HFS Medical Assistance Certificate

MeridianHealth Plan of Illinois, Inc.

How to Use Your Certificate

This Certificate should be read thoroughly. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two items may not give a clear understanding to the reader.

Many words used in this Certificate have special meanings. Such words will be capitalized, and are defined in Section I. By using these definitions, the clearest understanding will be obtained.

This Certificate may be subject to amendment, modification, or termination by mutual agreement between MeridianHealth Plan, Inc. ("Health Plan") and the Illinois Department of Healthcare and Family Services without the consent of any Member. Members will be notified of such changes as soon as possible after they are made. By choosing health care coverage under Health Plan, Members agree to all the terms and conditions in this Certificate.

Description of Coverage - Cover Page

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

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

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. Since the Description of Coverage is not a legal document, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll-free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Healthcare and Family Services at 800-226-0768. Please be aware that the Illinois Department of Healthcare and Family Services will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.

Description of Coverage Worksheet

Plan Name: MeridianHealth
Address: 300 S. Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700

Category	Services	Description of Coverage
Basics	Your Doctor	Members must select a PCP at the time of enrollment. This choice may be changed by calling Member Services. Female Members may receive services from any in-network Woman's Primary Health Care Provider (WHCP) without a referral from her PCP.
	Annual Deductible	None
	Out of Pocket Maximum	None. Health Plan does not charge any co-pays for covered services.
	Lifetime Maximum	None
	Preexisting Condition Limitations	None

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care	All	100%	$0
	Room and Board	All	100%	$0
	Surgeon's Fees	All	100%	$0
	Doctor's Visits	All	100%	$0
	Medications	State of Illinois Drug Product Selection Program (Formulary)	100%	$0
	Other Miscellaneous Charges	Medically Necessary and eligible services including laboratory, radiology and supplies provided by the hospital.	100%	$0
Emergency Care	Emergency Services	Medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to sever pain, such that a prudent lay person 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 the woman or her unborn child, in serious jeopardy; 2) serious impairment in bodily functions; or 3) serious dysfunction of any bodily organ or part.	100%	$0
	Emergency Post Stabilization Services	Services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.	100%	$0
In the Doctor's Office	Doctor's Office Visits	Primary Care and Specialist	100%	$0
	Routine Physical Exams	Covered	100%	$0
	Diagnostic Tests and X-Rays	Covered	100%	$0
	Immunizations	Covered	100%	$0
	Allergy Treatment and Testing	Covered	100%	$0
	Wellness Care	Covered	100%	$0
Medical Services	Outpatient Surgery	Covered	100%	$0
	Maternity Care Hospital Care	Covered	100%	$0

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
	Physician Care	Covered	100%	$0
	Infertility Services	Not Covered		
	Mental Health Outpatient Inpatient	 Covered Covered	 100% 100%	 $0 $0
	Substance Abuse Outpatient Inpatient	 Covered Covered	 100% 100%	 $0 $0
	Outpatient Rehabilitative Services	Covered	100%	$0
Other Services	Hospice	Covered	100%	$0
	Home Health Care	Covered	100%	$0
	Prescription Drugs	Not Covered*		
	Dental Services	Not Covered*		
	Vision Care	Not Covered*		
	Medical Transportation	Covered	100%	$0
	Skilled Nursing	Up to 90 days facility, services and supplies provided by the facility.	100%	$0
	Durable Medical Equipment	Covered, rental or purchase as per the Health Plan's decision	100%	$0

** Use your HFS Medical Card to obtain these services. They are not covered by Health Plan.*

Service Area
Counties of Adams, Brown, Cook, Henry, Lee, Mercer, Pike, Rock Island and Scott, and additional counties as approved by the Illinois Department of Healthcare and Family Services.

Exclusions and Limitations
Pharmacy, dental, optometric, elective cosmetic surgery, custodial care services, nursing facility services beginning on the ninety-first (91st) day, infertility services and termination of pregnancy except as allowed by State law.

Services and supplies that are not authorized by the Primary Care Provider and are not an Emergency. Services that are not medically necessary or are considered experimental, investigational and/or educational. Work related injury or illness or immunizations required for employment.

Pre-Certification and Utilization Review
For non-emergency care, the Member's Primary Care Physician ("PCP") participates in and concurs with all inpatient hospital stays by pre-approving all elective admissions, outpatient surgery and specialty services. In addition to the Primary Care Provider's pre-approval of all elective admissions, the Plan's Medical Director or designated Utilization Management ("UM") Department Representative must authorize all hospital admissions. The Primary Care Provider or specialist by referral will make the necessary arrangements for hospitalization, outpatient procedures or other services if medically necessary as defined in the certificate of coverage.

Emergency Care
In an Emergency, a Member immediately should seek medical care from the nearest hospital emergency department and notify Health Plan within twenty-four (24) hours of an emergency admission or within twenty-four (24) hours of when the Member is able to notify the Plan. Medically Necessary Emergency Services are covered regardless of whether or not the Emergency Services are provided by a Participating Provider. Medically Necessary Post-Stabilization Medical Services provided by a non-Participating Provider are covered if either pre-approved by Health Plan or if Health Plan does not deny approval for such Post-Stabilization Medical Services within one hour of the non-Participating Providers good faith attempt to obtain approval for such services from Health Plan.

Primary Care Provider ("PCP") Selection
Members must choose a Primary Care Provider from the provider directory available at time of enrollment. Member's Primary Care Provider is responsible for providing and coordinating care, approving referrals to specialists and other services. Members may change their Primary Care Provider by calling Member Services at 866-606-3700.

Access to Specialty Care
A Member may see a specialist Participating Provider for Medically Necessary services, if Member obtains a referral from Member's Primary Care Provider. The Primary Care Provider must approve services or additional referrals recommended by specialist Participating Providers. Members should contact their PCP to determine what referral arrangements exist. If a referral arrangement does not exist between a Member's PCP and the desired Specialist, then the member has the right to change his or her PCP by calling Member Services. In some situations, a Member may request a standing referral to a specialist who is a Participating Provider.

If a Member's Primary Care Provider determines a referral to a specialist is appropriate for Medically Necessary services and a qualified specialist who is a Participating Provider does not exist, the Primary Care Provider may approve a referral to a specialist who is not a Participating Provider; provided, however, that the specialist is an Illinois Medical Assistance Program Provider.

Female Members may choose, in addition to a Primary Care Provider, a family practitioner or obstetrician/gynecologist, who is also a Participating Provider, as her Woman's Health Care Provider ("WHCP"). After this selection, Member may see her designated Woman's Health Care Provider without a referral for all covered services. At the request of any Woman's Health Care Provider, the Plan shall follow its utilization and quality assurance procedures and protocols in evaluating the WHCP as a Primary Care Provider.

Out-of-Area Coverage
Out-of-Area coverage is only available for Emergency care. Once the condition has been stabilized, the Member must return to the Service Area as soon as medically appropriate to receive continuing and/or follow up care. Member must contact Health Plan within twenty-four (24) hours of an emergency admission or within twenty-four (24) hours of when the Member is able to notify the Plan if hospitalized for an Emergency condition.

