policies

Look up policies on specific drugs, treatments or procedures to learn about their coverage rules.

### Doctors, Hospitals and Clinics

Search for in-network doctors and hospitals in our Provider Directory. To change your Primary Care Physician (PCP), click "View Plan Detail" on your Member Dashboard and then choose "Change Primary Care Physician" about halfway down the page.

## Health Information

### Health Optimization Programs

Learn about our Be Well programs, which help you get more from your coverage.

### Health Navigation

Our new wellness tool helps you better navigate your health and keeps you on track with your health goals.

## Sign-up is Simple

To get a member account, go to [YourHealthAlliance.org](http://YourHealthAlliance.org). Click "Register" to sign up for a new account and follow the instructions. We'll then send you a confirmation email.

If you have questions about [YourHealthAlliance.org](http://YourHealthAlliance.org), please call us at the number on the back of your ID card.

For optimal viewing, please use the most recent version of Google Chrome, Apple Safari, Mozilla Firefox or Microsoft Internet Explorer available for your operating system.

[blog.HealthAlliance.org](http://blog.HealthAlliance.org)

[facebook.com/HealthAlliance](https://facebook.com/HealthAlliance)

[twitter.com/Health\\_Alliance](https://twitter.com/Health_Alliance)







*Be Your Best* brings together the programs, people and resources you need to understand and improve your health, all for no additional cost. For more information, call 1-800-851-3379, extension 8112. You can also visit [HealthAlliance.org](http://HealthAlliance.org) and click on the Health and Wellness tab.



## Is there a *Be Your Best* program that's right for you?

### **Active with Asthma**—asthma management program

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Don't let asthma stop you from doing the things you love to do. Health Alliance is here to help you take control and be active. Adults and parents of children with asthma receive educational materials, including the newsletter *Asthmazine*, to improve self-management skills. In addition, adolescents and teens receive a special newsletter, *Asthmagram*, covering asthma topics relevant to their unique perspective.

### **Get in Check**—diabetes management program

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As a program participant you'll receive regular educational materials with tips on diet, exercise and important routine screenings. Adults with diabetes receive the newsletter *everyDAY*, and the newsletter *everyDAY kidz* gives children with diabetes age-appropriate information. A case manager can work with you to manage your diabetes, in cooperation with your team of doctors and supporters.

### **BP Beat**—high blood pressure management program

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Members with high blood pressure receive educational materials to stress the importance of controlling blood pressure. By tracking your blood pressure, you can protect yourself from the increased risk of heart disease, stroke, blindness and kidney disease.

### **Road to Relief**—migraine prevention and management program

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Nearly 28 million Americans suffer from migraine headaches each year. The good news is that when properly managed, migraines don't have to interfere with your life. The *Road to Relief* program provides helpful information about identifying and avoiding your triggers, treating your migraines and taking control of your health.

### **I Can Quit**—smoking cessation program

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Want to quit smoking? Health Alliance, in partnership with Ceridian, encourages you to become smoke-free for life. The *I Can Quit* program includes telephone support from a trained health coach and coverage of over-the-counter or prescription smoking cessation aids. Call 1-866-345-5129 to see if you are eligible. Not available to all members/plan participants.

### **ImmYOUnize**—immunization program

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Timely mailings remind parents and children about the importance of vaccinations. Toddlers who are up-to-date on their immunizations receive a free gift. Members 65 years and older receive annual reminders on the importance of pneumococcal and influenza immunizations.



## ChoLESterol—cholesterol management program

Maintaining good cholesterol levels is an important part of keeping your heart healthy. To help our members better manage their cholesterol levels, we offer the *ChoLESterol* program. As a program participant, you can access our online newsletter, *ChoLESterol*, educational materials on eating right and helpful information on taking control of your cholesterol.



### HealthAlliance.org

You can further research the programs listed on this flier and do much more by visiting HealthAlliance.org. When you land on the Health Alliance homepage, click on the Health and Wellness tab on the top right of the screen.

