STATE OF ILLINOIS - OAP
EMPLOYEE HEALTH BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED JULY 1, 2021

Contents

I. Introduction

1. Your Group Insurance Benefits

Your benefits are a very important part of your compensation package as a State of Illinois employee. Please read this handbook carefully as it contains vital information about your benefits.

The Bureau of Benefits within the Department of Central Management Services (Department) is the Bureau that administers the State Employees Group Insurance Program (Program) as set forth in the State Employees Group Insurance Act of 1971 (Act). You have the opportunity to review your choices and change your Coverage for each Plan Year during the annual Benefit Choice Period. If a qualifying change in status occurs, you may be allowed to make a change to your Coverage that is consistent with the qualifying event. See the section 'Enrollment Periods' for more information.

2. MyBenefits Service Center (MBSC)

The MyBenefits Service Center (MBSC) is a custom benefits solution service Provider for the Department. The MBSC will manage the detailed enrollment process of member benefits through online technical support via the MyBenefits.illinois.gov website and telephonic support via the MyBenefits Service Center 844-251-1777. The MBSC is now the member's primary contact for answering general questions you may have about your eligibility for Coverage and to assist you in enrolling or changing the benefits you have selected.

3. Group Insurance Representative (GIR)

A Group Insurance Representative (GIR) is your employing agency's liaison to the Department. Every State agency has a GIR. Some of the larger agencies also have Group Insurance Preparers (GIP) who may assist the GIR with your insurance needs. GIRs and GIPs continue to be valuable resources concerning policies and rules set forth by CMS regarding members' benefits and eligibility as well as ensuring the successful enrollment process of the member. To identify your GIR, call your agency personnel office or visit MyBenefits.illinois.gov. If you have a change of address, or are on leave of absence, contact your employing agency GIR. If you are on an extended disability leave, your GIR may be located at your retirement system office. If you have terminated State service and are continuing Coverage under COBRA, contact the MBSC Service Center.

4. Where to get Additional Information

If you have questions after reviewing this book, please refer to the following:

- The Department's website contains the most up-to-date information regarding benefits and links to Plan administrators' websites. Visit MyBenefits.illinois.gov for information.
- Annual Benefit Choice Options booklet. This booklet contains the most current information regarding changes for the Plan Year. Visit MyBenefits.illinois.gov to view the booklet.
- Each individual Plan administrator can provide you with specific information regarding Plan Coverage inclusions/exclusions.
- The MyBenefits Service Center (MBSC) can answer general benefits questions or refer you to the appropriate resource for assistance. MBSC can be reached at:

MyBenefits Service Center
844-251-1777 or TDD/TTY: 844-251-1778
MyBenefits.illinois.gov

- The Department will continue to assist members regarding Leaves of Absence, Medicare, enrollment and eligibility information as well as answer your benefit questions or refer you to the appropriate resource for assistance. The Group Insurance Division can be reached at:

  DCMS Group Insurance Division
  801 S. 7th Street, P.O. Box 19208
  Springfield, IL 62794-9208
  800-442-1300 or 217-782-2548
  TDD/TTY: 800-526-0844

- View the State of Illinois Benefits Handbook located at MyBenefits.illinois.gov.

II. Important Notices

1. Notice Regarding Women's Health and Cancer Rights Act

Under this health Plan, as required by the Women's Health and Cancer Rights Act of 1998, Coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This Coverage will be provided in consultation with the attending Physician and the patient, and will be provided in accordance with the Plan design, limitations, Co-pays, Deductibles, and referral requirements, if any, as outlined in your Plan documents.

If you have any questions about our Coverage of mastectomies and reconstructive Surgery, please contact Aetna Member Services number on your ID card.

2. Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and health insurance issuers offering group health insurance Coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that you, your Physician, or Other health care Provider obtain Pre-certification or notify the Plan for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain Pre-certification

from the Plan for any days of confinement that exceeds 48 hours (or 96 hours). For information on Pre-certification, contact Aetna.

3. Choice of Provider

Under this Plan, you have the right to receive services from both In-Network or Participating Providers and Out-of-Network or Non-Participating Providers. Participating Providers are those who have an agreement with Aetna, whereas Non-Participating Providers do not. Keep in mind that using a Participating Provider may cost you less than using a Non-Participating Provider.

Although not required to have a Primary Care Physician ("PCP") under this Plan, you are encouraged to utilize one to assist you in coordinating your care. You may select a PCP from the Network of Providers. The role of the PCP is important to the coordination of your care; you should contact your PCP when medical care is needed. You and your PCP will work together to maintain your health, and your PCP will be able to provide or coordinate most of your health care needs. This may include providing preventive health services, obtaining authorization of certain services, consulting with Specialists and other Providers, and Emergency Services.

4. Notice of No Lifetime Limit and Enrollment Opportunity

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

5. Notice About Emergency Services

The Plan covers Emergency Services without the need for any Pre-certification determination and without regard as to whether the health care Provider furnishing such services is a Participating Provider. Care for Emergency Services provided by a Non-Participating Provider will be paid at no greater cost to the Covered person as if the services were provided by a Participating Provider. A Deductible applies to each visit to an emergency room which does not result in an inpatient admission.

6. Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance Plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care Providers (doctors, dentists, pharmacies, Hospitals and other caregivers) payors (health care Provider organizations, employers who sponsor self-funded health Plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your Plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information

confidential as provided by applicable law. In our health Plans, participating Network Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; Medical Necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; Formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life Plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

7. Notice of Nondiscrimination

The laws of the State of Illinois prohibit insurers from unfairly discriminating against any person based upon their status as a victim of family violence, sex, sexual preference or marital status and forbids excluding Coverage for Dependent child maternity.

III. Eligibility Requirements, Leaves of Absence, Continuation Rights and Termination of Coverage

All issues of employee, Retiree and Dependent eligibility; enrollment; and Effective Dates of Coverage are determined by the Illinois Department of Central Management Services ("CMS"). Individuals must meet CMS requirements for eligibility and enrollment. For more information, contact your Group Insurance Representative or CMS to determine whether you or your Dependents are eligible for Coverage, when they can enroll and their respective effective and termination dates. Please refer to your State of Illinois Benefits Handbook for more information regarding your eligibility requirements, leaves of absence, continuation and conversion rights and termination of Coverage. The contents of that Handbook are incorporated herein by reference.

IV. Medical Necessity and Pre-certification (Notification) Requirements

Your Plan pays for its share of the expense for Eligible Health Services only if the general requirements are met. They are:

- The Eligible Health Service is Medically Necessary.
- You or your Provider Pre-certifies the Eligible Health Service when required.

This section addresses the Medical Necessity and Pre-certification requirements.

1. Medically Necessary/Medical Necessity

Medical Necessity is a requirement for you to receive an Eligible Health Service benefit under this Plan.

The Medical Necessity requirements are stated in the Glossary section, where we define "Medically Necessary, Medical Necessity." That is where we also explain what our Medical Directors or their Physician designees consider when determining if an Eligible Health Service is Medically Necessary.

2. Pre-certification

Pre-certification is required for some elective and non-elective Eligible Health Services.

In-Network Providers: the Physician is responsible for obtaining any necessary Pre-certification before you receive care. If your Physician does not obtain the required Pre-certification, we will not pay the Provider who gives you the care. You will not be required to pay if your Physician fails to Pre-certify. If your Physician requests Pre-certification and Aetna deem the care not Medically Necessary, you can still receive the care, but the Plan will not pay for it.

Out-of-Network Providers: when you utilize an Out-of-Network Provider, it is your responsibility to obtain Pre-certification for any elective or non-elective procedure and/or supply listed on the Pre-certification list. If you do not Pre-certify, your benefits may be reduced or not covered. The list of services and supplies requiring Pre-certification appears later in this section but may be subject to change.

Pre-certification should be secured within the timeframes specified below. To obtain Pre-certification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your Physician or the facility will need to call and request Pre-certification at least 14 days before the date you are scheduled to be admitted.
For an emergency admission:	You, your Physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your Physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of

	or change in an Illness, the diagnosis of an Illness, or an Injury.
For outpatient non-emergency medical services requiring Pre-certification:	You or your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your Physician of the Pre-certification decision, where required by state law. **If your Pre-certified services are approved, the approval is valid for 60 days as long as you remain enrolled in the Plan.**

Aetna will also notify you, your Physician and the facility regarding the approval or denial of an inpatient admission to a facility. If your Physician recommends that your stay be extended, additional days will need to be Pre-certified. You, your Physician, or the facility will need to call Aetna at the number listed on your ID card as soon as reasonably possible, but no later than the final Pre-certified day. Aetna will review and process the request for the extended stay and notify you and your Physician of an approval or denial.

If Pre-certification determines the stay or services and supplies are not Eligible Health Services, the Pre-certification letter will explain why and how the decision can be appealed. You or your Provider may request a review of the Pre-certification decision.

What if you do not obtain the required Pre-certification?

- Your benefits may be reduced, or the Plan may not pay any benefits.
- You may be responsible for the unpaid balance of the bills.
- You may be responsible for additional penalties for failure to Pre-certify.

What types of services require Pre-certification?

Inpatient services and supplies	**Outpatient services and supplies**
Stays in a Hospital	Applied Behavior Analysis
Stays in a Skilled Nursing Facility	Complex Imaging
Stays in a Rehabilitation Facility	Comprehensive Infertility and ART services
Stays in a Residential Treatment Facility for treatment of Mental Disorders	Cosmetic and reconstructive Surgery
Advanced Reproductive Technology (ART) services	Emergency transportation by fixed wing airplane
Transplant	Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications)
Hospice	Kidney dialysis
	Outpatient back Surgery not performed in a Physician's office
	Hip or knee Surgery
	Psychological testing\neuropsychological testing
	Intensive Outpatient Program (IOP) - Mental Disorder diagnoses
	Outpatient Detoxification

	Partial Hospitalization Treatment - Mental Disorder diagnoses
	Certain Durable Medical Equipment

NOTE: this list may not be an all-inclusive list.

Certain Prescription drugs are Eligible Health Services under the medical Plan when they are given to you by your doctor or health care facility and not obtained at a pharmacy. The following Pre-certification information applies to these Prescription drugs:

For certain drugs Covered under your medical Plan, your Prescriber or your pharmacist needs to obtain approval from Aetna before the drug may be Covered. Sometimes the requirement for approval helps guide appropriate use of certain drugs and makes sure there is a medical need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com. For drugs Covered under your Prescription drug Plan, contact your Prescription benefit manager for more information.

V. Schedule of Covered Services

This Plan Covers only those medical services and supplies that are: (1) contained in this Schedule of Covered Services; (2) deemed Medically Necessary; (3) Prior Authorized, when applicable; and (4) not excluded from Coverage. A summary of medical services that constitute Eligible Health Services under the Plan is set forth in this Plan Document. This Plan will provide benefits in accordance with the applicable requirements of federal laws, such as Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Family Medical Leave Act of 1993 ("FMLA") and the Health Insurance Portability and Accountability Act ("HIPAA"), the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), the Newborns' and Mothers' Health Protection Act ("NMHPA"), the Women's Health and Cancer Rights Act ("WHCRA") and the Patient Protection and Affordable Care Act ("PPACA"). Aetna has the sole and discretionary authority to interpret the Plan and to determine all questions arising in the administration, interpretation and application of the Plan provisions. Aetna may delegate part of its authority and duties to others as it deems necessary and desirable.

The Plan covers only those health services and supplies that are deemed Medically Necessary by the Plan and not excluded under the exclusions and limitations section of this Plan Document. Covered transplants must be rendered by an Institutes of Excellence™ (IOE) facility in order to receive Coverage.

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

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

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Acupuncture	Eligible Health Services for charges for treatment of diagnosed chronic pain with a written referral from a Physician or dentist. **Note**: Chronic pain is defined as pain that persists longer than the amount of time normally expected for healing.	Coverage is subject to frequency limitations.
Allergy	Eligible Health Services for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	You are not Covered for non-Physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers or air ventilation system cleaning.
Ambulance	Eligible Health Services include transport by professional ground Ambulance services: • To the first Hospital to provide Emergency Services. • From one Hospital to another Hospital if the first Hospital cannot provide the Emergency Services you need. • From your home to a Hospital if an Ambulance is the only safe way to transport you. Your Plan also covers transportation to a Hospital by professional air or water Ambulance when: • Professional ground Ambulance transportation is not available. • Your condition is unstable and requires medical supervision and rapid transport. • You are traveling from one Hospital to another and - The first Hospital cannot provide the Emergency Services you need, and - The two conditions above are met.	You are not Covered for the following Ambulance services: 1. Transportation by Ambulance because you did not have any other form of transportation. 2. Routine transportation. 3. Transportation for outpatient care.

Anesthesia and Associated Services for Certain Dental Care	Eligible Health Services include general anesthesia and associated Hospital care for dental care if you are: • A Dependent child age 6 or under. • Have a medical condition that requires hospitalization or general anesthesia for care or • Disabled. As used in this section, you are "disabled" if you have a chronic condition that meets all of the following: • It is due to a mental and/or or physical impairment. • It is likely to continue. • It results in substantial limitations in 1 or more of the following activities: – Self-care – Open and expressive language – Learning – Ability to move – Ability to live alone – Financial independence Eligible Health Services also include dental anesthesia by a dental Provider, for an Autism Spectrum Disorder or a developmental disability. You must: • Be under 26 years of age. • Make 2 visits to the dental Provider before seeking other Coverage. We define developmental disability as a disability that meets all of the following conditions: • Is cerebral palsy, epilepsy, or any other condition, other than mental Illness. It must result in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services that are similar. For purposes of this definition, Autism is considered a related condition. • It is likely to continue indefinitely. • It results in substantial limitations in 3 or more areas of major life activity: – Self-care – Speech or self-expression – Learning – Being able to move – Self-direction – The ability to live alone Eligible health services can be provided in a dental office, oral surgeon's office, Hospital, or outpatient surgical treatment center.	Eligible Health Services only include the anesthesia and associated hospitalization. The dental care services are not a Covered Benefit.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Autism Spectrum Disorders	Eligible Health Services and care for the diagnosis of and treatment for Autism Spectrum Disorders when prescribed, provided, or ordered as part of a treatment Plan for a person diagnosed with an Autism Spectrum Disorder by a Physician licensed to practice medicine in all its branches or a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary. Eligible Health Services for the treatment of Autism Spectrum Disorders shall include the following: • Psychiatric and psychological care. • Habilitative or rehabilitative care, meaning speech, occupational, and physical therapies that provide treatment in the following areas: - self-care and feeding - pragmatic, receptive, and expressive language - cognitive functioning - applied behavioral analysis, intervention and modification - motor planning - sensory processing	Pre-certification is required for applied behavior analysis.