Financial Responsibility
There are no co-payments, deductibles or premiums payable by the Member for covered, eligible care. A Member may request a description of the financial relationships between the Health Plan and any health care provider, the percent of co-payments, deductibles and total premiums spent on health care and related administrative expenses, as well as a notice of the Member's right to request health care provider information from his or her provider as set forth in the Managed Care Reform and Patient Rights Act.

Continuity of Treatment
Subject to certain conditions described in greater detail in the Certificate, a new Member, who either requires an ongoing course of treatment or who is in her third trimester of pregnancy, may request to continue to see their existing specialty physician until ninety (90) days after the effective date of coverage, in the case of an ongoing course of treatment, and including post-partum care directly related to delivery in the case of pregnancy.

Subject to certain conditions described in greater detail in the Certificate, if an existing Member's Participating Provider leaves Health Plan's network and the existing Member is either receiving an ongoing course of treatment from the Participating Provider, or the existing Member is in her third trimester of pregnancy and is receiving care from the Participating Provider, the existing Member may request to continue to see that Provider for ninety (90) days from date Health Plan notifies Member that the provider is leaving Health Plan's network.

In either case, the Provider must agree to the Plan's Quality Improvement and Utilization Plan policies and procedures, and payment. If Member is new to Health Plan, Member must make their request in writing and an existing Member must make their request within thirty (30) days of being notified of this service. The Plan will respond in writing within fifteen (15) days of receiving the Member's request with approval or the specific reason for denial of the request.

Grievance and Appeal Process
All grievances and appeals must first be submitted to the Health Plan for resolution, but may later be appealed to the Illinois Department of Healthcare and Family Services. For administrative issues, Members may submit complaints in writing or by calling Member Services. A resolution to the grievance will be mailed to the Member, unless it is handled orally and informally. If the Member is not satisfied with the resolution, a second-level grievance may be submitted to the Grievance Committee. The Member will be notified of the Committee's decision. Information on this process will be included in any communication to the Member.

For clinical issues, Members may appeal decisions, which will be evaluated by a clinical peer who was not involved in the original decision. If this is further appealed, an external independent clinical peer in the same specialty of the original care provider will evaluate the appeal. The Member has the right to participate in the selection of the independent reviewer. In all appeals, the Member and Provider will be notified in writing within a time period to be determined by the nature of the appeal, e.g., Expedited or Non-Expedited. Information at each step of this process will be included in any communication to the Member.

Members may call 1-866-606-3700 to receive more information concerning the appeal process and request a grievance form.

Any Member not satisfied with the health care plan's resolution of any grievance or appeal may appeal the final plan decision to the Illinois Department of Healthcare and Family Services at the following location:

HFS Bureau of Administrative
Hearings 401 South Clinton
6th Floor
Chicago, IL 60607
800-435-0774
TTY: 877-734-7429

You may also contact the Department electronically at **http://www.hfs.illinois.gov**

To obtain a complaint form or to receive help in completing the form, the Member may call the Illinois Department of Healthcare and Family Services toll-free at 866-468-7543. TTY: 877-204-1012.

Note: External grievance determinations are appealable through the Illinois Department of Healthcare and Family Services.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

MeridianHealth
300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

CERTIFICATE OF COVERAGE

This Certificate is issued by MeridianHealth Plan of Illinois, an Illinois Corporation operating as a health maintenance organization, hereinafter referred to as "Health Plan" to _____ hereinafter referred to as "Member". In consideration of Member's enrollment, Health Plan shall provide and/or arrange for covered health services to Member in accordance with the provisions of this Certificate.

IN WITNESS WHEREOF, Health Plan has caused this Certificate to be executed by its duly authorized officer on the date indicated below, under which Certificate coverage will commence on the effective date indicated below.

Effective Date:

_____

MeridianHealth Plan of Illinois, Inc.

By: _____
President and CEO

Dated: _____

Certificate of Coverage Table of Contents

MeridianHealth Plan of Illinois, Inc.

SECTION I. DEFINITIONS

A. **"Action"** means a (i) denial or limitation of authorization of a requested service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) denial of payment for a service; (iv) failure to provide services in a timely manner; (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Contracting Area. (v) failure to respond to an appeal in a timely manner; and (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Contracting Area.

B. **"Appeal"** means a request for review of a decision made by the Health Plan with respect to an Action.

C. **"Chronic"** means an illness or injury that is, or is expected to be, but is not necessarily, of a long duration and/or frequently recurs and is always present to a greater or lesser degree. Chronic conditions may have acute episodes.

D. **"Contract"** means the agreement between Health Plan and the Department under which this coverage is made available to Eligible Persons.

E. **"Covered Services,"** as described more fully in Attachment A - Covered Services and Benefits, Limitations and Exclusions, are those benefits, services, and supplies which MeridianHealth of Illinois, Inc., ("Health Plan") has contracted with the Department to arrange for Members.

F. **"Department"** shall mean the Illinois Department of Healthcare and Family Services.

G. **"Dependent"** shall mean an individual meeting the requirements under the Medical Assistance Program who is a member of a medical assistance case and an Eligible Person.

H. **"Effective Date"** shall mean the date on which a Member's coverage becomes effective.

I. **"Eligible Person"** shall mean any person covered under the Contract.

J. **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possess 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 the woman or her unborn child, in serious jeopardy;
2. serious impairment to bodily functions ; or
3. serious dysfunction of any bodily organ or part

K. **"Emergency Services"** means those inpatient and outpatient health services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a provider qualified to furnish emergency services.
The need for pregnancy-related medical services, including routine prenatal care or delivery, received by a Member traveling outside the Service Area during the third-trimester of pregnancy against medical advice will not be deemed an Emergency, except when Member is outside the Service Area due to circumstances beyond her control.

L. **"EPSDT"** shall mean Early and Periodic, Screening, Diagnosis, and Treatment services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.).

M. **"Exclusion,"** as more fully described in Attachment A, is an item or service which is not a Covered Service under the Contract.

N. **"Experimental or Investigational Treatment"** means any drug, device, therapy, medical treatment, or procedure which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Health Plan:
The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
The drug, device, therapy, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other board serving a similar function, or if federal law requires such review and approval; or
Reliable Evidence (as that term is defined below) shows that such drug, device, therapy, medical treatment, or procedure has not been proven safe and effective for the treatment of the condition in question, using generally accepted scientific, medical, or public health methodologies or statistical practices; or

Reliable Evidence shows that the drug, device, therapy, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of on-going phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or efficacy as compared with a standard means of treatment or diagnosis; or

Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, therapy, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis or the prevailing opinion among experts as demonstrated by Reliable Evidence is that usage should be substantially confined to research settings.

O. **"Grievance"** means a Member's expression of dissatisfaction, including complaints, about any matter other than a matter that is properly the subject of an Appeal.

P. **"Group"** means the Illinois Department of Healthcare and Family Services.

Q. **"Hospital"** is a legally operated facility defined as an acute care or tertiary hospital and an institution licensed by the State and approved by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the American Osteopathic Association ("AOA") or by the Medicare program.