Here you can read relevant health articles and access additional wellness resources.

Our goal is to provide a comprehensive wellness site to guide you in becoming the healthiest you possible.

## Be Fit

### Nutrition and Exercise Tools

In today's fast-paced and stressful times, it can be easy to not pay attention to what you eat or how often you exercise. But being overweight can increase your chances of developing diabetes, high blood pressure or even certain cancers. To help your fitness efforts, Health Alliance has partnered with industry-leading weight-loss and fitness centers to offer discounts on weight-loss programs and fitness club memberships. Visit HealthAlliance.org to learn how you can access these discounts.



Health Alliance offers innovative newsletters and resources for children, with topics geared just for them. Using these fun, interactive tools, your children can learn how to control their asthma or diabetes.

## Case Management Support for Well-being

Health Alliance connects members who need additional help for health conditions with a case manager who can assist in getting the care needed to lead a healthier, more productive life. Our case managers provide support and education to members with diabetes, COPD, heart failure, asthma, cardiac disease (heart attack), high blood pressure and end-stage renal (kidney) disease/dialysis. We also offer our Case Management Program to members who have had a transplant, have experienced a major illness or an accident, or have a high-risk pregnancy or high-risk child. For more information, members or caregivers may call our Medical Management Department at 1-800-851-3379, extension 8112.

Be Healthy –  
Using Your Wellness Benefits



## Helping You Stay Healthy

Health Alliance  
emphasizes prevention  
through comprehensive  
wellness coverage.  
We support members  
throughout their lives,  
not just when  
they're sick.



We cover preventive services and tests, even when you are healthy. Here is a partial list of the services included in your comprehensive wellness benefit\*:

- One wellness exam, per member (no age limitations), per plan year.
- One wellness visit to a Women's Principal Health Care Provider, per year.
- Well-child care
- The screenings, procedures and immunizations listed below, within the applicable wellness benefit:
  - Blood sugar screening (including a basic metabolic panel and comprehensive metabolic panel)
  - Cervical cancer screening (Pap smear)
  - Cervical cancer vaccine
  - Childhood immunizations
  - Chlamydia screening
  - Cholesterol screening
  - Colorectal cancer screening (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test)

\*Office visit copayment or coinsurance may apply and/or be applicable to a deductible. Age limitations and frequencies may apply.

A detailed listing of wellness-covered procedures and services follows.

Procedure Codes

Descriptions

Immunizations	
90460-90461, 90471-90474	Immunization administration
90632-90634	Hepatitis A
90636	HepA-HepB adult
90644, 90733-90734	Meningococcal
90645-90648	Hib
90649 90650	HPV quadrivalent 3 dose (ages 9-26) HPV bivalent 3 dose (ages 9-26)
90653-90658, 90660-90664, 90666-90668, 90672, 90685-90688, Q2033-Q2039	Influenza
90669-90670, 90732, S0195	Pneumococcal
90680-90681	Rotavirus
90696	DTaP-IPV (4-6 years)
90698	DTaP – Hib – IPV
90700	DTaP < 7 years
90701	DTP – diphtheria, tetanus & pertussis
90702	DT < 7 years
90703	Tetanus toxoid
90704	Mumps
90705	Measles
90706	Rubella
90707	Measles, mumps & rubella MMR
90708	Measles and rubella
90710	Measles, mumps, rubella and varicella vaccine MMRV
90712-90713	Poliovirus (OPV or IPV)
90714	Td 7 years and older
90715	Tdap 7 years and older
90716	Varicella (VZV) – chicken pox
90718	TD
90719	Diphtheria toxoid
90720	DTP-Hib
90721	DtaP-Hib
90723	DtaP-HepB-IPV
90736	Herpes Zoster (shingles)
90739, 90740, 90743, 90744, 90746, 90747	Hepatitis B
90748	HepB-Hib
G0008	Administration of influenza virus vaccine