Behavioral / Mental Health	In an emergency or a life-threatening situation, call 911, or go to the nearest Hospital emergency room. Plan Participants must call the behavioral health Plan administrator within 48 hours to avoid a financial penalty. Pre-certification requirements still apply when Plan Participants have other Coverage, such as Medicare. 1. Inpatient services must be Pre-certified prior to admission or within 48 hours of an emergency admission to receive In-Network or Out-of-Network benefits. Pre-certification is required with each new admission. Failure to Pre-certify the behavioral health Plan administrator of an admission to an inpatient facility within 48 hours will result in a financial penalty and risk incurring non-Covered charges. 2. Partial Hospitalization and intensive outpatient treatment must be Pre-certified prior to admission to receive In-Network or Out-of-Network benefits. Pre-certification is required before beginning each treatment program. Failure to Pre-certify the behavioral health Plan administrator of a Partial Hospitalization or Intensive Outpatient Program will result in a financial penalty and risk incurring non-Covered charges. 3. Most routine outpatient services (such as therapy sessions, medication management and telemedicine) will be Eligible Health Services without the need for Pre-certification. Pre-certification for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a Plan Participant's condition will be subject to a Medical Necessity review. The behavioral health administrator will contact the Plan Participant's Provider to discuss the treatment if a review will be applied. Outpatient services received at the Out-of-Network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or Psychiatrist to be eligible for Coverage. 4. Electroconvulsive therapy, psychological testing and applied behavioral analysis must be Pre-certified to receive In-Network or Out-of-Network benefits. Failure to obtain Pre-certification will result in the risk of incurring non-Covered charges. 5. Residential services must be Pre-certified prior to admission to receive In-Network or Out-of-Network benefits. Pre-certification is required with each new residential admission. Failure to Pre-certify the behavioral health Plan administrator of an admission to a residential facility will result in a financial penalty and risk incurring non-Covered charges. 6. Coverage for benefits that are delivered through the psychiatric Collaborative Care Model. 7. For early treatment of a serious mental illness in a child or young adult under age 26, coverage for the following bundled, evidence-based treatment:	Pre-certification is required for Inpatient, Partial Hospitalization and Intensive Outpatient Program for mental health services. You are not Covered for the following mental health services: 1. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling. 2. Mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services. 3. Psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school. 4. Mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility. 5. Institutional care which is for the primary purpose of controlling or changing your environment. 6. Milieu therapy, biofeedback, behavior modification therapy, sensitivity training, hypnosis, electro hypnosis, electro sleep therapy or electro narcosis.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	• Coordinated specialty care for first episode psychosis treatment; and • Assertive community treatment (ACT) and community support team (CST) treatment.	
Blood and Blood Products	Eligible Health Services for Medically Necessary blood and blood products, including procurement and administrative charges, in connection with Eligible Health Services under the Plan.	You are not Covered for the following blood and blood products services and supplies: 1. The cost of whole blood and blood products replacement to a blood bank. 2. Services and related expenses for personal blood storage, unless associated with a scheduled Surgery for you. 3. Administration costs related to the procurement, processing and storage of blood from a person you designate as a donor. 4. Fetal cord blood harvesting and storage.
Breast Reconstruction	Eligible Health Services for the following breast reconstruction related services and supplies: 1. Breast reconstruction Surgery following a Medically Necessary mastectomy. Consistent with the Women's Health and Cancer Rights Act ("WHCRA"), if you elect breast reconstruction after a Medically Necessary mastectomy, Coverage will be provided for: • Reconstruction of the breast upon which the mastectomy was performed. • Surgery and reconstruction of the other breast to produce a symmetrical appearance. • Prostheses and treatment for physical complications at all stages of the mastectomy, including lymph edemas.	Pre-certification is required. You are not Covered for the following breast reconstruction related services and supplies or diagnostic testing related to those services and supplies: 1. Removal of breast implants if implanted solely for cosmetic or other non-Covered reasons, even if removal is determined to be Medically Necessary. 2. Removal of breast

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	2. Inpatient treatment following mastectomy for a length of time to be determined by attending Physician. 3. Availability of post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge. 4. Standard prosthetic breast devices, including surgical implants, external breast prostheses, and post-mastectomy surgical bras. 5. Removal of breast implants but only if the implants were inserted because of a Medically Necessary mastectomy and the implants are causing Illness or Injury.	implants, regardless of their indication for placement due to alleged or diagnosed systemic or rheumatologic disorders. 3. Breast enhancement or augmentation mammoplasty, with or without implants, unless associated with breast reconstruction Surgery following a Medically Necessary mastectomy incurred secondary to active disease. 4. Breast reduction/ reconstruction for male gynecomastia.
Breast-Related Services	Eligible Health Services for the following breast-related services: 1. Services related to the prevention of breast cancer and its early detection. 2. Services related to the diagnosis and treatment of abnormalities of the breast. 3. Mammogram Coverage as follows: a. Screening by low-dose mammography, including digital mammography and breast tomosynthesis, for all women over 35 (including baseline mammogram for women 35-39 and annual mammogram for women 40 and older). b. Mammograms for women under 40, with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at ages and intervals as considered Medically Necessary. c. Comprehensive ultrasound screening and MRI of an entire breast or breasts when a mammogram demonstrates heterogeneous or dense breast tissue and when Medically Necessary as determined by your Physician. d. A screening MRI when Medically Necessary, as determined by your Physician. 4. Clinical breast exams at least every three (3) years for women aged 20-39 and annually for women 40 years of age or older.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Cancer Treatment	Eligible Health Services for the following cancer treatment: 1. Services related to the prevention of cancer and its early detection, including those services outlined in the preventive services section of this Schedule of Benefits. 2. Services related to the diagnosis and treatment of cancer, including those outlined below and in other sections of this Schedule of Covered Services. a. Eligible Health Services for cancer treatments include Surgery, chemotherapy, and radiation therapy under the following conditions: i. the treatment must be Medically Necessary; ii. chemotherapeutic drugs used in the treatment of cancer are limited to those drugs: • which have been approved by the Federal Food and Drug Administration (FDA) and • recognized by the medical community for the specific type of cancer or which the drug has been prescribed in one of the following compendia: - the American Medical Association Drug Evaluations - the American Hospital Formulary Service Drug Information - the United States Pharmacopoeia Drug Information - if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer-reviewed professional journals published in the United States or Great Britain; iii. the treatment, including treatment combinations and treatment intervals, is considered to be the standard treatment for that particular cancer as recognized by a majority of the national medical community and as published in peer-reviewed medical journals. The published results must clearly demonstrate either a survival or quality of life enhancement advantage in clinical trials; iv. the treatment is currently not considered to be Experimental or in clinical trials. 3. Medically Necessary pain medication and pain therapy related to the treatment of breast cancer. Prescription drugs may be Covered separately through your pharmacy Coverage.	Pre-certification may be required for some services, such as brachytherapy, stereotactic radiation therapy and proton beam therapy. You are not Covered for the following cancer treatment: 1. Services related to the diagnosis and treatment of cancer that are not Medically Necessary or are not considered to be consistent with the standard treatment for that particular cancer. 2. Services related to alternative or nutritional treatments for cancer. 3. Phase I and Phase II clinical trials as well as any randomized and controlled Phase III clinical trials for the treatment of cancer that are not sanctioned by the National Cancer Institute (NCI). Note, however, that your Coverage may not be cancelled or non-renewed simply because of your participation in a qualified cancer trial as defined by Illinois law. 4. Services related to an Experimental or Investigational clinical trial. 5. Costs associated with an approved Investigational cancer trial that are specifically excluded, including:

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	4. Medically Necessary health care services provided as part of a randomized and controlled Phase III clinical trial for the treatment of cancer that is sanctioned by the National Cancer Institute (NCI). 5. An annual office visit for a whole body skin examination for lesions suspicious for skin cancer. 6. Medically necessary comprehensive cancer testing and testing of blood or constitutional tissue for cancer predisposition testing as determined by a physician licensed to practice medicine in all of its branches. 7. Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.	a. the cost of any clinical trial therapies, regimens or combinations thereof; b. the cost of any drugs or pharmaceuticals in connection with the approved clinical trial; c. the cost of any diagnostic testing which is part of the clinical trial; d. any costs associated with the provision of any goods, services or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer; e. any additional costs associated with the provision of any goods, services or benefits that previously have been provided to, paid for, or reimbursed, including diagnostic testing; or any other similar costs; or f. the costs of services provided for the convenience of the Physician or you.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Cardiac Rehabilitation Therapy	Eligible Health Services include cardiac rehabilitation services for Phase 1 and Phase II you receive at a Hospital, Skilled Nursing Facility or Physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your Physician.	You are not Covered for the following: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 6. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

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Chiropractic Care	Eligible Health Services include spinal manipulation to correct a muscular or skeletal problem, but only if your Provider establishes or approves a treatment Plan that details the treatment and specifies frequency and duration. Limited to 30 visits per Plan Year.	You are not Covered for the following chiropractic care: 1. Chiropractic therapy that is preventive in nature. 2. Massage therapy. 3. Chiropractic therapy for all non-musculoskeletal diseases and injuries. Examples include, but are not limited to, diabetes, asthma, obesity, hypertension, allergies, and infections. 4. Chiropractic services not otherwise defined as a Covered Service.
Christian Science Practitioners	Eligible Health Services for a Christian Science nurse or practitioner. A Christian Science nurse is a nurse who is listed in a Christian Science Journal at the time services are given and who: a. has completed nurses' training at a Christian Science Benevolent Association Sanitarium; or b. is a graduate of another school of nursing; or c. has three consecutive years of Christian Science nursing, including two years of training. A Christian Science practitioner is an individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.	

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Clinical Trial Therapies (Experimental or Investigational)	Eligible Health Services include Experimental or Investigational drugs, devices, treatments or procedures from a Provider under an "approved clinical trial" only when you have cancer or Terminal Illnesses and all of the following conditions are met: 1. Standard therapies have not been effective or are not appropriate. 2. You may benefit from the treatment based on published, peer-reviewed scientific evidence. An "approved clinical trial" is a clinical trial that meets all of these criteria: 1. The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it Investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval. 2. The clinical trial is approved by an Institutional Review Board that will oversee the investigation. 3. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization. 4. The trial conforms to standards of the NCI or other, applicable federal organization. 5. The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution. 6. You are treated in accordance with the protocols of that study.	
Clinical Trials (Routine Patient Costs)	"Routine patient costs" are the items and services that are typically Eligible Health Services when you are not enrolled in an "approved clinical trial". Eligible Health Services include "routine patient costs" incurred by you from a Provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	
Dental & Oral Surgical Services	Eligible Health Services include the following services: • Surgical removal of complete bony impacted teeth. • Excision of tumors or cysts of the: - Jaws - Cheeks - Lips - Tongue	You are not Covered for the following types of dental and oral surgical services: 1. The care, filling, removal or replacement of teeth. 2. Dental services related to the gums. 3. Apicoectomy (dental

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	- Roof and floor of the mouth • Excision of exostoses of the jaws and hard palate, when the procedure is not done to prepare for dentures or other prostheses. • Treatment of fractures of the facial bone. • External incision and drainage of cellulitis. • Incision of accessory sinuses, salivary glands or ducts. • Reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder. • Corrections from an accidental Injury. The Surgery must be performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected. Surgery to fix teeth injured due to an accident is an Eligible Health Service when: - Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the Injury. The Surgery returns the injured teeth to how they functioned before the accident.	root resection). 4. Orthodontics. 5. Root canal treatment. 6. Removal of soft tissue impactions. 7. Alveolectomy. 8. Augmentation and vestibuloplasty treatment of periodontal disease. 9. False teeth. 10. Dental implants, appliances or splints. 11. Dental care delivered during the treatment of accidental Injury to sound, natural teeth that are not related to the accidental Injury. 12. Dental services relating to the diagnosis or treatment, including appliances, for myofunctional disorders, craniofacial pain disorders and orthognathic Surgery. 13. Dental related oral surgical services to correct an overbite or under-bite. **NOTE**: Basic dental care is provided by the dental benefit carrier.

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Dermatological Services	Eligible Health Services for diagnosis and treatment of diseases of the skin, acne treatment, and the removal of skin lesions that interfere with normal body functions or are suspected to be malignant.	You are not Covered for: 1. The removal of benign skin lesions, growths (such as warts), or skin tags. 2. Any dermatological services that are primarily for cosmetic purposes. 3. Anti-aging services. 4. Sal abrasion, chemosurgery, laser Surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes. 5. Services performed for the treatment of acne scarring, even when medical or surgical treatment for acne has been provided by the Plan.
Diabetic Self-Management Training and Education	Eligible Health Services for the prevention, diagnosis and treatment of diabetes, which shall include the following: 1. Services related to the prevention of diabetes and its early detection is an Eligible Health Service as described in the preventive services section of this Schedule of Covered Services. 2. Foot care to minimize the risk of infection 3. Regular eye examinations by your Physician. (This does not include Coverage for refractive exams to check visual acuity). 4. Prescribed Supplies: a. Diabetic needles, syringes and pens b. Test strips – blood glucose, ketone and urine c. Injection aids for the blind d. Blood glucose calibration liquid e. Lancet devices and kits f. Alcohol swabs 5. Equipment:	

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	a. External insulin pumps and pump supplies b. Blood glucose monitors without special features, unless required due to blindness 6. Education - self-management training provided by a health care Provider certified in diabetes self-management training. This Coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy. Coverage also for licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the senior diabetes patients' homes to remove the hurdle of transportation for senior diabetes patients to receive treatment. NOTE: Diabetic pharmaceuticals and supplies, including insulin, syringes and needles, test strips for glucose monitors, FDA-approved oral agents used to control blood sugar and glucagon emergency kits may be Eligible Health Services under your Prescription drug benefit.	
Diagnostic Tests and Procedures	Eligible Health Services for Medically Necessary diagnostic tests and procedures (including, but not limited to, laboratory tests, radiographic tests, and other diagnostic procedures). 1. Diagnostic lab work includes lab services, pathology and other tests when performed from a licensed lab. 2. Radiological services when performed from a licensed lab. 3. A diagnostic mammogram at no cost share when Medically Necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant. 4. Complex imaging services by a Provider, including: a. Computed tomography (CT) scans b. Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA) c. Nuclear medicine imaging including positron emission tomography (PET) scans	You are not Covered for the following diagnostic tests and procedures: 1. That is considered to be Experimental or Investigational. 2. That has not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in peer-reviewed medical literature. 3. That is not done to evaluate current health problems or symptoms (e.g., premarital blood testing, paternity testing, screening for various conditions in the absence of symptoms or significant risk factors.)