R. **"Medical Assistance Program"** means the HFS Medical Assistance Program administered by the Illinois Department of Healthcare and Family Services.

S. **"Medical Director"** means a Physician designated by Health Plan to monitor and review the utilization and quality of health services provided to Members.

T. **"Medically Necessary"** means that a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to enable the Member to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with the Health Plan's guidelines, policies, and/or procedures.

U. **"Member"** shall mean an Eligible Person enrolled in the Health Plan under the Contract.

V. **"Out-of-Area Services"** are those Covered Services arranged or received outside the Service Area and are limited to Emergency Services.

W. **"Participating Provider"** is a Provider who, at the time of providing or prescribing Covered Services to a Member, has contracted directly or indirectly with Health Plan to provide and/or coordinate Covered Services and is currently enrolled as a provider in the Medical Assistance Program. A Participating Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Participating Physician.

X. **"Participating Provider"** is a Provider, medical group, Hospital, Skilled Nursing Facility, home health agency, or any other duly licensed institution or health professional that has contracted directly or indirectly with Health Plan to provide or facilitate Covered Services to Members, and is currently enrolled as a provider in the Medical Assistance Program. A Participating Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Participating Provider.

Y. **"Physician"** is a person licensed under the Medical Practice Act of 1987.

Z. **"Post-Stabilization Services"** means medically necessary non-emergency services furnished to a Member after the Member is Stabilized, in order to maintain such Stabilization, following an Emergency Medical Condition.

AA. **"Primary Care Provider"** means a Participating Provider who has primary responsibility for providing, arranging and coordinating all aspects of a Member's health care. A Member shall select or have selected on his or her behalf a Primary Care Provider. A Primary Care Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Primary Care Provider.

BB. **"Service Area"** means the geographic area within which Health Plan has received regulatory approval to operate and is designated by the Contract under which the Member is enrolled.

CC. **"Short-Term Rehabilitation Therapy"** means rehabilitation therapy that is limited to treatment for conditions which are subject to significant clinical improvement within two (2) months from the first day of care, as determined by Member's Primary Care Provider and Health Plan's Medical Director in advance and on a timely basis unless otherwise explicitly stated in Attachment A.

DD. **"Skilled Nursing Care"** means Covered Services that can only be performed by, or under the supervision of, licensed nursing personnel.

EE. **"Skilled Nursing Facility"** is a facility which is duly licensed by the State which provides inpatient acute skilled nursing care, acute rehabilitation services or other related acute health services.

FF. **"Specialty Care Physician"** is a Physician who provides certain specialty medical care upon referral by a Member's Primary Care Physician and is currently enrolled as a provider in the Medical Assistance Program and authorized by Health Plan.

GG. **"Stabilization or Stabilized"** means, with respect to an Emergency Medical Condition, and as determined by an attending emergency room Physician or other treating provider within reasonable medical probability, that no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

HH. **"Usual and Customary Charge"** is the charge which is based on the then current prevailing Medical Assistance Program fee schedule in the Member's Service Area. If a Member has a question as to Health Plan's determination of the Usual and Customary Charge in a specific instance, he or she may call Member Services.

II. **"Woman's Primary Health Care Provider"** ("WHCP") is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who is a Participating Physician and chooses to act as a WHCP.

SECTION II. ELIGIBILITY AND ENROLLMENT

A. **Who is Eligible to be a Member**
An Eligible Person who has enrolled in Health Plan pursuant to the Contract and confirmed by the Department. Also, a newborn child of the Eligible Person who is the Case Holder and who is enrolled in Health Plan shall have coverage from the moment of birth, subject to all applicable provisions of this Certificate. If you have a baby, call your caseworker right away. Then call the Health Plan so we are aware of your baby's birth.

B. **Enrollment**
Enrollment under this Agreement shall be on a voluntary basis.

1) Health Plan and the Department, or its contracted client enrollment broker, shall be responsible for the enrollment of Eligible Persons pursuant to agreed upon procedure. A newborn infant added to the medical assistance case within 45 days of birth will be automatically enrolled in the Health Plan if the mother is the grantee of the case and is enrolled in the Health Plan at the time of birth. The Effective Date of enrollment will be the infant's date of birth. Newborns added to a medical assistance case after 45 days of birth will be also automatically enrolled in the Health Plan if the mother is the grantee or all members of the case are enrolled in the Health Plan. The Effective Date of coverage will be prospective as determined by the Illinois Department of Healthcare and Family Services.

2) Health Plan, as part of its marketing and member service functions, will educate and assist Eligible Persons to understand their enrollment options, facilitate their contact with the client enrollment broker or, if necessary, submit to the Department, or its contracted client enrollment broker, an approved enrollment form completed and signed by the Eligible Person who is the grantee of the case. An adult Eligible Person who is not the grantee of the case may enroll himself/herself only.

3) A Member may disenroll at any time under procedures established by the Department. Every Eligible Person shall be notified at the time of enrollment, and annually thereafter, of the right to voluntarily terminate the enrollment at any time.

C. **Nondiscrimination**
Enrollment shall be without regard to race, color, religion, sex, national origin, ancestry, age or physical or mental handicap. Health Plan will not discriminate against Eligible Persons on the basis of health status or need for health services.

D. **Delivery of Documents**
Health Plan will provide a copy of this certificate to each Member upon enrollment, and annually upon request.

E. **Notice of Ineligibility**
It shall be the State's responsibility to notify Health Plan of any changes which will affect Member's eligibility.

SECTION III. TERMINATION OF MEMBER'S COVERAGE

A. **Termination**
Except as expressly provided in this Certificate, Health Plan may seek to have the Illinois Department of Healthcare and Family services terminate coverage under this Certificate for a Member as follows:

1) if a Member permits the use of his or her or any other Member's Health Plan ID card for any other person, or uses another person's Health Plan ID card, the card may be revoked by Health Plan and Member's eligibility for coverage may be canceled and coverage of the Member shall end upon written notice to the Member or may be voided retroactive to the date of the unauthorized use of the Health Plan ID card. Member shall be liable to Health Plan for all costs incurred as a result of the misuse of the identification card or, if the actual costs cannot be determined, the Usual and Customary Charges of such services or benefits;

2) if Participating Providers are unable to establish or maintain a satisfactory provider-patient relationship with a Member after repeated and aggressive outreach attempts, Member's eligibility for coverage may be canceled and coverage of the Member shall end upon no less than thirty-one (31) days written notice to the Member that Health Plan considers such provider-patient relationship to be unsatisfactory; provided, however, that: (a) Member has repeatedly refused to follow treatment as prescribed by

the Participating Provider and (b) Health Plan has in good faith provided Member with an opportunity to select an alternative Participating Provider. Further grounds for terminating a Member's coverage include, but are not limited to, abusive or disruptive behavior in a Physician's office, and Member's securing services in a manner that impairs the ability of the Primary Care Provider to coordinate Member's care;

3) if a Member commits a material violation of the terms of this Certificate then the coverage of such Member may be terminated upon no less than thirty-one (31) days written notice to the Member;

4) unless otherwise provided herein, if a Member ceases to be an Eligible Person, coverage shall terminate effective the day following the date upon which eligibility ceases.