<b>Alcohol Screenings</b>		
99408, 99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention [SBI] services; 15 to 30 minutes)	Four visits per year
G0442	Annual alcohol misuse screening, 15 minutes	
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	Four visits per year
<b>Bone Density</b>		
76977, 77078, 77080, 77081, G0130	DXA, bone density study	One per lifetime
<b>Cholesterol</b>		
80061	Lipid profile	Once every 5 years for men 35 and older; women 45 and older  Once every 5 years for men ages 20-35; women ages 20-45 (with V17.3-V17.4X, V81.0-V81.2)
82465	Cholesterol, serum or whole blood, total	Once every 5 years for men 35 and older; women 45 and older  Once every 5 years for men ages 20-35; women ages 20-45 (with V17.3-V17.4X, V81.0-V81.2)
83718	Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	Once every 5 years for men 35 and older; women 45 and older  Once every 5 years for men ages 20-35; women ages 20-45 (with V17.3-V17.4X, V81.0-V81.2)
83721	Lipoprotein, direct measurement; LDL cholesterol	Once every 5 years for men 35 and older; women 45 and older  Once every 5 years for men ages 20-35; women ages 20-45 (with V17.3-V17.4X, V81.0-V81.2)
84478	Triglycerides	Once every 5 years for men 35 and older; women 45 and older  Once every 5 years for men ages 20-35; women ages 20-45 (with V17.3-V17.4X, V81.0-V81.2)



Colorectal		
G0104	Colorectal cancer screening, flexible sigmoidoscopy	Once every 5 years starting at age 50
G0105	Colorectal cancer screening, colonoscopy	Once every 10 years starting at age 50
G0106	Colorectal cancer screening, alternative to G0104, screening sigmoidoscopy, barium enema	Once every 5 years starting at age 50
G0120	Colorectal cancer screening, alternative to G0105, screening colonoscopy, barium enema	Once every 10 years starting at age 50
G0121	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk	Once every 10 years starting at age 50
G0328	Colorectal cancer screening, fecal occult blood test, immunoassay, 1-3 simultaneous determinations	Annually starting at age 50
45330	Flexible sigmoidoscopy	Once every 5 years starting at age 50
45383-PT, 45384-PT, 45385-PT, 45378-PT, 45380-PT	Colonoscopy, flexible	Once every 10 years starting at age 50
82270, 82271, 82274	Blood occult screening	Annually starting at age 50
Diabetes		
82947	Glucose (fasting blood sugar)	
82950	Glucose, post prandial	
82951	Glucose, tolerance test	
G0108	Diabetes self-management training, individual session (two or more), 30 minutes	
G0109	Diabetes self-management training, group session (two or more), 30 minutes	
HIV		
86689	Antibody, HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	
86701	Antibody, HIV-1	
86702	Antibody, HIV-2	
86703	Antibody, HIV-1 and HIV-2, single assay	
87389	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; HIV-1	
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; HIV-2	
G0432, G0433, G0435	Infection agent antibody detection	
S3645	HIV-1 antibody testing of oral mucosal transudate	
Men's Health		
G0102-G0103, 84152-84154	Prostate cancer screening	
G0389	Ultrasound AAA screening	Men age 65-75

<b>Newborn</b>		
84030	Phenylalanine (PKU)	
84443	Thyroid stimulating hormone (TSH)	
85660	Sickling of RBC, reduction	
85014, 85018 with V20.2	Anemia test	Age 21 and younger
83655 (with V20.2)	Lead screening	Age 21 and younger
86580 (with V20.2)	TB testing	Age 21 and younger
80061, 82465, 83721, 84478 (with V20.2 and V77.91)	Dyslipidemia screening	Age 21 and younger
<b>Sexually Transmitted Diseases</b>		
G0445	Semi-annual high-intensity behavioral counseling to prevent STIs. Includes education, skills training and guidance on how to change sexual behavior	Two every 12 months
86592-86593	Syphilis test	
87270, 87320, 87490-87492, 87810	Chlamydia	
87850, 87590-87592	Gonorrhea	
87620-87622	Papillomavirus (HPV)	Screening should begin at 30 years of age and should occur no more frequently than every three years.
<b>Women's Health</b>		
P3000-P3001, Q0091, R923	Pap smear	
G0101	Cervical or vaginal cancer screening, pelvic and breast exam	
G0123, G0124, G0141, G0143-G0145, G0147-G0148	Screening cytopathology, cervical or vaginal	
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175	Cytopathology, cervical or vaginal	
86304	Immunoassay for ovary tumor antigen	
E0602	Breast pump, manual	