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		4. That is part of a non-Covered clinical trial.
Dialysis	Eligible Health Services for hemodialysis and peritoneal services provided by an outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies and maintenance are Eligible Health Services.	
Durable Medical Equipment (DME)	Eligible Health Services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your Plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for Coverage if you need it for long-term use. When it is Pre-certified, we cover the instruction and appropriate services needed for a member to learn how to properly use the item. Coverage includes: 1. One item of DME for the same or similar purpose. 2. Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse. 3. A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item. Your Plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your Plan does not. All maintenance and repairs that result from misuse or abuse are your responsibility. Coverage also includes Medically Necessary cardiopulmonary monitors for persons 18 years old or younger who has had a cardiopulmonary event. Coverage also includes pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, if the covered person is an infant under the age of 12 months, a licensed medical practitioner prescribes the milk for the covered person, and applicable medical criteria has been met.	Pre-certification is required for some equipment. You are not Covered for the following: 1. Eyeglasses, contact lenses, and other equipment intended to improve vision. 2. Equipment for environmental control, such as air conditioners, furnaces or heaters, air filters or purifiers, humidifiers or dehumidifiers. 3. Allergenic pillows or mattresses. 4. Improvements or modifications to your home or place of business. 5. Whirlpool baths or portable whirlpool pumps. 6. Fitness or exercise equipment. 7. Repair or replacement of DME due to misuse, neglect or loss. 8. Convenience or comfort items, including, but not limited to, tub grab bars, over the bed tables and raised toilet seats. 9. Replacement items,

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		including, but not limited to, replacement batteries, tires, and light bulbs. 10. Cranial caps and helmets, except for certain diagnoses. 11. Message devices, communication aids and telephone alert systems. **NOTE:** The excluded items are presented as a representation and should not be considered as an all-inclusive list.
Emergency Services for Emergency Medical Conditions	Eligible Health Services include services and supplies for the evaluation, treatment and stabilization of accidental Injury or Emergency Illness that constitutes an Emergency Medical Condition as that term is defined in the Glossary Section and by Illinois law. Emergency Services are Eligible Health Services in and outside of the Plan's Service Area 24 hours a day, 7 days a week by a Provider qualified and licensed to provide those types of services. Emergency Services also include outpatient visits and referrals for emergency mental health problems. Emergency Services do not include post-stabilization services. Once your Emergency Medical Condition has been stabilized and the emergency no longer exists, you must obtain all further care from participating Providers in order to receive continued In-Network Coverage.	While emergency room visits do not require Pre-certification, if you are admitted to the Hospital following an emergency room visit, you should notify the Plan within 48 hours of admission, the next business day or as soon as reasonably possible after care begins. You are not Covered for the following: 1. Visits to a Hospital emergency room when you do not have an Emergency Medical Condition. (This includes follow-up care provided in an emergency room). 2. Visits to the emergency room for services that are otherwise not Covered under the Plan (*e.g.*, non-traumatic dental services).
Eyeglasses and Corrective Lenses (Vision Services)	Eligible Health Services for Medically Necessary vision services required for the diagnosis and treatment of diseases of, or injuries to, the eye.	You are not Covered for the following vision services: 1. Routine eye examinations to check visual acuity,

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		except as provided by your PCP in his or her office. 2. The measurement, fitting or adjustment, or polishing of eyeglasses or contact lenses. 3. Contact lenses, eyeglass frames, corrective lenses, tints, or other lenses, services, or treatments, except for the first pair of eyeglasses or corrective lenses immediately following cataract Surgery performed while you are enrolled in the Plan. 4. Vision therapy or orthoptics treatment (eye exercises). 5. Surgery for the correction of a refractive disorder, including, but not limited to: radial keratotomy (RK), astigmatic keratotomy (AK), automated lamellar keratoplasty (ALK), (excimer laser) photorefractive keratectomy (PKR), phototherapeutic keratectomy (PTK) and laser assisted in situ keratomieusis (LASIK).
Family Planning	Eligible Health Services for outpatient contraceptive service, including consultations, examinations, procedures and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Eligible Health Services also for all outpatient contraceptive devices approved by the Food and	You are not Covered for the following: 1. Any contraceptive methods that are not approved by the FDA.

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	Drug Administration, such as intra-uterine devices (IUD's), implants, cervical caps and diaphragms. You may have Coverage for FDA-approved contraceptive drugs and devices purchased through a pharmacy through a separate Prescription drug benefit. Eligible Health Services also include coverage for abortion care services.	2. Reversal of a voluntary sterilization. 3. Costs of any services rendered by/to a surrogate mother.
Foot Orthotics	Must be custom molded or fit to the foot and ordered by a Physician or podiatrist. Must be prior authorized.	You are not Covered for the following: Over the counter foot orthotics.
Hearing Services	Coverage includes hearing instruments and related services for all members when a hearing care professional prescribes a hearing instrument to augment communication **Hearing instrument** means any wearable non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords. **Related Services** means those services necessary to assess, select, and adjust or fit the hearing instrument to insure optimal performance including, but not limited to, audiological exams, replacement ear molds, and repairs to the hearing instrument. **Hearing care professional** means a person who is a licensed hearing instrument dispenser, licensed audiologist, or a licensed physician. This coverage shall be subject to all applicable copayments, coinsurance, deductibles, and out-of-pocket limits for the cost of a hearing instrument for each ear, as needed, as well as hearing instrument and related services of no more than $2,500 per hearing instrument every 24 months. Nothing precludes a member from selecting a hearing instrument that costs more than the amount covered by the plan and paying the uncovered cost at his or her own expense. Eligible Health Services include hearing services required for the diagnosis and treatment of diseases of, or injuries to, the ears, hearing screenings to determine hearing loss; and newborn screening examinations, any necessary re-screening, audiological assessment and any required follow-up.	You are not Covered for: 1. Hearing aid reconditioning, supplies or batteries. 2. Hearing therapy and related diagnostic hearing tests. 3. Replacement of a hearing aid that is lost, stolen or broken. 4. Replacement parts or cords to a hearing aid.

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	Eligible Health Services for individuals under the age 18 include hearing instruments and related hearing aid services for children when prescribed by a hearing care professional as described below: 1. Hearing instrument include: a. Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing b. Parts, attachments or accessories 2. Hearing aid services include: a. Audiological exam b. Selection, fitting and adjustment of ear molds c. Hearing instrument repairs Eligible Health Services also include bone anchored hearing aids and cochlear implants for children.	
Home Health Care	Eligible Health Services for Medically Necessary Home Health Care and/or home infusion services provided in your home under the following circumstances: 1. The services are provided in lieu of hospitalization or placement in a Skilled Nursing Facility or you are unable to receive the same services outside your home. 2. You are homebound because of Illness or Injury. 3. The services have been ordered by your Physician. 4. The services are part of a Home Health Care Plan. 5. The services are Skilled Nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy. 6. Home health aide services are provided under the supervision of a registered nurse. 7. Medical social services are provided by or supervised by a Physician or social worker. **NOTE:** Rehabilitation services provided in the home will be Eligible Health Services under the applicable rehabilitative services sections of this Plan and will be subject to the applicable Coinsurance as described in your Schedule of Benefits.	You are not Covered for the following Home Health Care services: 1. Housekeeping services. 2. Home care that is full-time, continuous or long-term. 3. Services provided by a person who ordinarily resides in your home or is in your immediate family. 4. Custodial Care. 5. Services outside the home or to help meet personal, family or domestic needs. 6. Private duty nursing for non-Custodial Care.
Hospice Care	Eligible Health Services include inpatient and outpatient Hospice care when given as part of a Hospice care program. The types of Hospice care services that are eligible for Coverage include: 1. Room and Board. 2. Services and supplies furnished to you on an inpatient or outpatient basis.	You are not Covered for the following types of services under a Hospice care program: 1. Private or special nursing services. 2. Funeral arrangements.

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	3. Services by a Hospice care agency or Hospice care provided in a Hospital. 4. Psychological and dietary counseling. 5. Pain management and symptom control. 6. Respite care. 7. Nursing services – skilled and non-skilled. Hospice care services provided by the Providers below may be Eligible Health Services, even if the Providers are not an employee of the Hospice care agency responsible for your care: 1. A Physician for consultation or case management. 2. A physical or occupational therapist. 3. A Home Health Care agency for: a. Physical and occupational therapy b. Medical supplies c. Outpatient Prescription drugs d. Psychological counseling e. Dietary counseling	3. Financial or legal counseling, including estate planning or drafting of a will. 4. Homemaker or caretaker services that may include: a. Sitter or companion services. b. Transportation. c. House cleaning or household maintenance. d. Services by volunteers or persons who do not regularly charge for their services. e. Services rendered by or at the direction of a person residing in the member's household, including family members such as the member's spouse, child, parent, grandparent, sibling or any person related in the same way to the member. 5. Pastoral Counseling.
Hospital Care (Acute Inpatient)	Eligible Health Services for inpatient Hospital services, including, but not limited to, the following: 1. Pre-admission testing. 2. Semi-private Room and Board or specialty units, such as intensive care and coronary care. 3. General nursing care and services of Physicians employed by the Hospital. 4. Lab, x-ray, diagnostic tests, medical treatment, and the administration and processing of whole blood and blood	Pre-certification is required unless the admission is emergent. In addition, you are not Covered for the following inpatient Hospital care services: 1. Take-home drugs dispensed prior to your release, whether billed directly or separately by

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	plasma. 5. Use of an operating and recovery rooms, including anesthesia. 6. Medical supplies used by you during your inpatient stay. 7. Medications administered to you during your inpatient stay. 8. Therapy services, including rehabilitative therapy, radiation therapy, and inhalation therapy. 9. Oxygen and its administration. 10. Intensive or special care units of a Hospital**.** 11. Discharge planning.	the Hospital. 2. Expenses incurred prior to your Effective Date of Coverage or after your Coverage has ended. 3. Private duty nursing. 4. Hospitalization for the purpose of receiving services, such as Cosmetic Surgery, that are not Covered under this certificate. 5. Personal comfort or convenience items, such as, but not limited to, in-Hospital television, telephone, guest trays and housekeeping. 6. Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home. 7. Any confinement for which the member is not legally obligated to pay.
Immunizations	Eligible Health Services for preventive childhood and adult immunizations to prevent or arrest the further manifestation of human Illness or Injury. These are Eligible Health Services according to the Plan's recommended immunization schedule guidelines and the guidelines of the Centers for Disease Control (CDC). Copies of recommended immunization schedules are available upon request. This includes, but is not limited to, influenza shots, shingles vaccines (for members 50 years of age and older) and human papillomavirus ("HPV") vaccines.	You are not Covered for: 1. Immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entities whose role it is to establish eligibility guidelines and recommend preventive guidelines. 2. Immunizations where you do not meet the recommended eligibility guidelines. 3. Immunizations for non-

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		health related reasons, such as for travel, education or employment. 4. Immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups.
Infertility	As used in this Section, "Infertility" means a disease, condition, or status characterized by: 1. a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility; 2. a person's inability to reproduce either as a single individual or with a partner without medical intervention; or 3. a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. Eligible Health Services for basic Infertility includes: 1. Diagnoses and evaluation of the underlying medical cause of Infertility. 2. Surgery to treat the underlying medical cause of Infertility. Examples are endometriosis Surgery or, for men, varicocele Surgery. Eligible Health Services for comprehensive Infertility services includes: 1. Ovulation induction with menotropins. 2. Intrauterine insemination/artificial insemination. You are eligible for comprehensive Infertility services only if: 1. There exists a condition that: a. Meets the definition of Infertility b. Has been identified by your Physician or Infertility specialist and documented in your medical records 2. You have not had a voluntary sterilization, without surgical reversal, or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation,	Pre-certification required. You are not Covered for: 1. Non-medical costs of an egg or sperm donor. 2. Charges associated with cryopreservation (freezing) of eggs, embryos or sperm except as otherwise stated. However, subsequent non-Experimental or Investigational procedures that use the cryopreserved substance are Covered. 3. Reversal of voluntary sterilizations. However, if voluntary sterilization is successfully reversed, Infertility benefits shall be available if the diagnosis meets the definition of Infertility. 4. Services provided to a surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. If you choose to use a surrogate,

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	hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. 3. You do not have Infertility that is due to a natural physiologic process such as age-related ovarian insufficiency (e.g. perimenopause, menopause). 4. You are unable to conceive or sustain a successful pregnancy through reasonable, less costly Infertility treatment for which Coverage is available under this Plan. 5. Efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial inseminations, have failed and are not likely to lead to a successful pregnancy. Eligible Health Services also include Advanced Reproductive Technology (ART) only if: 1. There exists a condition that: a. Meets the definition of Infertility b. Has been identified by your Physician or Infertility specialist and documented in your medical records 2. You have not had a voluntary sterilization, without surgical reversal, or you had a successful surgical reversal of the voluntary sterilization. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. 3. You do not have Infertility that is due to a natural physiologic process such as age-related ovarian insufficiency (e.g. perimenopause, menopause). 4. You are unable to conceive or sustain a successful pregnancy through reasonable, less costly Infertility treatment for which Coverage is available under this Plan. 5. You have exhausted the comprehensive Infertility services benefits or have a clinical need to move on to ART procedures based on our clinical policy bulletin. Comprehensive services did not result in a documented fetal heartbeat. Eligible Health Services for Standard Fertility Preservation Services involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for Standard Fertility Preservation Services only when you: 1. Are believed to be fertile. 2. Have planned services that will result in Infertility such as: - Chemotherapy - Pelvic radiotherapy	this exclusion does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a Covered individual. 5. Travel costs within 100 miles of your home or travel cost not required by Aetna 6. Experimental or Investigational Infertility treatment as determined by the American Society for Reproductive Medicine. 7. Infertility treatments rendered to Dependents under the age of 18.