Coverage under this Certificate will not be terminated based upon the status of a Member's health or the exercise of Health Plan's Grievance Procedure by a Member.

B. **Reinstatement**
A Member shall not be reinstated automatically in the Plan if coverage is terminated by the Department for cause.

If a Member's coverage is terminated due to eligibility cancellation, and if such person's eligibility is regained within 60 days, he or she will automatically be reinstated as a Member of Health Plan and assigned to his or her previous Primary Care Provider and covered under this Certificate. If eligibility is canceled longer than 60 days, membership is not automatically reinstated. A new enrollment application will be required.

C. **Creditable Coverage Certificate**
Health Plan will track periods of "creditable coverage" of each Member. Upon termination of coverage under this Certificate and during the two (2) year period following termination, you may request a Certificate of Creditable Coverage from the Department by calling 888-281-8497.

SECTION IV. COVERED SERVICES AND BENEFITS

Each Member shall select or have selected on his or her behalf a Primary Care Provider through whom certain primary care medical services shall be provided or coordinated and who will coordinate the other Covered Services to be received by the Member from other Participating Providers. In addition to a Primary Care Provider, all female members may select a WHCP with a referral arrangement with their Primary Care Provider if they so choose. It is not required to have or select a WHCP, but the option is available for female Members. If a Member receives services through a Physician or health care provider other than his or her Primary Care Provider and such services were not ordered by his or her Primary Care Provider and authorized by Health Plan, those services will not be covered except in a true Emergency. Members may change their Primary Care Provider by calling Member Services. Changes requested prior to or on the 15th of a month will take effect on the first day of the following month. Changes made after the 15th of the month will take effect within thirty (30) days following the request.

A Member shall receive Covered Services from Participating Providers, except for family planning services or in an Emergency, including medical, surgical, diagnostic, therapeutic and preventive services, as set forth in Attachment A, which are determined to be Medically Necessary and are performed, prescribed, directed or ordered by a Member's Primary Care Provider or WHCP, within the scope of that provider's practice, experience, and training.

When a Primary Care Provider, WHCP or other Participating Provider, upon referral from the Primary Care Provider, determines services are Medically Necessary and notifies the Health Plan of a recommended course of treatment, and a second course of treatment is determined to be medically equivalent or substantially medically equivalent by Health Plan, Health Plan has the right, at its discretion, and provided that the decision is made on a timely and prospective basis, to cover only the less costly services or benefits rather than those which would otherwise be covered or available under the Contract. This provision does not preclude the physician's right to appeal pursuant to 215 ILCS 134/45. This remains true whether such less costly services or benefits would or would not otherwise be covered. This means, for example, that if both inpatient care in a Skilled Nursing Facility and nursing care in the home on a part time intermittent basis would be medically appropriate, and inpatient care would be less costly, Health Plan can limit coverage to inpatient care. Moreover, Health Plan can limit coverage to inpatient care even if it means extending the quantity of the inpatient benefit beyond that provided in this Certificate.

In order for a proposed course of treatment, service or supply to be considered a Covered Service, that treatment, service or supply, must be Medically Necessary (see definition in Section I-T.) A proposed course of treatment, service or supply is not Medically Necessary or a Covered Service merely because a Participating Physician or Provider prescribes, orders, recommends or approves the service or supply. In addition, the requirements of Medical Necessity apply to all treatments, services or supplies covered under this Certificate, even treatments, services or supplies which are specifically covered by Health Plan or which are not expressly excluded. Thus, a proposed course of treatment, service or supply will not be considered a Covered Service when it is not Medically Necessary even though the treatment, service or supply itself is not specifically listed as an Exclusion and/or may be expressly provided for in Attachment A and/or is otherwise a benefit under the Medical Assistance Program. Health Plan shall hold Member harmless from any financial responsibility for services that retrospectively are considered not Medically Necessary, unless the Member has committed fraud.

Members may be referred by the Primary Care Provider to a non-Participating Provider in the event that a Participating Provider cannot meet the medical needs of the patient.

A Member shall not obtain a vested interest in any Covered Service merely by virtue of the fact that the Member has begun to receive that Covered Service. Health Plan may amend or terminate this Certificate as provided herein and Member shall not have a vested interest in continued coverage under this Certificate or any Covered Service.

Health Plan will not cover services rendered to a member if a member consults a health professional without a referral from his or her primary care physician or WHCP and authorized by Health Plan except in an emergency. The Health Plan allows a member to obtain behavioral health and substance abuse services without a referral from his or her primary care physician or WHCP.

SECTION V. CONTINUITY OF CARE

A. **New Members**

In two situations, a new Member has the option to continue to see, for a limited period of time, a physician who is not a Participating Provider. The first situation is where a new Member who, as of the effective date of coverage, was receiving an ongoing course of treatment from a provider who is not a Participating Provider. An ongoing course of treatment means treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by that physician because of the potential for changes in the therapeutic regime. The second situation is where a new Member who, as of effective date of coverage, is in her third trimester of pregnancy and has been receiving pre-natal care from a physician who is not a Participating Provider. Health Plan will notify new Members of this option. A new Member must request in writing approval from the plan to use the option.

Health plan will approve a new Member's request to use this option if all of the following conditions are met by the provider from whom the new member desires to continue receiving care:

- Provider is located within Health Plan's Service Area.
- Provider meets Health Plan's credentialing standards.
- Provider is a Medical Assistance Program provider.
- Provider agrees to follow Health Plan's procedures and policies including accepting reimbursement rates at prevailing Medical Assistance Program fee schedules, following quality assurance requirements, providing encounter and other clinical data as required of Participating Physicians, and adhering to utilization policies and procedures.
- Provider completes and returns the appropriate form to Health Plan, within fourteen (14) days of Health Plan receiving Member's request, indicating his or her agreement to follow the Health Plan's policies and procedures.

Within fifteen (15) days after receiving a new Member's request, Health Plan will notify the new Member in writing if the new Member's request has been approved or denied. Such notification shall set forth the specific reasons for denial. If a new Member, who is receiving an ongoing course of treatment, receives approval from Health Plan to use this option, new Member may continue to see the physician to receive the ongoing course of treatment until the earlier of either: (a) the ninety (90) day period, which starts on the effective date of coverage, ends; or (b) the provider stops meeting the above conditions. If a new Member, who is in her third trimester of pregnancy, receives approval from Health Plan to use this option, new Member may continue to see the physician for pregnancy related care, including post-partum care directly related to the delivery until the provider stops meeting the above conditions.