<b>Women's Health - Contraceptive Management (with Diagnosis*)</b>		
A4261	Cervical cap for contraceptive use	
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	
A4266	Diaphragm for contraceptive use	
S4989, J7300, J7307, Q0090	Contraceptive intrauterine device (IUD), including implants and supplies	
J1050	Medroxyprogesterone acetate	
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla)	
J7302	Levonorgestrel-releasing intrauterine contraceptive system (Mirena)	
57170	Diaphragm or cervical cap fitting with instructions	
58300, 58301	Insertion and removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600, 58605, 58611	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g. band, clip or Falope ring)	
<b>Women's Health - Mammography</b>		
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	
77052, 77057, G0202, R403	Screening mammography	Once a year ages 35 and up
96040 (with diagnosis)	Medical genetics counseling (for BRCA)	
<b>Women's Health - Obstetric Exams and Screening With Maternity Diagnosis</b>		
80055	Obstetric profile	
81000-81002	Urinalysis	
83540	Iron	
85007, 85009	Differential WBC count	
85025, 85027	Automated hemogram	
86762	Antibody, rubella	
86850	Transfusion screen	
86900, 86901	Blood typing	
87086, 87088	Urine culture/colony count; urine bacteria	
87340-87341	Hepatitis B surface antigen detection	
87350	Hepatitis B antigen (HBeAg)	
85004	Blood count; automated differential WBC	

\* For members with pharmacy benefits, a listing of contraceptives covered at the pharmacy can be found at [HealthAlliance.org](http://HealthAlliance.org).

Smoking Cessation		
99406, 99407, G0436-G0437	Smoking and tobacco use cessation counseling visit	
Miscellaneous		
G0117, G0118	Glaucoma screening	
92551	Hearing screening, pure tone	Age 21 and younger
80048	Basic metabolic panel	
80053	Comprehensive metabolic panel	
G0270, G0271 97802-97804 (with diagnosis codes)	Medical nutrition therapy	
G0444	Annual depression screening; 15 minutes	
G0446	Bi-annual face-to-face intensive behavioral therapy to reduce CVD risk; 15 minutes	
G0447 (with diagnosis codes)	Face-to-face behavioral counseling for obesity, 15 minutes	26 every 12 months
99173	Screening test of visual activity	Age 21 and younger
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	
96110	Developmental testing	
Preventive Care Exams		
99381-99387, 99391-99397	Preventive Medicine Services	
99401-99404, 99411, 99412	Preventive counseling	
R770	Preventive Care Services	
R771	Preventive Care Services Vaccine Administration	
R779	Other preventive services	
G0402-G0405	Initial preventive physical exam	
G0438, G0439	Preventive Care Exams	

Visit our website at [HealthAlliance.org](http://HealthAlliance.org) and log in as a member to view the most current listing of covered preventive service codes. If your doctor bills Health Alliance with a code that is not on this list, the service may not be covered under the wellness benefit.

If you have any questions about your wellness benefit, please call Health Alliance at 1-800-851-3379, Monday through Friday, 8 a.m.-5 p.m.



301 S. Vine St.  
Urbana, IL 61801-3347



COLOMBO,RENEE A  
401 WOODVALE LN  
HERRIN, IL 62948