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	- Other gonadotoxic therapies - Ovarian or testicular removal Along with the eligibility requirements above, you are eligible for Standard Fertility Preservation Services if, for example: 1. You, your partner or Dependent child are planning treatment that is proven to result in Infertility. Planned treatments include: - Bilateral orchiectomy (removal of both testicles) - Bilateral oophorectomy (removal of both ovaries) - Hysterectomy (removal of the uterus) - Chemotherapy or radiation therapy that is established in medical literature to result in Infertility 2. The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below: a. A female under 35 years of age. You need to have an un-medicated day 3 FSH test done with in the past twelve (12) months and the results must be less than 19 mIU/ml in your most recent lab test to use your own eggs. b. A female 35 years of age or older. You need to have an un-medicated day 3 FSH test done within the past six (6) months and the results must be: - If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. - If you are age 40 and older, must be less than 19 mIU/mL in all prior tests to use your own eggs. Eligible Health Services for Standard Fertility Preservation Services are paid on the same basis as other ART services benefits for individuals who are Infertile. Coverage is provided for the following ART services: 1. In vitro fertilization (IVF). 2. Uterine embryo lavage. 3. Zygote intrafallopian tube transfer (ZIFT). 4. Gamete intrafallopian tube transfer (GIFT). 5. Low tubal ovum transfer (LTOT). 6. Cryopreserved (frozen) embryo transfers. 7. Prescription drug therapy used during an oocyte retrieval cycle. 8. Intracytoplasmic sperm injection (ICSI) or ovum microsurgery. 9. Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The	

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	embryo transfer itself is not an Eligible Health Service. 10. Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you. 11. Medical costs of oocytes or sperm donors for ART procedures used to retrieve oocytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the Covered recipient. We will also cover associated donor medical expenses, established by us, as a prerequisite to donation. 12. The procedures are done while not confined in a Hospital or any other facility as an inpatient.	
Injectables	Eligible Health Services for any charges for the administration or injection of Prescription drugs or injectable insulin and other injectable drugs Covered by us. Needles and syringes, except those used for self-administration of an injectable drug. For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified Provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.	You are not Covered for the following prescribed injectables: 1. Injectables which are related to the treatment of a non-Covered Service. 2. Experimental or Investigational drugs or drugs that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA. 3. Certain classes of injectables, such as anabolic steroids, when used for performance enhancement.
Maternity and Prenatal Services	Eligible Health Services for prenatal services include your routine prenatal physical exams as preventive care, which includes the initial and subsequent physical exam services such as: 1. Maternal weight. 2. Blood pressure. 3. Fetal heart rate check. 4. Fundal height. 5. Anemia screening. 6. Chlamydia infection screening. 7. Hepatitis B screening.	You are not Covered for the following maternity related services: 1. Planned home deliveries. 2. Maternity care delivered by non-Physicians, such as doulas. 3. Personal comfort or convenience items.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	8. Rh incompatibility screening. 9. Expanded tobacco intervention and counseling for pregnant tobacco users. 10. HIV testing. You can get this care at your Physician's, PCP's, OB's, GYN's, or OB/GYN's office. After your child is born, Eligible Health Services include: 1. A minimum of 48 hours of inpatient care in a Hospital after a vaginal delivery. 2. A minimum of 96 hours of inpatient care in a Hospital after a cesarean delivery. 3. A shorter stay, if the attending Physician, with the consent of the mother, discharges the mother or newborn earlier. If an earlier discharge is recommended, Eligible Health Services include an in-home nurse visit. Coverage for your child includes: 1. Routine inpatient Hospital nursery charges. 2. One routine inpatient exam when done by a Physician other than the delivering Physician. 3. One inpatient hearing test. 4. The services and supplies needed for circumcision by a Provider.	
Morbid Obesity Surgery	Surgical treatment, vertical-banded gastroplasty (gastric stapling), gastric banding and roux-en-Y gastric bypass, of Morbid Obesity will be Covered when all of the following criteria are met: • Presence of Morbid Obesity. • Physician documentation that outlines the member has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a twelve-month Physician-supervised multidisciplinary program within the past six months that included: - dietary therapy; - physical activity; and - behavior therapy and support • It is documented in the patient's medical record that the patient has completed a psychological evaluation by a licensed mental health professional, all psychosocial issues have been identified and addressed and the patient has been recommended for bariatric Surgery.	Pre-certification is required. In order for benefits to be paid, services must be received from one of the Plan's Bariatric Surgery Centers of Excellence. Members must meet all of the Coverage criteria in order to be eligible for these benefits. You are not Covered for: • Morbid Obesity surgical services received from any Provider not designated by the Plan as a Bariatric Surgery Center of Excellence. • Members who have any of the following are not

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	• Morbid Obesity has persisted for at least 5 years after reaching adulthood of >/= 18 years of age. • There is no treatable metabolic cause for the Morbid Obesity. • The patient has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use. • The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated. • Following Surgery, the patient has agreed to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and behavior and social support.	eligible for Morbid Obesity surgical services: - Active substance abuse. - Active peptic ulcer disease. - Illnesses that greatly reduce life expectancy and are unlikely to be improved with weight reduction, including but not limited to cancer, symptomatic coronary artery disease, and end-stage renal disease. - Psychiatric disorders, including but not limited to schizophrenia, borderline personality disorder, and uncontrolled depression. - Members that have a documented history of not complying with recommended medical care are not eligible for Coverage. - Members who have voluntarily ended a weight loss program that produced demonstrable weight loss are not eligible for Coverage. The following are also not Covered: • Jejunoileal bypass • Biliopancreatic bypass

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
		• Gastric balloon • Duodenal switch • Abdominoplasty and other Cosmetic Surgery • Panniculectomy and other procedures for removal of excess skin • Reversals of surgical treatments for Morbid Obesity • Surgical treatment of Morbid Obesity in adolescents • Weight reduction therapy, supplies and services including but not limited to diet programs, food or food supplements, diet pills, tests, examinations or services
Newborn Care	Eligible Health Services for the following newborn care services: 1. Illness or Injury and premature birth. 2. Congenital defects and birth abnormalities and Reconstructive Surgery related to the same, when specific criteria are met. (See Reconstructive Surgery Section for further details). 3. Preventive care for all eligible newborns according to published preventive care guidelines and for them to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. 4. Newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up. 5. Nursery charges. 6. Routine care of a newborn provided by a Pediatrician while in the Hospital, including circumcision. ➢ **Note:** Coverage for children shall be granted immediately with respect to a newly born child from the moment of birth but is subject to eligibility requirements and other policy limitations. (See the Eligibility section for further information).	
Nutritional Support	Eligible Health Services include amino acid-based formula products ordered by a Physician for the treatment of eosinophilic	You are not Covered for: 1. Any food item, including

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	disorders or short bowel syndrome, regardless of the delivery method. Eligible Health Services also include formula and low protein modified food products ordered by a Physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids. For purposes of this benefit, "low protein modified food product" means foods specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.	infant formulas, nutritional supplements, vitamins, plus Prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. 2. Non-FDA approved drugs, vitamins, minerals or supplements. 3. Diet pills, diet programs, weight reduction therapy, services, tests, examinations or supplies. 4. Exercise or fitness equipment or other equipment used to promote health or wellness. 5. Gym or fitness club memberships.
Outpatient Rehabilitative Therapy	Eligible Health Services for cognitive rehabilitation, physical, occupational and speech therapy include: 1. Physical therapy, but only if it is expected to: - Significantly improve or restore physical functions lost as a result of an acute Illness, Injury or Surgical Procedure. - Treat parts of the body affected by multiple sclerosis to maintain your level of function. 2. Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to: - Significantly improve, develop or restore physical functions you lost as a result of an acute Illness, Injury or Surgical Procedure. - Relearn skills so you can significantly regain your ability to perform the activities of daily living on your own. 3. Speech therapy (except for services provided in an educational or training setting or to teach sign language), but only if it is expected to: - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute Illness, Injury or Surgical Procedure. - Improve delays in speech function development caused by a	You are not Covered for: 1. Rehabilitative services provided for long-term, chronic medical conditions, except as provided for herein. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. 4. Cognitive rehabilitation associated with physical rehabilitation, but only when: - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy. - The therapy is coordinated with us as part of a treatment Plan intended to restore previous cognitive function.	services designed to retrain you for employment. 5. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 6. Alternative medical treatment and rehabilitation services, such as holistic medicine, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, reiki, reflexology, therapeutic touch, massage therapy, herbal therapy, and hypnotherapy. 7. Fees, costs or similar services associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment. 8. Sports-related services designed to affect performance or physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility and diversion.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Outpatient Surgery/Services	Eligible Health Services for outpatient Surgery include services provided and supplies used in connection with outpatient Surgery performed in a Surgery Center or a Hospital's outpatient department.	Pre-certification may be required. You are not Covered for the following: 1. Outpatient services that are considered to be Experimental or Investigational. 2. Outpatient services that have not demonstrated significant usefulness in the peer-reviewed medical literature. 3. Outpatient services otherwise not Covered under the Plan.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Outpatient Therapies	Outpatient infusion therapy Eligible Health Services include infusion therapy you receive in an outpatient setting including but not limited to: • A free-standing outpatient facility. • The outpatient department of a Hospital. • A Physician in his/her office. • A home care Provider in your home. Eligible Health Services also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including but not limited to the use of intravenous immunoglobulin therapy. Immune gamma globulin therapy will be an Eligible Health Service for persons diagnosed with a primary immunodeficiency when medically appropriate and ordered by a Physician. Initial Pre-certification will be for no less than 3 months with Pre-certification every 6 months after. If you have been in treatment for 2 years, Pre-certification will be every 12 months, unless more frequently indicated by your Physician. Infusion therapy is the administration of prescribed medications or solutions through an IV. Certain infused medications may be an Eligible Health Service under the outpatient Prescription drug section. You can access the list of Specialty Prescription drugs. When infusion therapy services and supplies are provided in your home, they will not count toward any applicable Home Health Care limits. Outpatient radiation therapy Eligible Health Services include the following radiology services provided by a health professional: • Radiological services • Gamma ray • Accelerated particles • Mesons • Neutrons • Radium • Radioactive isotopes	

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
Physician Services	Eligible Health Services include services by your Physician to treat an Illness or Injury. You can get those services: • At the Physician's office. • In your home. • In a Hospital. • From any other inpatient or outpatient facility. • By way of Telemedicine. • Other services and supplies that your Physician may provide: - Allergy testing and allergy injections - Radiological supplies, services, and tests <u>Physician surgical services</u> Eligible Health Services include the services of: • The surgeon/assistant surgeon who performs your Surgery • Your surgeon who you visit before and after the Surgery • Another surgeon you go to for a second opinion before the Surgery Eligible Health Services include one additional surgical opinion at your request following a recommendation for elective Surgery if, in your opinion, the need for Surgery is not resolved by the first arranged consultation. The additional surgical opinion is limited to one consultation and related diagnostic service by a Physician. We will provide benefits at 100% for this Eligible Health Service.	You are not Covered for the following primary care services: 1. Services, treatments or supplies that are otherwise not a Covered Benefit under the Plan. 2. Any appointment you did not attend or failed to cancel on a timely basis.
Podiatry	Eligible Health Services for regular foot exams if you have diabetes or for Medically Necessary treatment of conditions associated with the foot and ankle.	You are not Covered for the following: 1. Treatment of corns, calluses or the clipping of toenails, unless Medically Necessary for the treatment of diabetes. 2. Treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches, or chronic foot strain. 3. Metatarsalgia or bunions (except an open cutting operation or procedure). 4. Medical or surgical

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
		treatment of onychomycosis (nail fungus) for cosmetic reasons. Coverage is not excluded for the treatment of nail fungus for members who have metabolic peripheral vascular disease or diabetes. 5. Foot or shoe inserts and other non-Covered orthotic devices.
Preventive Services	The following preventive services shall be Eligible Health Services without regard to any Deductible or Coinsurance requirement that would otherwise apply: 1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. 2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered person involved. 3. With respect to Covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. 4. With respect to Covered persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For purposes of this section, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current. No recommendation of the United States Preventive Service Task Force shall serve to reduce the mammogram benefits required by Illinois law.	You are not Covered for the following preventive services: 1. Unexpected mass immunizations directed or ordered by federal, state or local public health officials for general population groups. 2. Preventive chiropractic services, including, but not limited to, long-term or periodic manipulation of bones or joints, massage therapy, or holistic or alternative medicine. 3. Membership or service fees associated with health clubs, weight loss clinics and fitness programs. 4. Equipment and supplies to promote health or exercise, including, but not limited to, exercise equipment, videos, software, whirlpools, jacuzzies, air conditioners, air purifiers, humidifiers, and

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
		dehumidifiers. 5. Hearing examinations, except that provided in the Physician's office or for the treatment and diagnosis of diseases of, or Injury to the ear. 6. Vision examinations, except that provided in the Physician's office or for the treatment and diagnosis of diseases of, or Injury to, the eye. 7. Certain services or diagnostic or screening procedures determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation. 8. Comprehensive preventive clinics or spas.
Preventive Contraceptives and Devices	For females who are able to become pregnant, your outpatient Prescription drug plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing. Your outpatient Prescription drug plan also covers related services and supplies needed to administer Eligible Health Service devices. At least one form of contraception in each of the methods identified by the FDA is included. We cover each of the methods identified by the FDA at no cost share. If a device is not available for a certain method, you may obtain certain devices for that method at no cost share.	You are not Covered for the following: 1. Contraceptive devices not approved by the Food and Drug Administration.

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	For information regarding Prescription drug plan refer to your Prescription benefit manager policies. Eligible Health Services also include coverage for abortion care services	
Prosthetic and Customized Orthotic Devices	Eligible Health Services include the initial provision and subsequent replacement of a prosthetic device and a customized orthotic device that your Physician orders and administers. Prosthetic device means: • A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or Injury. Customized orthotic device means: • A prosthetic device based on your physical Illness. Coverage includes: • Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed. • Replacements required by ordinary wear and tear or damage. Instruction and other services (such as attachment or insertion) so you can properly use the device.	You are not Covered for the following: 1. Eyeglasses, contact lenses, and other equipment intended to improve vision (except for the first pair of eyeglasses or contact lenses, but not both, purchased within 30 days following cataract Surgery). 2. Ear molds and other equipment intended to improve hearing. 3. Dentures; dental implants techniques, including prosthetic devices related to such techniques. 4. Implants for Cosmetic purposes. 5. Over the counter or convenience items. 6. Wigs, hairpieces or prostheses, toupees, hair transplants and/or other equipment or supplies for the treatment of the loss of hair (except as provided herein). 7. Prosthetic devices that are non-durable, such as support garments, ted hose, jobst or compression stockings, clothing and like items. 8. Repair or replacement of prostheses, prosthetic

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

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
		with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.
Reconstructive Surgery and Supplies	Eligible Health Services include all stages of reconstructive Surgery and related supplies provided in an inpatient or outpatient setting only in the following circumstances: 1. Your Surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It includes Surgery on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses. It also includes a Physician office visit or in-home nurse visit within 48 hours after discharge. 2. Your Surgery is needed to improve a significant functional impairment of a body part. 3. Your Surgery corrects a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury). The Surgery will be an Eligible Health Service if: • The defect results in severe facial disfigurement or major functional impairment of a body part. • The purpose of the Surgery is to improve function.	Pre-certification is required. You are not Covered for the following: 1. Any Surgery from which no significant improvement in physiologic function could be reasonably expected or that does not meaningfully promote the proper function of the body or prevent or treat Illness or disease or is done primarily to improve the appearance or diminish an undesirable appearance of any portion of the body. 2. Any medical or surgical treatment, drug or hospitalization for plastic or Cosmetic Surgery and/or which is undertaken to improve your appearance. 3. Pharmacological regimens, plastic Surgery and non-Medically Necessary dermatological procedures. 4. Surgery to remove excess skin, including pannus, and services of a similar nature resulting from

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
		Morbid Obesity Surgery or severe weight loss.
Routine cancer screenings	Eligible Health Services include the following routine cancer screenings: 1. Low-dose mammography screening for women age 35 and over (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows: • For women 35-39, a baseline mammogram. • For women 40 years of age and older, annually. • For woman under 40, with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, at Medically Necessary age and intervals. • Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue and when Medically Necessary, as determined by your Physician. • Screening MRI when Medically Necessary, as determined by your Physician. 2. Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your Physician, PCP. This includes: • Asymptomatic men age 50 and older. • African American men age 40 and over. • Men age 40 and over with family history of prostate cancer. 3. Colorectal cancer screening for adults over 45. 4. Fecal occult blood tests. 5. Sigmoidoscopies. 6. Double contrast barium enemas (DCBE). 7. Colonoscopies which include removal of polyps performed during a screening procedure and a pathology exam on any removed polyp. 8. Lung cancer screenings for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years. These benefits will be subject to any age, family history and frequency guidelines that are: 1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force.	