B. **Existing Members**

In two situations, an existing Member, who has been notified that their Participating Provider has left the network, may continue to see that Provider for a limited period of time. The first situation is where an existing Member who, as of the date the provider's contract was terminated, was receiving an ongoing course of treatment from that physician. An ongoing course of treatment means treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by that physician because of the potential for changes in the therapeutic regime. The second situation is where an existing Member who, as of the date the provider's contract was terminated, is in her third trimester of pregnancy and has been receiving pre-natal care from that physician. Within thirty (30) days of receiving notification that the provider has left the network, an existing Member must request in writing approval from the plan to use this option.

Health Plan will approve an existing Member's request to use this option if all of the following conditions are met by the provider from whom the new member desires to continue receiving care:

- Provider's contract was terminated for reasons other than either a final disciplinary action by the State of Illinois or quality of care issues.
- Provider continues to be located with Health Plan's Service Area.
- Provider continues to meet Health Plan's credentialing standards.
- Provider continues to be a Medical Assistance Program provider.
- Provider agrees to continue following Health Plan's procedures and policies including accepting reimbursement rates at prevailing Medical Assistance Program fee schedules, following quality assurance requirements, providing encounter and other clinical data as required of Participating Provider, and adhere to utilization policies and procedures.
- Provider completes and returns the appropriate form to Health Plan, within fourteen (14) days of Health Plan receiving Member's request, indicating his or her agreement to continue to follow the Health Plan's policies and procedures.

Within fifteen (15) days after receiving an existing Member's request, Health Plan will notify the existing Member in writing if the existing

Member's request has been approved or denied. Such notification shall set forth the specific reasons for denial. If an existing Member, who is receiving an ongoing course of treatment, receives approval from Health Plan to use this option, the existing Member may continue to see the provider to receive the ongoing course of treatment until the earlier of either: (a) the ninety (90) day period, which starts on the date when the Member is notified that Participating Provider is leaving the network, ends; or (2) the provider stops meeting the above conditions. If an existing Member, who is in her third trimester of pregnancy, receives approval from Health Plan to use this option, the existing Member may continue to see the provider for pregnancy related care until either the first post-partum office visit or the provider stops meeting the above conditions, whichever occurs earlier.

SECTION VI. STANDING REFERRAL

Under Section IV and Attachment A – Section I, a Member is required to obtain a referral from either his or her Primary Care Provider or WHCP prior to consulting or receiving care from any other health professional, except in an Emergency. However, a standing referral may be approved by the Health Plan, if the Member requests such referral from his or her Primary Care Provider or the WHCP and such Primary Care Provider or the WHCP provides the Member with a referral to a Participating Provider in accordance with Section IV and the Primary Care Provider determines in consultation with the Participating Provider that the Member's condition requires the Member to receive ongoing care from a health professional other than the Primary Care Provider. If a standing referral is approved, the Member does not need to seek an additional referral for each visit to the Participating Provider listed on the standing referral for the duration of the referral period. The referral period shall be stated on the written referral and shall be no longer than the period necessary for the Participating Provider to provide the course of treatment listed on the referral or one (1) year from the date the standing referral is approved, whichever occurs earlier. The referral shall immediately expire if the Participating Provider listed on the standing referral leaves the Health Plan's network. Member then will be required to obtain a new referral from his or her Primary Care Provider before receiving additional care.

To request a standing referral, Member must submit to Member's Primary Care Provider a written request containing the following information:

- Member's name and Health Plan identification number found on the Member's ID card;
- Participating Provider's diagnosis of the Member's condition;
- Participating Provider's recommended course of treatment;
- A statement as to the amount of time that will be required to complete the course of treatment;
- Participating Provider's printed name, address and telephone number; and
- Participating Provider's signature.

Health Plan shall not deny requests on grounds of failing to provide all above information without first attempting to assist Member in obtaining such information. If the Health Plan approves the Member's request the Member's Primary Care Provider will provide a written standing referral which lists the name of the Participating Provider to whom the Member is being referred, the services authorized by the standing referral, and the referral period. If a standing referral is approved, the Member will be referred to a Participating Provider with whom the Member's Primary Care Provider has a referral arrangement. If no qualified Participating Provider who has a referral arrangement with the Primary Care Provider, the Primary Care Provider will provide the standing referral to a Participating Provider without a referral arrangement with Member's Primary Care Provider. If a qualified Participating Provider with whom the Primary Care provider has a referral arrangement exists, but the Member desires to receive ongoing care from a Participating Provider who does not have a referral arrangement with the Member's designated Primary Care Provider the Member may elect to change his or her Primary Care Provider (by following the procedures in Section IV) to a Primary Care Provider who has a referral arrangement with the Participating Provider. If the Member's request for a standing referral is denied by the Health Plan, the Member may appeal the Health Plan's decision through the external independent review process described in Section X-D.

The Member's Primary Care Provider will continue to coordinate the Member's care. Further, the Participating Provider may not refer the Member to other health professionals. The Member must obtain additional referrals to other health professionals from the Member's Primary Care Provider.

SECTION VII. RELATIONSHIP OF PARTIES

A. **Independent Contractors**
The relationship between Health Plan and participating providers is that of an independent contractor relationship; participating providers are not agents or employees of health plan, nor is health plan, or any employee of health plan, an employee or agent of participating providers. Health Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any participating provider or in any participating provider's facilities resulting from the participating provider's own negligence in the performance of the participating provider's duties arising from the Member's treatment.

B. **Provider/ Patient Relationship**
Participating Providers maintain the provider/patient relationship with Members and are solely responsible to Members for all health services or treatment afforded or recommended by Participating Providers. Members may refuse to accept certain procedures.

Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of their provider/patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate medical care in a manner compatible with a Participating Provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure after the Participating Provider has used his or her best efforts to elicit the Member's cooperation, and the Participating Provider believes that no professionally acceptable alternative exists, such Member shall be so advised. In such case, Health Plan will notify the Member to select a new Participating Provider. If the Member has failed to select a new Participating Provider within thirty (30) days of the notice, Health Plan will select a new Participating Provider on the Member's behalf. In addition, Health Plan may notify Illinois Department of Healthcare and Family Services of such noncompliance and request that the Department disenroll the Member from Health Plan. The repeated refusal by the Member to follow prescribed treatment(s) or procedure(s) may result in termination of the Member's coverage, pursuant to Section III, Termination of Member's Coverage. Prior to termination, however, Health Plan will provide Member an opportunity to select an alternative Primary Care Provider.

Health Plan or a Participating Provider may terminate their contract or limit the numbers of Members that the provider will accept as patients. Health Plan does not promise that a specific Participating Provider will be available to render services throughout the period that a Member is covered by Health Plan. However, Health Plan will provide all Members with 60 days advance notice of the termination of any Primary Care Provider previously seen by Member, provided Health Plan receives such notice from provider. If Health Plan receives less than 60 days advance notice from the provider, Health Plan shall provide immediate notice to Member of such termination.

Health Plan shall not intervene with the provision of medical services, it being understood that the traditional relationship between the provider and patient will be maintained. However, Health Plan is not responsible for the payment of medical services in those cases where a particular course of treatment is not a covered service under the Member's Health Plan coverage. Health Plan shall hold Members harmless from any financial responsibility for services that Health Plan retrospectively deems not to be covered, by virtue of not being medically necessary, unless fraud has been committed by the Member.