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	2. Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Routine physical exams	Eligible Health Services include office visits to your Physician for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and it includes: 1. Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. 2. Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. 3. Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to: – Screening and counseling services on topics such as: • Interpersonal and domestic violence • Sexually transmitted diseases • Human Immune Deficiency Virus (HIV) infections for everyone ages 15-65 and other ages at increased risk – Screening for gestational diabetes for women, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes – Screening for diabetes (type 2) for adults with high blood pressure – High risk Human Papillomavirus (HPV) DNA testing for women – Bone density screenings for osteoporosis – Aspirin use to prevent cardiovascular disease for men and women of certain ages – Blood pressure screening – Cholesterol screening for adults of certain ages or at higher risk – Depression screening – Hepatitis B screening for adults and adolescents ages 11-17 at high risk. This includes:	

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	• People from countries with 2% or more Hepatitis B prevalence • U.S. born people not vaccinated as infants and with at least 1 parent born in a region with 8% or more Hepatitis B prevalence – Hepatitis C screening for: • Adults at increased risk • 1 time for everyone born 1945-1965 – Falls prevention in community-dwelling adults age 65 and older who are at increased risk for falls. This includes: • Vitamin D supplementation • Exercise or physical therapy – Tuberculosis screening for populations at increased risk – Skin cancer behavioral counseling for fair skinned individuals ages 10-24 4. Radiological services, lab and other tests given in connection with the exam. 5. For Covered newborns, an initial Hospital checkup.	
Skilled Nursing Facility Services	Eligible Health Services include inpatient Skilled Nursing Facility care. The types of Skilled Nursing Facility care services that are eligible for Coverage include: 1. Room and Board, up to the Semi-Private Room Rate. 2. Services and supplies that are provided during your stay in a Skilled Nursing Facility. For your stay in a Skilled Nursing Facility to be eligible for Coverage, the following conditions must be met: • The Skilled Nursing Facility admission will take the place of: - An admission to a Hospital or sub-acute facility. - A continued stay in a Hospital or sub-acute facility. • There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time. • The Illness or Injury is severe enough to require constant or frequent Skilled Nursing care on a 24-hour basis.	Pre-certification is required. You are not Covered for the following: 1. Custodial, convalescent, or domiciliary care in a Hospital, Skilled Nursing Facility, or any other facility. This includes care that assists members in the activities of daily living, like walking, getting in and out of bed, bathing, and dressing, feeding and using the toilet. 2. Charges for services or supplies which are for the primary purpose of controlling or changing your environment or providing you with a rest

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		cure or respite care. 3. Preparation of special diets and supervision of medication that is usually self-administered regard-less of who orders the services. 4. Personal comfort or convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Sleep Studies	Eligible Health Service.	You are not Covered for the following: 1. Alternative therapies, such as sleep therapies.
Substance Use Disorder Services	Eligible Health Services include the treatment of Substance Use Disorders provided by a Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician or Behavioral Health Provider as follows: 1. Inpatient Room and Board at the Semi-Private Room Rate and other services and supplies provided during your stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Treatment of Substance Use Disorders in a general medical Hospital is only an Eligible Health Service if you are admitted to the Hospital's separate Substance Use Disorders section or unit, unless you are admitted for the treatment of medical complications of Substance Use Disorders. 2. As used here, "medical complications" include, but are not limited to, detoxification, electrolyte imbalances, malnutrition, and cirrhosis of the liver, delirium tremens and hepatitis. 3. Outpatient treatment received while not confined as an inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility, including: a. Office visits to a Physician or Behavioral Health Provider such as a Psychiatrist, psychologist, social worker or licensed professional counselor (includes Telemedicine consultation).	Pre-certification is not required for inpatient, Partial Hospitalization and Intensive Outpatient Program for substance use disorder treatment services. However, the treating provider or facility must notify us within 2 business days of start of treatment. Concurrent review of the treatment will be conducted by us. You are not Covered for the following substance abuse services: 1. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling. 2. Alcohol or substance abuse services which are primarily non-medical in nature, including, but not

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	b. Other outpatient Substance Use Disorders treatment such as: - Outpatient detoxification. - Partial Hospitalization Treatment provided in a facility or program for Substance Use Disorders treatment provided under the direction of a Physician. - Intensive Outpatient Program. - Provided in a facility or program for Substance Use Disorders treatment provided under the direction of a Physician. - Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other Substance Use Disorders, including administration of medications. - Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • You are homebound. • Your Physician orders them. • The services take the place of a stay in a Hospital or a Residential Treatment Facility, or you are unable to receive the same services outside your home. • The skilled behavioral health care is appropriate for the active treatment of a condition, Illness or disease to avoid placing you at risk for serious complications; o Treatment of withdrawal symptoms o Substance Use Disorder injectables o 23-hour observation	limited to, social work, teaching, Custodial Care and chronic rehabilitative services. 3. Court-ordered intoxication evaluations, programs or treatments or therapy related to judicial or administrative proceedings or orders, when employer requested or when required for school. 4. Care in lieu of detention or correctional placement or that is required to be treated in a public facility. 5. Institutional care which is for the primary purpose of controlling or changing your environment. 6. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electro sleep therapy or electronarcosis. 7. Treatment programs, services or supplies having to do with the cessation of tobacco usage or nicotine habits or addictions. 8. An addiction to a controlled substance or cannabis that is used in violation of law.
Transplants	Eligible Health Services include transplant services provided by a Physician and Hospital only when Pre-certification is obtained. If the transplant donor does not have medical Coverage (from any source) for organ transplant services, Eligible Health Services	Pre-certification is required. Transplant services must be performed at Institutes of Excellence™ (IOE) facility.

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

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	When both donor and recipient are members of the same family and are both Covered by the Plan, no Deductible or Coinsurance shall apply. The transplant Hospital network is subject to change throughout the year. Call the Medical Case Management Plan Administrator for current transplant Hospitals.	
Transplant Travel and Other Related Services	The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals. The Plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those Plan Participants who have been accepted as a candidate for transplant services. Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to: Organ Transplant Reimbursement DCMS Group Insurance Division 801 S. 7th Street P.O. Box 19208 Springfield, IL 62794-9208 The Plan Participant has twelve (12) months from the date expenses were incurred to submit eligible charges for reimbursement. Requests submitted after the twelve (12) month limit will not be considered for reimbursement.	
Urgent Care	Eligible Health Services for care for an unexpected Illness or Injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention when provided at an alternate facility, such as an Urgent Care center or after-hours facility. Some examples of cases involving Urgent Care include but are not limited to: • High fever; • Non-severe bleeding; • Sprains Your Physician can help you determine whether your condition is urgent and/or whether you need to receive care at an alternate facility. If possible, contact your Physician in the event you receive Urgent Care. Your Physician is available to provide guidance and	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	direction in situations that may require Urgent Care. If follow-up care related to your initial Urgent Care services is required, you should contact your Physician-and coordinate such follow-up care with him or her.	
Voluntary sterilization	Eligible Health Services include charges billed separately by the Provider for voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.	You are not Covered for reversal of voluntary sterilization procedures.
Walk-In Clinic	Eligible Health Services include health care services provided at Walk-In Clinics for: • Unscheduled, non-medical emergency Illnesses and injuries • The administration of immunizations administered within the scope of the clinic's license	
Well child preventive visits	Eligible Health Services include routine: 1. Autism screening for children at 18 and 24 months. 2. For children ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years, the following: – Behavioral assessments – Dyslipidemia screening for children at higher risk of lipid disorders – Height, weight and Body Mass index (BMI) measurements – Medical history throughout development – Tuberculin testing for children at higher risk of tuberculosis 3. Cervical dysplasia screening for sexually active females. 4. Developmental screening for children under age 3. 5. Fluoride chemoprevention supplements for children without fluoride in their water source. 6. Gonorrhea preventive medication for the eyes of all newborns. 7. Hematocrit or hemoglobin screening. 8. Hemoglobinopathies or sickle cell screening for newborns. 9. HIV screening for adolescents at higher risk. 10. Hypothyroidism screening for newborns. 11. Iron supplements for children ages 6-12 months at risk for anemia 12. Lead screening for children at risk of exposure. 13. Oral health risk assessment for young children ages: 0-11 months, 1-4 years and 5-10 years.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**PRE-CERTIFICATION REQUIREMENTS AND LIMITATIONS**
	14. Phenylketonuria (PKU) screening for newborns.	
Well woman preventive visits	Eligible Health Services include your routine: 1. Well woman preventive exam office visit to your Physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes annual pap smears, including surveillance tests for ovarian cancer for women at risk for ovarian cancer. Your Plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified Illness or Injury. 2. Preventive care breast cancer (BRCA) gene blood testing by a Physician and lab. 3. Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment. 4. Clinical breast exams as follows: - For women over 20 years of age but less than 40, at least every 3 years. - For women 40 years of age and older, annually. 5. Breast cancer chemoprevention counseling. 6. Cervical cancer screening for sexually active woman. 7. Chlamydia infection screening for younger women and other women at higher risk. 8. HIV screening and counseling for sexually active woman. 9. Osteoporosis screening for women over age 60 depending on risk factors. Eligible Health Services for pregnant or women who may become pregnant include: 1. Anemia screening on a routine basis. 2. Folic acid supplements for women who may become pregnant. 3. Gonorrhea screening for all women at higher risk. 4. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk. 5. Syphilis screening. 6. Urinary tract or other infection screening.	

VI. Behavioral Health / Dental / Outpatient Prescription Drugs

For information pertaining to your behavioral health, dental or outpatient Prescription drug benefits, please contact your respective Plan administrator for more information.

VII. Exceptions and Exclusions

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

1. **Allergy services** - Those non-Physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers, air ventilation system cleaning, carpet cleaning, treatment of environmental factors such as mold, hypo-allergenic pillows, mattresses and blankets, allergy drops and allergy treatment by a chiropractor.

2. **Alternative Therapies** - Alternative therapies, including, but not limited to, holistic, homeopathic or naturopathic care, aroma or massage therapy, milieu, recreational, wilderness, educational, music, or sleep therapies, biofeedback (except in limited circumstances), ecological or environmental medicine, ayurveda and ayruvedic nutrition, craniosacral therapy, yoga, aquatic classes, movement therapy tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion) therapy except in the treatment of heavy metal poisoning, reiki, reflexology, therapeutic touch, colon therapy, herbal or vitamin therapy and hypnotherapy or hypnosis, any treatment that is provided to enhance the life style of a person without treating an Injury or Illness.

3. **Ambulance Service** - Non-emergency and non-medically appropriate Ambulance services, regardless of who requested the services, including Ambulance transport due to the absence of other transportation for the member; charges for general travel to and/or from a healthcare Provider or facility; routine transportation; transportation for outpatient care; travel out of the U.S. when the travel is for the sole purpose of obtaining medical care.

4. **Artificial Organs** - Any device that would perform the function of a body organ.

5. **Autopsies** - Services and associated expenses related to the performance of autopsies.

6. **Behavior Modification** - Those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of: behavioral conduct problems, oppositional defiant disorder, learning disabilities, developmental delay, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-acute head injuries or cerebral palsy, except as otherwise provided herein.

7. **Biofeedback** - Unless as part of the treatment for fecal/urinary incontinence.

8. **Blood, Blood Plasma, Synthetic Blood, Blood Derivatives or Substitutes -** Examples of these are:

- The provision of blood to the Hospital, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

9. **Charges -** Charges resulting from the failure to appropriately cancel a scheduled appointment; charges for non-healthcare related items, such as shipping charges, copying charges and postage; charges for copying of medical records; charges for chart reviews and other assessments where the member is not physically present; charges for services or supplies which are not otherwise specifically stated to be a Eligible Health Service; charges for services or supplies provided before or after the member's Effective Date of Coverage; charges for services or supplies that are prohibited by federal, state or local law; charges for services or supplies that have not been prescribed or ordered by a Physician; charges for lost or stolen items, such as Durable Medical Equipment or injectable medications; services or supplies for which no charge is made or for which no payment would have been made absent this Coverage.

10. **Chiropractic Services -** Chiropractic services not otherwise defined as an Eligible Health Service in the Schedule of Covered Services; massage therapy; spinal manipulations for all non-musculoskeletal diseases and injuries or musculoskeletal disorders that are not improved with short-term chiropractic care and become maintenance in nature.

11. **Clinical Trial Therapies (Experimental or Investigational) -** Your Plan does not cover clinical trial therapies (Experimental or Investigational), except where described in the Schedule of Covered Services.

12. **Clinical Trial Therapies (Routine Patient Costs)** - Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs); services and supplies provided by the trial sponsor without charge to you; The Experimental intervention itself (except Medically Necessary Category B Investigational devices and promising Experimental and Investigational interventions for Terminal Illnesses in certain clinical trials in accordance with Aetna's claim policies).

13. **Cosmetic services** - Those services, associated expenses and the complications resulting from Cosmetic Services or Surgeries that alter or improve physical appearance but do not correct or materially improve a physiological function and are not Medically Necessary for the prompt repair of accidental Injury or Illness or to improve the function of a congenital anomaly. These services include, but are not limited to, pharmacological regimens, plastic Surgery, rhinoplasty, Cosmetic procedures, non-Medically Necessary dermatological procedures, implantation and/or removal of breast implants for Cosmetic or other non-Covered reasons, even if the implant removal is considered Medically Necessary; breast reduction (unless Medically Necessary), enhancement or augmentation mammoplasty; breast reduction or reconstruction for male gynecomastia; removal of benign skin lesions, growths (such as warts) or skin

tags; anti-aging services; salabrasion, chemosurgery, laser Surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes; services for the treatment of acne scarring; elective or voluntary enhancement procedures, services and medications (growth hormones and testosterone), such as weight loss, hair growth, sexual performance, athletic performance; however, reconstructive Surgery and other expenses mandated by the Women's Health and Cancer Rights Act of 1998 will be Covered.

14. **Counseling** - Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

15. **Court-ordered services** - Court-ordered services or services that are a condition of probation, parole, and release or because of any legal proceeding.

16. **Custodial Care -**
Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you.
- Respite care, adult (or child) day care, or convalescent care, except as provided for Hospice care.
- Institutional care. This includes Room and Board for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, and dressing, getting in or out of bed, going to the bathroom, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service performed by a person without any medical or paramedical training.

17. **Dental services** - Dental services provided by a Doctor of Dental Surgery("DDS"), a Doctor of Medical Dentistry ("DMD") or a Physician licensed to perform dental-related oral Surgical Procedures, including, but not limited to general and preventive dental services (fillings, root canals, crowns, bridges, dentures, dental x-rays and other routine dental care), services for overbite or under bite, dental splints, supplies, appliances (including occlusal splints/orthodontia), orthodontia and related services; dental

implants and dental implantology techniques, including prosthetic devices related to such techniques, dental prostheses, treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, gum disease such as periodontitis and gingivitis; Prescription medication written by a dentist or Physician for the purpose of treating a dental condition; dental care delivered during the treatment of accidental Injury to sound natural teeth that is not related to the accidental Injury.

18. **Dental or Oral Surgery**. - Surgical or non-Surgical removal of wisdom teeth or impacted teeth; removal, replacement, repair, artificial restoration of the teeth (either natural or artificial); removal of teeth as a complication of or in preparation for radiation therapy or as a result of radionecrosis; dental implants; services related to Surgery for cutting through the lower or upper jaw bone, resulting from dislocation of the cartilage without dislocation of the mandible or from other dental anomalies including osteoarthritis; removal of dentiginous cysts, mandibular tori and odontoid cysts; surgical correction of malocclusion of the teeth and/or jaw, such as maxillofacial, orthognathic and prognathic Surgery; orthodontic correction of tooth alignment or malocclusion; dental related oral Surgical services to correct an overbite or under bite.

19. **Diagnostic tests** - Diagnostic tests, laboratory tests and procedures that are considered to be Experimental or Investigational; that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in peer-reviewed medical literature; that are not done to evaluate current health problems or symptoms; that are done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question; that are inappropriate for the delivery to or screening of an entire population or subpopulation; prophylactic procedures to prevent a sickness that has not yet occurred.

20. **Disposable medical supplies** - Self-administered dressings, splints and supplies; supplies that are typically purchased over the counter, such as ACE wraps, elastic supports and other supplies; supplies that do not perform a medical function; filters; paper or fabric face masks, irrigating kits; clothing and garment items, such as elastic stockings, support hose, jobst and teds stockings, foot coverings, corsets and any elastic joint supports (which are not considered orthopedic appliances).

21. **Durable Medical Equipment –** The examples are included, but not limited to the following: equipment for environmental control, such as air conditioners, furnaces, heaters, heat lamps, room heaters; air filters or air purifiers, humidifiers or dehumidifiers; improvements or modifications to a home or place of business; whirlpool or sauna baths; portable whirlpool pumps; fitness or exercise equipment; repair or replacement of Durable Medical Equipment due to misuse, neglect or loss; Durable Medical Equipment which may be used by multiple individuals; electrical continence aids, either anal or urethral; convenience or comfort items, such as tub grab bars, over the bed tables and raised toilet seats; items necessary for the operation of the Durable Medical Equipment that are not directly related to the medical function of the equipment; replacement items, such as batteries, tires and light bulbs; replacement of the Durable Medical Equipment when the existing one continues to meet basic medical needs; cribs, special strollers, standing frames; cranial caps and helmets, except in limited circumstances; electronically controlled cooling compression therapy devices

(such as polar ice packs, ice man cool therapy, water circulation cold pads with pumps or cryo-cuff); home traction units; message devices, communication aids or telephone alert systems.

22. **Education -** Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs; services provided by a school district.

23. **Emergency -** Visits (including follow-up care) to a Hospital emergency room when no Emergency Medical Condition exists (*e.g.*, remove sutures, renew Prescriptions); care at an emergency room for non-Covered Services (such as dental conditions);

24. **Examinations -** Physical, psychiatric, educational or psychological examinations or testing (unless part of a treatment program for a Eligible Health Service), vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, licensing, adoption, premarital, marital or those ordered by a third party; exams directed or requested by a court of law.

25. **Exercise –** Exercise or fitness equipment or supplies or equipment used to promote health and fitness; exercise videos, software and equipment; membership or fees associated with health and athletic club memberships, weight loss clinics and fitness programs; services for weight control or weight reduction; dietary consultations or programs; body composition or underwater weighing procedures; exercise therapy weight control or reduction programs; hot tubs, steam rooms, swimming pools and saunas.

26. **Experimental or Investigational –** Any procedure or treatment that are determined to be Experimental or Investigational as that term is defined herein unless otherwise Eligible Health Services under clinical trial therapies (Experimental or Investigational) or Eligible Health Services under clinical trials (routine patient costs).

27. **Eyes -** Eye refractive exams to check visual acuity, except as otherwise provided; measurement, fitting, adjustment or polishing of eyeglasses and contact lenses; contact lenses, eyeglass frames, corrective lenses, tints or other lenses, services or treatments, except for the first pair of eyeglasses or corrective lenses within thirty (30) days following cataract Surgery; contact lenses except for bandage contact lenses for the treatment of keratoconus; eye exercises, video equipment, vision therapy (orthoptics), radial keratotomy, astigmatic keratotomy, automated lamellar keratoplasty, photorefractive keratectomy, phototherapeutic keratectomy and laser assisted in situ keratomieusis and similar surgeries for the correction of a refractive disorder and other equipment intended to improve vision.

28. **Facility Charges –** Services or supplies provided in a rest home, assisted living facility, health resorts, spas or sanitariums, infirmaries at schools, colleges or camps or similar institutions serving as a person's main residence or providing mainly Custodial or rest

care.

29. **Family Planning -** Outpatient contraceptive drugs and devices not approved by the FDA; reversal of a voluntary sterilization.

30. **Food or food supplements -** Products that provide nutritional needs, such as formulas, feeding solutions and supplements, vitamins and dietary foods and programs, except as otherwise provided herein.

31. **Foot care -** Foot care, including the treatment of weak, strained, flat, unstable or unbalanced feet, hammertoes, fallen arches or chronic foot strain; metatarsalgia or bunions (except open cutting operations); treatment of corns, calluses or toenails (except in the treatment of diabetes); supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

32. **Genetic counseling -** Genetic testing and counseling done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question.

33. **Growth/Height Care -** A treatment, device, drug, service or supply with the primary purpose to increase or decrease height or alter the rate of growth; Surgical Procedures, devices and growth hormones to stimulate growth. This does not include growth hormone therapy.

34. **Hair care -** Services relating to the analysis of hair unless used as a diagnostic tool to determine poisoning; hairstyling, hairpieces, hair transplants and hair prostheses or wigs (except we allow coverage for wigs up to $1,000 for diagnosis as medically necessary); treatment of hair loss or alopecia, including drugs and treatments to promote hair growth, whether or not prescribed by a Physician.

35. **Hearing -** Equipment intended to improve hearing, except as otherwise provided herein; hearing aid reconditioning, supplies or batteries; hearing therapy and related diagnostic hearing tests.

36. **Home Health Care -** Housekeeping, house cleaning or household maintenance services; health aid services; home care that is full-time; continuous or long-term services provided by a relative of the member or who ordinarily resides in the home of the member; Custodial Care; services to help meet personal, family or domestic needs; homemaker or caretaker services; sitter or companion services; services by volunteers or persons who do not regularly charge for their services; services provided by an agency not licensed to provide the services rendered and transportation.

37. **Hospice Care –** Funeral arrangements; pastoral, financial or legal counseling; estate planning or drafting of a will; homemaker or caretaker services that may include transportation, maintenance of the house and sitter or companion services.

38. **Hospitalization –** Hospitalization for the purpose of receiving non-Covered Services or primarily for diagnostic purposes or related to a Surgical operation when suitable

outpatient facilities are available; hospitalization solely because of a Surgical Procedure scheduled the next day; Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home; any confinement for which the Member is not legally obligated to pay; personal comfort or convenience items, such as television, telephone, guest trays and housekeeping services; private rooms, unless one is determined to be Medically Necessary; take home drugs; charges for services or supplies provided before or after your Effective Date of Coverage.

39. **Immunizations -** Immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entity whose role it is to establish eligibility guidelines and recommend preventive guidelines; immunizations where the recommended eligibility guidelines are not met; immunizations for non-health related reasons, such as for travel, education or employment; immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups.

40. **Infertility -** Charges associated with services provided to a surrogate. A surrogate is a female carrying a child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. If you choose to use a surrogate, this exclusion does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a Covered individual; cryopreservation (freezing) of eggs, embryos or sperm except in conjunction with standard fertility preservation services related to iatrogenic infertility. However, subsequent non-Experimental or Investigational procedures that use the cryopreserved substance are Eligible Health Services; Reversal of voluntary sterilizations; travel costs within 100 miles of your home or travel cost not required by Aetna; treatment for Covered Dependents under age 18; non-medical costs of an egg or sperm donor; Experimental or Investigational Infertility treatment as determined by the American Society for Reproductive Medicine.

41. **Injectables -** Injectable medications that are related to the treatment of a non-Covered Service or are Experimental or Investigational; injectable medications, such as anabolic steroids, when used for performance enhancement.

42. **Maintenance Care** - Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function except for habilitation therapy services

43. **Maternity Services -** X-rays, laboratory tests, diagnostic tests or other procedures that are not Medically Necessary; planned home deliveries; doulas.

44. **Medical Complications -** Medical complications that arose from a non-Covered Service, even if the requested service is Medically Necessary.

45. **Medical Necessity –** Any procedure, service or supply that is determined not to be Medically Necessary, as that term is defined herein: those services, supplies, equipment and facility charges that are provided to a member, not excluded under this agreement and are determined by the Plan to be:

    a. Medically appropriate, so that the expected health benefits (such as but not

limited to increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks;

b. Necessary to meet your health needs, improve physiological function and required for a reason other than improving appearance;

c. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;

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

e. Consistent with the diagnosis of the condition at issue;

f. Required for reasons other than your comfort or the comfort and convenience of your Physician; and

g. Of demonstrated value based on clinical evidence reported by peer-reviewed medical literature and by generally recognized academic medical experts; not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

46. Medical Supplies-Outpatient Disposable - Any outpatient disposable supply or device. Examples include, but not limited to:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

47. **Mental Health -**Mental health services for the following categories (or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)):

- Stay in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment.
- Sexual deviations and disorders except for gender identity disorders.
- Tobacco use disorders.
- Pathological gambling, kleptomania, pyromania.
- School and/or education service, including special educational, remedial education, wilderness treatment programs or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities.
- Transportation.
- Hypnosis and Hypnotherapy.

48. **Military Health Services** - Those services for treatment of military or service-connected disabilities when the member is legally entitled to other Coverage and for which facilities are reasonably available to the member; or those services for any otherwise eligible employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

49. **Non-Covered Service** - Any service or supply that is not an Eligible Health Service or that is directly or indirectly a result of receiving a non-Covered Service.

50. **Non-FDA Approved Items** - Any drugs, vitamins, minerals or supplements not approved by the FDA; any medical procedure or drug that is approved for use but is not used for the specific indication that led to its approval.

51. **No Physician Care or Prescription** - Services or supplies provided while you were not under the care of a Physician or which were not Pre-certified or prescribed by a Physician.

52. **Orthotics/Prosthetics** – Over the counter foot orthotics or insoles; orthopedic shoes (unless they are an integral part of a lower body brace), diabetic shoes, foot or shoe inserts, shoe lifts, shoe orthotics, other special shoe accessories, arch supports, heel lifts, heel cups, heel or sole wedges, heel pads, and other similar items, except as otherwise provided for herein; braces, supports and other orthotic appliances needed for sports or athletic participation, recreational activities or employment; convenience items or model enhancements; repair or replacement of orthotic appliances due to misuse, neglect or loss; replacement of orthotic appliances when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan; trusses, corsets and other support items; over-the-counter items, such as ACE

wraps or bandages, elastic supports, finger splints, over the counter foot orthotics, braces and the like.

53. **Outpatient Infusion Therapy** - Enteral nutrition; blood products.

54. **Outpatient Rehabilitation Services** - Rehabilitative services provided for long-term, chronic medical conditions, except as provided for herein; rehabilitative services whose primary goal is to maintain current level of function, as opposed to improving functional status; rehabilitative services whose primary goal is to return to a specific occupation or job, such as work-hardening or work-conditioning programs; educational or vocational therapy, schools or services designed to retrain for employment; rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay or congenital anomalies, except as provided for herein; rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated; speech therapy or voice training when prescribed for stuttering or hoarseness; massage therapy; sports-related services designed to affect performance or physical conditioning programs such as athletic training, body-building, exercise fitness, flexibility and diversion.

55. **Outpatient Surgery/Physician Surgical Services** – A stay in a Hospital; separate facility charge for Surgery performed in a Physician's office; services of another Physician for the administration of a local anesthetic.

56. **Primary Payor -** Any charges that would have been paid by a primary Plan had you complied with all of the Pre-certification guidelines or requirements of that Plan.

57. **Prohibited services -** Charges for services or supplies that are prohibited by federal, state or local law.

58. **Relative care** - Charges for services or supplies ordered by, or care rendered to you by, a family member or relative or someone who ordinarily resides with you in your home.

59. **Replacement items** - Replacement items, such as batteries, tires and light bulbs.

60. **Sports-related services** - Services or devices specifically used as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, including braces and orthotics.

61. **Third party liability -** Services for which a third party has primary liability, such as when services are Eligible Health Services by any governmental agency as a primary Plan, coordination of benefits, workers' compensation and claims under policies of automobile or homeowner insurance.

62. **Transplants** – Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing Illness; outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence; harvesting and/or storage of bone marrow or hematopoietic stem cells without intending to use them for transplantation within twelve (12) months from

harvesting, for an existing Illness; organ and tissue procurement, evaluation and transplantation provided by a non-Institutes of Excellence™ (IOE) facility.

63. **Travel** - Travel or transportation expenses, even if prescribed by a Provider, except as specifically provided for herein.

64. **Weight or Obesity services** - Weight reduction therapy, supplies and services, including, but not limited to, diet programs, diet pills, tests, examinations or services and medical or surgical treatments, such as jejunoileal bypass, biliopancreatic bypass, gastric balloon, duodenal switch, stomach stapling, wiring of the jaw and the like.