SECTION VIII. WORKERS' COMPENSATION, AUTOMOBILE LIABILITY INSURANCE, MEDICARE AND OTHER HEALTH COVERAGE

A. **Workers Compensation and Automobile Liability Insurance**
The benefits under this Certificate are not designed to duplicate any benefit to which such Members are eligible under Workers' Compensation or Automobile Liability Insurance. All sums payable pursuant to Workers' Compensation and Automobile Liability Insurance for services provided or arranged for Members are payable to and retained by Health Plan. It is also understood that coverage under this Certificate is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation and Automobile Liability Insurance. A Member's failure to pursue his or her Workers' Compensation rights, Automobile Liability benefits (if in force) or the waiver of those rights or benefits shall be considered a violation of this provision.

B. **Medicare**
Except as otherwise provided by applicable Federal law, the benefits under this Certificate for Members age sixty-five (65) and older, or Members otherwise covered by Medicare, do not duplicate any benefit to which such Members are eligible under the Medicare Act, including Part B of such Act, except Medicare copayments and deductibles. Where Medicare is the primary payor, all sums payable pursuant to the Medicare Program for services provided under this Certificate are payable to and retained by Health Plan, or as otherwise directed by Health Plan.

C. **Other Health Coverage**
Any services which have been paid or are payable under any other health plan or health insurance under which a Member is covered is always primary to this coverage which, like the Medical Assistance Program, is always the coverage of last resort.

D. **Members' Cooperation**
Each Member shall complete and submit to Health Plan such consents, releases, assignments and other documents as may be requested by Health Plan in order to obtain or assure reimbursement where Health Plan is the secondary payer under this Section. Health Plan may request that the Department disenroll any Member who fails to so cooperate, including enrolling under Part B of the Medicare Program as soon as possible where Medicare is the primary payor.

SECTION IX. SUBROGATION

If a Member is injured or becomes ill through the act of a third party, Health Plan shall provide care for such injury or sickness. Acceptance of such services will constitute consent to the provisions of this Section.

In the event of any payments for benefits provided to a Member under this Certificate, Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member has against any person or organization and Health Plan shall be entitled to receive from any such recovery an amount up to the actual amount paid by Health Plan, and if the actual amount paid cannot be determined, then the Usual and Customary Charges, for the services provided by Health Plan. Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Health Plan.

Health Plan shall have a lien on all funds received by Member up to the actual amount paid by Health Plan, and if the actual amount paid cannot be determined, then the Usual and Customary Charge for the services and supplies provided to Member. Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits received under this Certificate. This includes Health Plan's right to bring suit against the third party in the Member's name.

Any such right of subrogation or reimbursement provided to Health Plan under this policy shall not apply or shall be limited to the extent that Illinois statutes or the courts of Illinois eliminate or restrict such rights.

The Member must take such action, furnish such information and assistance, and execute such instruments as Health Plan may require to facilitate enforcement of its rights under this provision. The Member shall take no action prejudicing the rights and interests of Health Plan under this provision.

SECTION X. UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program is intended to assure the most appropriate level, amount, and quality of care in the most cost effective manner.

A. **Scope of Program**
The utilization management program applies to all covered services. Referral from member's primary care provider or WHCP and authorization from health plan is required for all referrals to other health care providers, including participating providers, and follow-up visits. Covered services subject to this utilization management program include, but are not limited to, the following:

1. All inpatient stays and extension whether in a Hospital, Skilled Nursing Facility, Mental Health Facility or drug and alcohol detoxification facility
2. Home Health Care
3. Short-Term Rehabilitative Services whether on an inpatient or outpatient basis
4. Mental Health and Psychiatric Services
5. Prosthetic Devices
6. Surgical services whether performed on an inpatient or outpatient basis
7. All Specialty Physician referrals
8. Durable Medical Equipment
9. Alcohol and Substance Abuse Services
10. Services of all non-Participating Providers except in the case of an Emergency

B. **The Program**
Under the Utilization Management Program, Health Plan will review the Primary Care Physician's or WHCP's determination that services are Medically Necessary. Factors that will be considered include, but are not limited to, the following elements:

1. whether the recommended level and/or site of care is Medically Necessary
2. whether the recommended level and/or site of care is medically appropriate and efficient in light of the available alternatives
3. whether the duration of treatment is Medically Necessary and/or appropriate

Health Plan will utilize a number of steps in conjunction with the Primary Care Provider or WHCP in these determinations including, but not limited to: pre-admission review; admission review; continued stay review; and case management.

C. **Appeals**
A Member may appeal Health Plan’s determination denying referrals, pre-approval or coverage of medical services. An appeal may be filed by the Member or a personal representative such as a physician or guardian in writing or orally, and must be filed within 90 days of the date on the notice of action.

(1) Expedited Review. When the failure to receive a medical service or treatment which is subject of the appeal could significantly increase the risk to the enrollee’s health or when the subject of the appeal is a medical service or treatment to be provided as part of an ongoing course of treatment, an appeal may be filed either orally or in writing within twenty-four (24) hours of receipt of an adverse determination.

Within twenty-four (24) hours of receipt of Member’s appeal, Health Plan will preliminarily review the claim and notify the person filing the appeal of any additional information necessary to evaluate the appeal. The person filing the appeal must provide the requested additional information or request additional time to provide the requested additional information. Within twenty-four (24) hours of receipt of all of the necessary information, Health Plan will issue a decision concerning the appeal and orally notify the person filing the appeal, Member, Member’s PCP and provider recommending the medical service or treatment which is the subject of the appeal. Health Plan will subsequently provide the decision in writing to the Member containing (a) clear and detailed reasons for the determination, (b) the medical or clinical criteria for the determination, and (c) if an adverse decision, the procedures for requesting an external independent review.

(2) Non-Expedited Review. All other appeals of adverse determinations by Health Plan concerning a referral, pre-approval, or

coverage of a medical service (i.e., where the failure to receive a medical service or treatment which is subject of the appeal should not significantly increase the risk to the enrollees health, as determined by Member's Provider) must be filed in writing to Health Plan. Within (3) business days of receiving the appeal, the Health Plan will notify the person filing the appeal of any additional information necessary to process the appeal. Both the Health Plan and the member maintain the right to ask for a 14 day extension to obtain more information relating to the appeal, if such an extension is in the best interest of the member filing the appeal.

The person filing the appeal must provide the requested additional information or request additional time to provide the requested additional information. The Health Plan will make a decision about the appeal within 15 days of receiving all required information. The Health Plan will then notify the member, the member's Primary Care Provider (PCP), as well as any other Providers involved in the appeal, orally and in writing, within 5 days of reaching a decision. Health Plan's written decision will contain (a) clear and detailed reasons for the determination, (b) the medical or clinical criteria for the determination, and (c) if an adverse decision, the procedures for requesting an external independent review.

During the appeal, the course of care or proposed course of care will not be interrupted and, if the appeal prevails, the care will be covered, subject to other provisions of the Certificate. If the appeal does not prevail and the Member agreed to pay for non-covered services prior to the services being provided, the Member will be financially liable for that care. Health Plan's obligation to Member with respect to the medical service or treatment which is the subject of the appeal shall be terminated if Member and/or person filing the appeal on Member's behalf fails to pursue the appeal or fails to respond to requests for additional information in a timely manner.

D. **External Independent Review**

If Member receives an adverse determination of an appeal filed under Section X-C, the Member, or a personal representative authorized in writing by the Member, may request, in writing, within thirty (30) days of receipt of adverse determination, an External Independent Review (the "Review"). Member shall have the right to appeal a denial of External Independent Review pursuant to the Fair Hearing Process of the Illinois Department of Healthcare and Family Services. Within thirty (30) days of receipt of the written request, Health Plan will provide member with the names of two Independent Review organizations. Member may select one organization to hear his or her appeal. All Independent Reviewers: (1) must be board certified clinical peers who are actively engaged in clinical practice; (2) will have no direct financial interest in the case; and (3) will not know the identity of the Member. The Independent Reviewer will render a decision within five (5) days of receipt of all required information. Health Plan will notify Member of the decision within five (5) business days of Reviewer's decision. Health Plan shall pay all fees incurred by the Independent Reviewer.

If the appeal was an Expedited appeal under Section X above, the Member must request a Review of an adverse determination and provide all necessary information to conduct such Review. Independent Reviewer will issue a decision within twenty-four (24) hours of receiving all of the necessary information, which in the Independent Reviewer's sole discretion is required to evaluate the appeal. For Non-Expedited appeals under Section X above, which contains all of the necessary information needed to evaluate the appeal, within thirty (30) days of receipt of the request for Review, Health Plan will acknowledge receipt of the Review request, provide to Member procedures for selecting one of two Independent Review organizations, and will forward all medical and supporting necessary information to the Independent Reviewer. Within five (5) days of receiving all of the necessary information, the Independent Reviewer will issue a decision. Within five (5) business days of the decision, Plan will inform the member of the decision. If the Independent Reviewer determines that the medical services which are the subject of the appeal are Medically Necessary, Health Plan shall pay for covered medical services.

The Illinois Department of Healthcare and Family Services requires that we inform you that if you are not satisfied with the determination of the Independent Reviewer you may request review by the Department. You may direct your request for review to the HFS Bureau of Administrative Hearings, 401 South Clinton, 6th Floor, Chicago, IL 60607 (phone) 1-800-435-0774 (TTY) 1-877-734-7429.

E. **Use of Genetic Testing**

Health Plan will not seek information derived from genetic testing for use in connection with this Contract for the purpose of disclosing any genetic testing information to anyone not involved in the clinical care of the patient.

SECTION XI. GENERAL PROVISIONS

A. **Entire Certificate**

This Certificate any Attachments hereto, and the individual applications and questionnaires, if any, of the Member constitute the entire agreement between the parties and as of the effective date of coverage, and supersede all other agreements between the parties. No portion of Health Plan's charter, by-laws or other document of Health Plan shall be considered part of this Certificate unless set forth in full herein or attached hereto.

B. **Form or Content of Certificate**

No agent or employee of Health Plan is authorized to change the form or content of this Certificate. Such changes can be made only through endorsement signed by an authorized officer of Health Plan.

C. **Identification Card**

Cards issued by Health Plan to Members pursuant to this Certificate are for identification only. Possession of a Health Plan ID card confers no right to services or other benefits under this Certificate. To receive benefits under this Certificate, the holder of the ID card must, in fact, be an Eligible person. Any other person receiving services or other benefits under this Certificate and any Member assisting such person shall be liable for the actual cost of such services or benefits or, if the actual costs cannot be determined, the

Usual and Customary Charges of such services or benefits and Member's coverage may be terminated pursuant to Section III-A(1) and may be in criminal violation of Illinois law.

D. **Authorization to Examine Health Records**
By accepting benefits under the Certificate, the Member consents to and authorizes all health care providers, including but not limited to, Physicians, Hospitals, Skilled Nursing Facilities, and Participating Providers to permit the examination and copying of any portion of the Member's hospital and medical records, when requested by Health Plan, in accordance with the consents obtained in Section VIII-D above. Information from medical records of Members and information received from providers incident to the provider/patient relationship shall be kept confidential and except for uses reasonably necessary in connection with government requirements established by law, may not be disclosed without the consent of the Member.

E. **Notice of Claim**
If submission of a claim is required to receive benefits under this Certificate, such claim shall be allowed only if notice of that claim is submitted to Health Plan within ninety (90) days from the date on which the expense was first incurred. However, if it was not reasonably possible to give notice within the above time limit, and notice was furnished as soon as was reasonably possible, the submission date will be extended accordingly. However, in no event will benefits be allowed if notice of claim is made beyond twelve (12) months from the date on which the expense was incurred, or in the case of an Emergency hospitalization, ninety (90) days from the date Member regained physical or mental capacity to provide such notice, whichever is later. A Member may make a claim to Health Plan by submitting bills from the providers for the health care services Member received along with a description of the circumstances surrounding the receipt of the health care services and proof of payment if the Member is seeking reimbursement.

F. **Notice**
Any notice under this Certificate may be sent by Certified Mail, Return Receipt Requested or by Federal Express or similar overnight delivery service, including courier, addressed as follows:

MeridianHealth
300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

Or, if to a Member, at the last address known to Health Plan.

G. **Interpretation of Certificate**
The laws of the State of Illinois shall be applied to interpretations of this Certificate.

H. **Assignment**
This Certificate is not assignable by Member. A Member's benefits under this Certificate are not assignable.

I. **Member Grievances**
Member may seek resolution of a Grievance in accordance with Health Plan's Member Administrative Grievance Procedure. A copy of the Member Administrative Grievance Procedure is annexed as Attachment B. As described more fully in the Member Administrative Grievance Procedure in Attachment B, Health Plan will provide Member with the following notice with any written determination by the Appeals and Grievance Committee:

The Illinois Department of Healthcare and Family Services requires that we inform you that if you are not satisfied with the determination of the Appeals and Grievance Committee you may request review by Healthcare and Family Services. You may direct your request for review to the HFS Bureau of Administrative Hearings, 401 South Clinton, 6th Floor, Chicago, IL 60607. (phone) 800-435-0774 (TTY) 877-734-7429.

J. **Gender**
The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural and vice versa.

K. **Clerical Error**
Clerical error, whether of the Group or Health Plan in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

L. **Policies and Procedures**
Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate.

M. **Amendment**
This Certificate shall be subject to amendment or modification upon written notice to Member upon the amendment or modification by Health Plan of all other Certificate bearing Form Number: MHP-ILCERT2008. By electing medical and hospital coverage under Health Plan or accepting Health Plan benefits, all Members legally capable of contracting agree to all terms, conditions, and provision hereof.