65. **Work** - Work-hardening or work-conditioning programs; vocational therapy.

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

VIII. Coordination of Benefits

If a Plan Participant enrolled in the program is entitled to primary benefits under another group Plan, the amount of benefits payable under the program may be reduced. The reduction may be to the extent that the total payment provided by all Plans does not exceed the total allowable expense incurred for the service. Allowable expense is defined as a Medically Necessary service for which part of the cost is eligible for payment by this Plan or another Plan(s).

Under coordination of benefits (COB) rules, the Department's Plan first calculates what the benefit would have been for the claim if there was no other Plan involved. The Department's Plan then considers the amount paid by the primary Plan and pays the claim up to 100 percent of the allowable expense.

NOTE: When a managed care health Plan is the secondary Plan and the Plan Participant does not utilize the managed care health Plan's network of Providers or does not obtain the required referrals, the managed care health Plan is not required to pay. Refer to the managed care Plan's summary Plan document for additional information.

The State of Illinois coordinates benefits with the following:

- Any group insurance Plan.
- Medicare.
- Any Veterans' Administration (VA) Plan.
- Any "no-fault" motor vehicle Plan. This term means a motor vehicle Plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault. A person who has not complied with the law will be deemed to have received the benefits required by the law.

The State of Illinois does not coordinate benefits with the following:

- Private individual insurance Plans.
- Any student insurance policy (elementary, high school and college).
- Medicaid or any other State-sponsored health insurance program.
- TRICARE.

It is the member's responsibility to provide other insurance information (including Medicare) to the Department's Medicare COB unit. Any changes to other insurance Coverage must be reported promptly to the Department's Medicare COB unit (contact information located in the Medicare section).

1. Order of Benefit Determination

The Department's medical and dental Plans follow the National Association of Insurance Commissioners (NAIC) model regulations. These regulations dictate the order of benefit determination, except for members who are eligible for Medicare due to End-Stage Renal Disease (ESRD). Refer to the 'Medicare' section for details regarding coordination of benefits for Plan Participants eligible for Medicare. The rules below are applied in sequence. If the first rule does not apply, the sequence is followed until the appropriate rule that applies is found.

Special rules apply for adult children and children of civil union partners. Contact the Department for more information.

A. Employee or Member

The Plan that covers the Plan Participant as an active employee or member is primary:

1. Over the Plan that covers the Plan Participant as a Dependent.

2. Over the Plan that covers the Plan Participant as a laid off employee or Retiree.

3. Over the Plan that covers the Plan Participant under COBRA.

4. If it has been in effect the longest, back to the original Effective Date of Coverage under the employer group, whether or not the insurance company has changed over the course of Coverage.

B. Dependent Children of Parents Not Separated or Divorced

The following "birthday rule" is used if a child is Covered by more than one group Plan. The Plans must pay in the following order:

1. The Plan covering the parent whose birthday* falls earlier in the calendar year is the primary Plan.

2. If both parents have the same birthday, the Plan that has provided Coverage longer is the primary Plan.

** Birthday refers only to the month and day in a calendar year, not the year in which the person was born.*

NOTE: Some Plans not Covered by state law may follow the gender rule for Dependent children. This rule states that the father's Coverage is the primary carrier. In the event of a disagreement between two Plans, the gender rule applies.

C. Dependent Children of Separated or Divorced Parents

If a child is Covered by more than one group Plan and the parents are separated or divorced, the Plans must pay in the following order:

1. The Plan of the parent with custody of the child;

2. The Plan of the spouse of the parent with custody of the child;

3. The Plan of the parent not having custody of the child.

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

D. Dependent Children of Parents with Joint Custody

The birthday rule applies to Dependent children of parents with joint custody.

IX. Medicare / Coordination of Benefits

1. Overview

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

The Social Security Administration (SSA) or the Railroad Retirement Board (RRB) determines Medicare eligibility upon application and enrolls eligible Plan Participants into the Medicare program. The Medicare program is administered by the Centers for Medicare and Medicaid Services (also known as the federal CMS).

In order to apply for Medicare benefits, Plan Participants should contact the Social Security Administration (SSA) office or call the SSA at 800-772-1213. Plan Participants may enroll in Medicare on the SSA website at ssa.gov/Medicare.

Railroad Retirement Board (RRB) Participants should contact their local RRB office or call the RRB at 877-772-5772 to apply for Medicare.

Medicare has the following parts:

- Part A is insurance that helps pay for inpatient Hospital facility charges, Skilled Nursing Facility charges, Hospice care and some home healthcare services. Medicare Part A does not require a monthly premium contribution from Plan Participants with enough earned work credits. Plan Participants without enough earned work credits have the option to enroll in Medicare Part A and pay a monthly premium contribution.
- Part B is insurance that helps pay for outpatient services including Physician office visits, labs, x-rays and some medical supplies. Medicare Part B requires a monthly premium contribution.
- Part C (also known as Medicare Advantage) is insurance that helps pay for a combination of the Coverage provided in Medicare Parts A, B and sometimes D. An individual must already be enrolled in Medicare Parts A and B in order to enroll in a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- Part D is insurance that helps pay for Prescription drugs. Generally, Medicare Part D requires a monthly premium contribution.

2. Medicare Due to Age (Age 65 and older)

A. Medicare Part A

Eligibility for premium-free Medicare Part A occurs when an individual is age 65 or older and has earned at least 40 work credits from paying into Medicare through Social Security. An individual who is not eligible for premium-free Medicare Part A benefits based on his/her own work credits may qualify for premium-free Medicare Part A benefits based on the work history of a current, former or deceased spouse. All Plan Participants that are determined to be ineligible for Medicare Part A based on their own work history are required to apply for premium-free Medicare Part A on the basis of a spouse (when applicable).

If the SSA determines that a Plan Participant is eligible for premium-free Medicare Part A, the State Employees Group Insurance Program requires that the Plan Participant accept the Medicare Part A Coverage and submit a copy of the Medicare identification card to the Department's Medicare COB unit upon receipt.

If the SSA determines that a Plan Participant is not eligible for Medicare Part A benefits at a premium-free rate, the State Employees Group Insurance Program does not require the Plan Participant to purchase Medicare Part A Coverage; however, the State does require the Plan Participant to provide a written statement from the SSA advising of his/her Medicare Part A ineligibility. The Plan Participant is required to submit a copy of the SSA statement to the Department's Medicare COB unit.

1) Requirements

   a. State of Illinois employees (actively working full time or part time) who become eligible for Medicare benefits are not required to enroll in Medicare Part A.

   b. State of Illinois retirees, survivors, and employees on a disability related leave of absence who do not have current employment status and become eligible for Medicare benefits **are required** to enroll in Medicare Part A.

B. Medicare Part B

Most Plan Participants are eligible for Medicare Part B upon turning the age of 65.

1) Requirements

   a. State of Illinois employees (actively working full time or part time) who become eligible for Medicare benefits are not required to enroll in Medicare Part B.

   b. State of Illinois retirees, survivors, and employees on a disability related leave of absence who do not have current employment status and are eligible for premium-free Medicare Part A benefits **are required** to enroll in Medicare Part B.

All Plan Participants who enroll in Medicare are required to submit a copy of the Medicare identification card to the Department of Central Management Services Medicare Coordination of Benefits (COB) Unit.

3. Medicare Due to Disability (Age 64 and Under)

Plan Participants are automatically eligible for Medicare Parts A and B disability benefits after receiving Social Security disability payments for a period of 24 months.

1) Requirements

   a. State of Illinois employees (actively working full time or part time) who become eligible for Medicare disability benefits are not required to enroll in Medicare.

   b. State of Illinois retirees, survivors, and employees on a disability related leave of absence who do not have current employment status and are

eligible for Medicare disability benefits **are required** to enroll in Medicare Parts A and B. Refer to the "Failure to Enroll in Medicare" section for more information.

All Plan Participants who enroll in Medicare are required to submit a copy of the Medicare identification card to the Department of Central Management Services Medicare Coordination of Benefits (COB) Unit.

4. Medicare Due to End-Stage Renal Disease (ESRD)

All State Employees Group Insurance Program Plan Participants who are receiving regular dialysis treatments or who have had a kidney transplant on the basis of ESRD are required to apply for Medicare benefits.

Plan Participants eligible for Medicare on the basis of ESRD, must contact the Department's Medicare Coordination of Benefits (COB) Unit at 800-442-1300. The Department's Medicare COB Unit calculates the 30-month coordination period in order for Plan Participants to sign up for Medicare benefits on time and avoid additional out-of-pocket expenditures.

1) Requirements
    a. All Plan Participants who become eligible for Medicare ESRD benefits are required to enroll in Medicare Parts A and B by the end of the ESRD coordination period. Refer to the "Failure to Enroll in Medicare" section for more information.

All Plan Participants who enroll in Medicare are required to submit a copy of the Medicare identification card to the Department of Central Management Services Medicare Coordination of Benefits (COB) Unit.

5. Failure to Enroll in Medicare (Medicare Parts A and B Reduction)

Members who do not enroll in Medicare Parts A and B, are responsible for the portion of healthcare costs that Medicare would have Covered. Failure to enroll or remain enrolled in Medicare when Medicare is determined to be the primary payer will result in a reduction of eligible benefit payments.

6. Services and Supplies Not Covered by Medicare

Services and supplies that are not Covered by Medicare will be paid in the same manner (i.e., same benefit levels and Deductibles) as if the Plan Participant did not have Medicare (provided the services and supplies meet Medical Necessity and benefit criteria and would normally be eligible for Coverage).

7. Private Contracts with Providers who Opt Out of Medicare

Some healthcare Providers choose to opt out of the Medicare program. When a Plan Participant has medical services rendered by a Provider who has opted out of the Medicare program, a private contract is usually signed explaining that the Plan Participant is responsible for the cost of the medical services rendered. Neither Providers nor Plan Participants are allowed to bill Medicare. Therefore, Medicare will not pay for the service (even if it would normally qualify as being Medicare eligible) or provide a Medicare Summary Notice to the Plan Participant. If the service(s) would have normally been Covered by Medicare, Aetna will estimate the portion of

the claim that Medicare would have paid. Aetna will then subtract that amount from the total charge and adjudicate the claim for an eligible secondary reimbursement.

8. Medicare COB Unit Contact Information

Department of Central Management Services
Medicare Coordination of Benefits Unit
801 S. 7th Street, P.O. Box 19208
Springfield, Illinois 62794-9208

Phone: 800-442-1300 or 217-782-7007
Fax: 217-557-3973

X. Claim Filing

In general, most dental, medical and Behavioral Health Providers file claims for reimbursement with the insurance carrier. Out-of-Network vision claims and pharmacy expenses typically must be filed by the member. In situations where a claim is not filed by the Provider, the member must file the claim within a specific period of time.

All claims should be filed promptly. Claim forms are available on the Plan administrators' website and on the MyBenefits.illinois.gov website.

- In-Network medical and behavioral health claims must be filed within 90 days from the date in which the charge was incurred.
- Out-of-Network medical, behavioral health and vision claims must be filed within 180 days from the date in which the charge was incurred.
- Out-of-Network dental and pharmacy claims must be filed no later than one-year from the ending date of the Plan Year in which the charge was incurred.

Filing deadlines for managed care Plans, including behavioral health services offered under the managed care Plan may be different. Contact the managed care Plan directly for deadlines and procedures.

1. Claim Filing Procedures

All communication to the Plan administrators must include the employee's social security number (SSN) and appropriate group number as listed on the identification card. This information must be included on every page of correspondence.

- Complete the claim form.
- Attach the itemized bill from the Provider of services to the claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the Provider's name, address and telephone number.
- If the person for whom the claim is being submitted has primary Coverage under another group Plan or Medicare, the explanation of benefits (EOB) or the Medicare Summary Notice (MSN) from the other Plan must also be attached to the claim.
- Aetna may communicate directly with the Plan Participant or the Provider of services regarding any additional information that may be needed to process a claim.

- The benefit check will be sent and made payable to you or under certain circumstances, to the Dependent, unless benefits have been assigned directly to the Provider of service.
- If benefits are assigned, the benefit check will be made payable to the Provider of service and mailed directly to the Provider. An EOB is sent to the Plan Participant to verify the benefit determination.

XI. Claim Appeal Process

Under the State Employees Group Insurance Program (Program) there are formal procedures to follow in order to file an Appeal of an Adverse Benefit Determination

Categories of Appeal

There are two separate categories of Appeals: medical and administrative. Aetna determines the category of Appeal and will send you written notification regarding the category of Appeal, your Appeal rights and information regarding how to initiate an Appeal.

- **Medical Appeals** - Medical Appeals pertain to benefit determinations involving medical judgment, including claim denials determined by Aetna to be based on lack of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; denials pursuant to Section 6.4 of the State Employees Group Insurance Act; and denials for services determined by Aetna to be Experimental or Investigational. Medical Appeals also pertain to retroactive cancellations or discontinuations of Coverage, unless the cancellation or discontinuation relates to a failure to pay required premiums or contributions.
- **Administrative Appeals** - Administrative Appeals pertain to benefit determinations based on Plan design and/or contractual or legal interpretations of Plan terms that do not involve any use of medical judgment.

2. Appeal Process

Enrolled members may utilize an internal Appeal process which may be followed by an external review, if needed. For urgent care situations, you may bypass the internal Appeal process and request an expedited external review (see "Expedited External Review- Medical Appeals Only" below for urgent care situations).

A. Expedited External Review - Medical Appeals Only

For medical Appeals involving urgent care situations, you may make a written or oral request for expedited external review after Aetna makes an Adverse Benefit Determination, even if Aetna's internal Appeal process has not been exhausted. The external reviewer will review the request to determine whether it qualifies for expedited review. If the external reviewer determines that the request qualifies for expedited review, the external reviewer will provide a final external review decision within 72 hours after the receipt of the request. The external reviewer's decision will be final and binding on all parties.

B. Step 1: Internal Appeal Process

First-level Appeals must be initiated within 180 days of the date of receipt of the initial Adverse Benefit Determination. All Appeals will be reviewed and decided by an individual(s) who was not involved in the initial claim decision. Each case will be

reviewed and considered on its own merits. If the Appeal involves a medical judgment, it will be reviewed and considered by a qualified healthcare professional. In some cases, additional information, such as test results, may be required to determine if additional benefits are available. Once all required information has been received by Aetna, Aetna will provide a decision 15 days for pre-service Pre-certification, 30 days for post-service claims, or 72 hours for urgent care claims.

Aetna's internal Appeal process must be followed before you may seek an external review, except for urgent care situations. For urgent care situations, the Plan Participant may request an expedited external review (see "Expedited External Review- Medical Appeals Only" above for urgent care situations).

C. Step 2: External Review Process

After the completion of Aetna's internal Appeal process, you may request an external review of the final internal benefit determination. The process for external review will depend on whether the Appeal is an administrative Appeal or medical Appeal.

1. Administrative Appeals

For administrative Appeals, if, after exhausting every level of review available through Aetna and you feel that the final benefit determination by Aetna is not consistent with the published benefit Coverage, you may Appeal Aetna's decision to CMS' Group Insurance Division. For an Appeal to be considered by CMS' Group Insurance Division, you must Appeal in writing within sixty (60) days of the date of receipt of Aetna's final internal Adverse Benefit Determination. All Appeals must be accompanied by all documentation supporting the request for reconsideration.

Submit Administrative Appeal Documentation to:
CMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

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

2. Medical Appeals

For medical Appeals, if, after exhausting every level of review available through Aetna, you still feel that the final benefit determination is not consistent with the published benefit Coverage, you may request an independent external review of Aetna's decision. A request for an external review must be filed in writing within four (4) months of the date of receipt of Aetna's final internal Adverse Benefit Determination. Aetna will provide more information regarding how to file a request for external review as part of its final benefit determination. The external reviewer will provide a final external review decision within 45 days of the receipt of the request. The external reviewer's decision will be final and binding for all parties.

3. Assistance with the Appeal Process

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

Office of Consumer Health Insurance Consumer Services Section
122 S. Michigan Ave., 19th FL
Chicago, IL 60603
insurance.illinois.gov
877-527-9431
Email: doi.director@illinois.gov

or

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

XII. Right of recovery

1. Subrogation

Aetna has the right to recover from a negligent third party, or their insurer, benefits we paid for an Injury or Illness.

To help us get paid back, you are agreeing to provide us with any requested:

- Information or assistance
- Documentation

This provision applies whether or not the third party admits liability.

2. Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

XIII. HIPAA Privacy

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

If you are enrolled in the Program, a copy of the Notice of Privacy Practices will be sent to you on an annual basis. Additional copies are available on the MyBenefits.illinois.gov website.

XIV. Glossary

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

1. Abortion
The use of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of an individual known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

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

3. Additional Deductible
Deductibles that are in addition to the annual Plan Deductible.

4. Aetna
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with Aetna.

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

6. Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

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

8. Authorized Representative
An individual authorized by the Participant or state law to Act on the Participant's behalf to submit Appeals and file claims. A Provider may act on behalf of a Participant with the

Participant's express consent, or without the Participant's express consent in an urgent care situation.

9. Autism Spectrum Disorders
Autism Spectrum Disorders means pervasive develop Mental Disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including Autism, Asperger's disorder, and pervasive develop Mental Disorder not otherwise specified.

10. Autism Spectrum Disorders Diagnosis
Autism Spectrum Disorders Diagnosis means one or more tests, evaluations, or assessments to diagnose whether an individual has Autism Spectrum Disorder that is prescribed, performed, or ordered by (A) a Physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders.

11. Behavioral Health Provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for Mental Disorders and Substance Use Disorder under the laws of the jurisdiction where the individual practices.

12. Body Mass Index
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

13. Brand-name Prescription drug
A U.S. Food and Drug Administration (FDA) approved Prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

14. Claims Administrator
Aetna Life Insurance Company

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

16. Co-pay/Co-payment
A specified dollar amount you must pay as a condition of the receipt of certain Eligible Health Services. Co-payments are set forth in the Schedule of Benefits.

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

18. Coverage or Covered
The entitlement by a Participant to Covered Services/ Eligible Health Services under the Plan subject to the terms, conditions, limitations and exclusions contained in this document and the

Schedule of Benefits, including the following conditions: (a) health services must be provided prior to the date that any of the termination conditions occur; and (b) health services must be provided only when the recipient is a Participant and meets all eligibility requirements specified in this document; and (c) health services must be Medically Necessary.

19. Covered Employee or Retiree

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

20. Covered Services/Benefits

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

21. Custodial Care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be Custodial Care even if it prescribed by a Physician or given by trained medical personnel.

22. Deductible

The amount you pay for Eligible Health Services per Plan Year before your Plan starts to pay as listed in the Schedule of Benefits.

23. Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs
- This can be done by metabolic or other means determined by a Physician, or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

24. Dependent

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

25. Durable Medical Equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an Illness or Injury
- Suited for use in the home
- Not normally used by people who do not have an Illness or Injury
- Not for altering air quality or temperature
- Not for exercise or training

26. Effective Date of Coverage

The date you and your Dependent's Coverage begin under this booklet-certificate as noted in Aetna's records.

27. Eligible Health Services

The health care services and supplies and Prescription drugs listed in the Eligible Health Services under your Plan section and not carved out or limited in the exceptions section or in the Schedule of Benefits.

28. Emergency Medical Condition

A condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) inadequately controlled pain; or (5) with respect to a pregnant woman who is having contractions: (A) inadequate time to complete a safe transfer to another hospital before delivery; or (B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

29. Emergency Services

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

30. Experimental or Investigational

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

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the Illness or Injury involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is Experimental or Investigational or suitable mainly for research purposes
- It is the subject of a phase I, phase II or the Experimental or research arm of a phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility Provider state that it is Experimental or Investigational.

31. Formulary

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

32. Formulary Exclusions List

A list of Prescription drugs not Covered under the Plan. This list is subject to change.

33. Generic Prescription drug

A Prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

34. Genetic Information

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

35. Home Health Care

Services delivered in your home by or under the supervision of a licensed healthcare professional (nurse or therapist) and provided by a licensed and certified agency.

36. Hospice

Care designed to give supportive care to people in the final phase of a Terminal Illness and focus on comfort and quality of life, rather than cure.

37. Hospital

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

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric Hospital
- Residential Treatment Facility for substance abuse
- Residential Treatment Facility for Mental Disorders
- Extended care facility
- Intermediate care facility
- Skilled Nursing Facility

38. Illness

Poor health resulting from disease of the body or mind.

39. Infertile/Infertility
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

40. Injury
Physical damage, independent of disease or bodily infirmity, done to a person or part of their body.

41. In-Network/Network/Participating Provider
A Provider who has entered into a direct or indirect written agreement with the claims administrator to provide health services to Participants. For a list of Providers included in the network is available on our website at www.aetna.com/docfind or by contacting our Customer Service Department. The participation status of Providers may change from time to time.

42. Institutes of Excellence™ (IOE) facility
A facility designated by Aetna in the Provider directory as Institutes of Excellence Network Provider for specific services or procedures.

43. Intensive Outpatient Program (IOP)
Clinical treatment provided in a facility or program provided under the direction of a Physician. Services are designed to address a Mental Disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

44. L.P.N.
A licensed practical nurse or a licensed vocational nurse.

45. Mail order pharmacy
A pharmacy where Prescription drugs are legally dispensed by mail or another carrier.

46. Maximum Out-of-Pocket Limit
The Maximum Out-of-Pocket amount for payment of Co-payments and Coinsurance including any Deductible, to be paid by you or any Covered Dependents per Plan Year for Eligible Health Services.

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

48. Medically Necessary or Medical Necessity
Health care services that we determine a Provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease.

- Not primarily for the convenience of the patient, Physician, or Other health care Provider.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

49. Mental Disorder

Mental Disorders are defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized Mental Disorders. In general, a Mental Disorder is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. Mental Disorders are often connected to significant distress or disability in social, work or other important activities. It includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

50. Morbid Obesity/Morbidly Obese

This means the Body Mass Index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

51. Negotiated charge

As to health Coverage, (other than Prescription drug Coverage for services obtained from a network pharmacy): The amount a network Provider has agreed to accept for rendering services or providing Prescription drugs or supplies to members of your Plan.

As to Prescription drug Coverage when Prescription drugs are obtained from a network pharmacy: The amount Aetna has established for each Prescription drug obtained from a network pharmacy under this Plan. This Negotiated charge may reflect amounts Aetna has agreed to pay directly to the network pharmacy or to a third-party vendor for the Prescription drug, and may include an additional service or risk charge set by Aetna.

The Negotiated charge does not reflect any amount Aetna, an affiliate, or a third-party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any Prescription drug, including Prescription drugs on the Preferred drug guide.

Aetna may receive rebates from the manufacturers of Prescription drugs and may receive or pay additional amounts from or to third parties underprice guarantees. These amounts will not change the Negotiated charge under this Plan.

52. Non-Preferred drug

A Prescription drug or device that may have a higher out-of-pocket cost than a Preferred drug.

53. Other health care
Eligible Health Services that are neither network services or supplies nor Out-of-Network services or supplies. Other health care can include care given by a Provider who does not fall into any of the categories in the Provider directory.

54. Out-of-Network Coverage Option
Eligible Health Services provided to Participants by a Non-Participating Provider. These Eligible Health Services may require Pre-certification.

55. Out-of-Network/Non-Participating Provider
A Provider who has no direct or indirect written agreement with the Claims Administrator to provide health services to Participants.

56. Partial Hospitalization Treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be Medically Necessary and provided by a Behavioral Health Provider with the appropriate license or credentials. Services are designed to address a Mental Disorder or substance abuse issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring
- Care is delivered according to accepted medical practice for the condition of the person.

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

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

59. Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, Doctor of Medicine or osteopathy.

60. Plan
The State of Illinois OAP Health Plan.

61. Plan Sponsor
The State of Illinois.

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

63. Pre-certification/Pre-certify/Pre-certified

A requirement that you or your Physician contact Pre-certify Aetna before you receive Coverage for certain services. This may include a determination by us as to whether the service is Medically Necessary and eligible for Coverage.

64. Preferred drug
A Prescription drug or device that may have a lower out-of-pocket cost than a Non-Preferred drug.

65. Prescriber
Any Provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient Prescription drugs.

66. Prescription
A written order for the dispensing of a Prescription drug by a Prescriber. If it is a verbal order, it must promptly be put in writing by the Network pharmacy.

67. Prescription drug
An FDA approved drug or biological which can only be dispensed by Prescription.

68. Provider(s)
A Physician, other health professional, Hospital, Skilled Nursing Facility, Home Health Care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

69. Psychiatric Hospital
An institution specifically licensed as a Psychiatric Hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, Mental Disorders (including substance-related disorders), or mental Illnesses.

70. Psychiatrist
A Psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

71. Qualified Beneficiary
Shall have the meaning set forth in COBRA.

72. Recognized charge
The amount of an Out-of-Network Provider's charge that is eligible for Coverage. You are responsible for all amounts above the Recognized charge. The Recognized charge may be less than the Provider's full charge.

In all cases, the Recognized charge is based on the geographic area where you receive the service or supply.

A service or supply provided by a Provider is treated as Eligible Health Services under the Other health care Coverage category when:

- You get services or supplies from an Out-of-Network Provider. This includes when you get care from Out-of-Network Providers during your stay in a network Hospital.

- You could not reasonably get the services and supplies needed from a network Provider.
- The Other health care Coverage does not apply to services or supplies you receive in an Out-of-Network emergency room.

When the Other health care Coverage applies, you will pay the Other health care cost share. Except as otherwise specified below, the Recognized charge for each service or supply is the lesser of what the Provider bills and:

- For professional services and for other services or supplies not mentioned below: 125% of the Medicare allowable rate
- For services of Hospitals and other facilities: 125% of the Medicare allowable rate
- For Prescription drugs: 110% of the Average wholesale price (AWP)
- For Emergency Services, the Recognized charge is the Negotiated charge for Providers with whom we have a direct contract but are not network Providers.

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the Recognized charge. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the Provider

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of Physicians and dentists practicing in the relevant clinical areas
- We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms that are used Average wholesale price (AWP), geographic area, and Medicare allowable rates are defined as follows:

- Average wholesale price (AWP) is the current average wholesale price of a Prescription drug listed in the Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Geographic area the geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Medicare allowable rates except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates.

- Look at what other Providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

73. Retiree

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

74. R.N.

A registered nurse.

75. Residential Treatment Facility (Mental Disorders)

An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating Mental Disorders:

- A Behavioral Health Provider must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a Psychiatrist at least once per week.
- The Medical Director must be a Psychiatrist.
- Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).
- Residential Treatment Facility (Substance Use Disorders)

An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for Substance Use Disorders residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating Mental Disorders:

- A Behavioral Health Provider must be actively on duty 24 hours per day for 7 days a week.

- The patient must be treated by a Psychiatrist at least once per week.
- The Medical Director must be a Psychiatrist.
- Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).

76. Retail pharmacy
A community pharmacy that dispenses outpatient Prescription drugs at retail prices.

77. Room and Board
A facility's charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

78. Semi-Private Room Rate
An institution's Room and Board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

79. Service Area
The geographic area where network Providers for this Plan are located.

80. Schedule of Covered Services
Description of Eligible Health Services.

81. Schedule of Benefits
Shall mean the Schedule of Benefits provided with this document.

82. Skilled Nursing Facility
A facility specifically licensed as a Skilled Nursing Facility by applicable state and federal laws to provide Skilled Nursing care.

Skilled Nursing Facilities also include rehabilitation Hospitals, and portions of a rehabilitation Hospital and a Hospital designated for skilled or rehabilitation services.

Skilled Nursing Facility does not include institutions that provide only:
- Minimal care
- Custodial Care services
- Ambulatory care
- Part-time care services
- It does not include institutions that primarily provide for the care and treatment of Mental Disorders or Substance Use Disorders.

83. Specialty Care Physician/Specialist
A Physician who practices in any generally accepted medical or surgical sub-specialty.

84. Specialty Prescription drugs
These are Prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

85. Standard Fertility Preservation Services
Procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

86. Step therapy
A form of Pre-certification under which certain Prescription drugs will be excluded from Coverage, unless a first-line therapy drug(s) is used first by you. The list of Step-therapy drugs is subject to change.

87. Substance Use Disorders
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a Mental Disorder that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

88. Surgery Center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient Surgery Services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

89. Surgery or Surgical Procedures
The diagnosis and treatment of Injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

90. Telemedicine
A telephone or internet-based consult with a Provider that has contracted with Aetna to offer these services.

91. Terminal Illness
A medical prognosis that you are not likely to live more than 12 months.

92. Therapeutic drug class
A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or Injury.

93. Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an Urgent condition.

94. Urgent condition

An Illness or Injury that requires prompt medical attention but is not an Emergency Medical Condition.

95. Value Prescription drugs

A group of medications determined by the Plan that may be available at a reduced Coinsurance and are noted on the Preferred drug guide.

96. Walk-In Clinic

A free-standing health care facility. Neither of the following should be considered a Walk-in Clinic:

- An emergency room
- The outpatient department of a Hospital

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Illinois law that determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
1520 Kensington Road, Suite 112
Oak Brook, Illinois 60523-2140
(773) 714-8050

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.