SECTION XII. GENERAL EXCLUSIONS AND LIMITATIONS

Health Plan will not be required to cover the following services:

1. Pharmacy Services
2. Personal comfort items or services
3. Custodial Care
4. Cosmetic surgery, except for the repair of accidental injury or for improvement of a malfunctioning body part or for correction of congenital deformities evidenced in infancy or reconstructive surgery following a mastectomy.
5. Any treatment covered under Workers' Compensation.
6. Any treatment covered under programs of the Federal or State Government where the Illinois Department of Healthcare and Family Services has no obligation to pay for such services under the State Medical Assistance Program.
7. Health services rendered, including those related to pregnancy, after the termination date of the Member's coverage.
8. Dental surgery, treatment or care, except for selected limited services for adults age 21 and over as approved by HFS, or dental hospitalization in case of trauma or when related to a medical condition or acute medical detoxification.
9. Voluntary termination of pregnancy.
10. Diagnostic and/or therapeutic procedures and services related to infertility/sterility. Treatment of infertility, services of sperm banks, artificial insemination procedures including determinations, diagnostic procedures and fertility drugs used in preparation of treatment. Gamete intrafallopian tube transfer, embryo transfer, embryo freezing and cost of donor sperm.
11. Behavioral Training and Modification including biofeedback, neuro-muscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, play therapy, educational therapy, and recreational therapy.
12. Dietary supplements that are not Medically Necessary.
13. Exercise, health club membership, self-help, hygienic, and beautification equipment.
14. Gender (sex) transformation, transsexual surgery or any procedures or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations.
15. Medications to enhance athletic performance.
16. Military service connected care, care for military service-connected disabilities and conditions for which the Member is legally entitled and for facilities which are in the Service Area.
17. Personal or comfort items, such as, but not limited to, radio, television, telephone, guest meals, cosmetics, dietary supplements that are not Medically Necessary, and health or beauty aids, personal lodging, meals, travel expenses and all other non-medical expenses.
18. Replacement prescription medications involving fraud of the Member.
19. Reversal of voluntary surgically-induced infertility.
20. Non-emergency transportation services that are not Medically Necessary.
21. Complications resulting from a non-covered service will be determined on a case by case basis.
22. Any treatment required as the result of war, or the act of war occurring after the Individual Effective Date, in the event of a major disaster or epidemic.

The benefits under this certificate are intended to be equal to those covered under the medical assistance program unless otherwise expressly provided, consistent with the contract. Exclusions and benefits are consistent with the Medical Assistance Program fee schedule provided by the medical assistance program for the state of Illinois' Healthcare and Family Services. In addition, the exclusions listed above are not exhaustive and shall automatically be supplemented and revised to conform with the services covered or excluded by the Medical Assistance Program and the Contract, and any amendments thereto.

Attachment A
Covered Services and Benefits, Limitations and Exclusions

SECTION I. COVERED SERVICES AND BENEFITS

Each Member shall select or have selected on his or her behalf a Primary Care Provider or WHCP through whom certain primary care medical services shall be provided or coordinated and who will coordinate the other Covered Services to be received by the Member from other Participating Providers. In addition to a Primary Care Provider, all female members may select a Woman's Health Care Provider with a referral arrangement with their Primary Care Physician if they so choose. It is not required to have or select a Woman's Health Care Provider, but the option is available. If a Member receives services through a Physician or health care provider other than his or her Primary Care Provider/Woman's Health Care Provider and such services were not ordered by his or her Primary Care Provider/Woman's Health Care Provider and authorized by Health Plan, those services will not be covered except in a true Emergency. Members may change their Primary Care provider/Woman's Health Care Provider by calling Member Services.

A Member shall receive Covered Services from Participating Providers, except for family planning services and in an Emergency, including medical, surgical, diagnostic, therapeutic and preventive services, as set forth in Attachment A, which are determined to be Medically Necessary and are performed, prescribed, directed or ordered by a member's primary care provider and WHCP, within the scope of that provider's practice, experience and training, and if required, authorized on a prospective and timely basis by health plan's medical director. A Member may receive Covered Family Planning Services from any provider currently enrolled as a provider in the Medical Assistance Program and who provides the Covered Services.

When a Primary Care Provider, WHCP or other Participating Provider, upon referral from the Primary Care Provider determines services are Medically Necessary and recommends a course of treatment, and a second course of treatment is determined to be medically equivalent or substantially medically equivalent, as determined by Health Plan in accordance with generally accepted clinical protocols and/or guidelines, Health Plan has the right, at its discretion, to cover only the less costly services or benefits rather than those which would otherwise be covered or available under the Contract. This remains true whether such less costly services or benefits would or would not otherwise be covered. This means, for example, that if both inpatient care in a Skilled Nursing Facility and nursing care in the home on a part time intermittent basis would be medically appropriate, and inpatient care would be less costly, Health Plan can limit coverage to inpatient care. Moreover, Health Plan can limit coverage to inpatient care even if it means extending the quantity of the inpatient benefit beyond that provided in this Certificate.

In order for a proposed course of treatment, service or supply to be considered a Covered Service, that treatment, service or supply, must be Medically Necessary (see Section I-T of this handbook). A proposed course of treatment, service or supply is not Medically Necessary or become a Covered Service merely because a Participating Provider or Provider prescribes, orders, recommends or approves the service or supply. In addition, the requirements of Medical Necessity apply to all treatments, services or supplies covered under this Certificate, even treatments, services or supplies which are specifically covered by Health Plan or which are not expressly excluded. Thus, a proposed course of treatment, service or supply will not be considered a Covered Service when it is not Medically Necessary even though the treatment, service or supply itself is not specifically listed as an Exclusion and/or may be expressly provided for in Attachment A.

A Member shall not obtain a vested interest in any Covered Service merely by virtue of the fact that the Member has begun to receive that Covered Service. Health Plan may amend or terminate this Contract as provided herein and Member shall not have a vested interest in continued coverage under this Contract or any Covered Service.

Health Plan will not cover services rendered to a member if a member consults a health professional without a referral from his or her primary care physician and authorized by health plan, except in an emergency. If the Member is unable to reach his or her PCP, then the Member should contact the Health Plan Member Services Department for further instructions.

SECTION II. BENEFITS AND COVERAGES

The benefits under this Certificate are intended to be equal to those covered under the Medical Assistance Program unless otherwise expressly provided, consistent with the Contract.

In order for a service to be a covered service it must be medically necessary, performed, prescribed, directed or ordered by a Member's primary care physician and authorized by Health Plan.

A. **Physician Services**

1. **Participating Provider Services**. Medically Necessary physician services received in the office of Member's Primary Care Provider, WHCP or in the office of a Participating Specialist.

2. **Surgical Services.** Medically Necessary surgical services in a Participating Hospital, a Participating Hospital's outpatient surgical facility, ambulatory surgical facility, or in a Participating Provider's office (where medically appropriate) including surgical assistants where Medically Necessary and Medically Necessary anesthesiologist services performed in connection with surgical services. Reconstructive surgery incident to a mastectomy is covered, provided that the mastectomy is performed after July 1,

1981. For purposes of this Contract, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons, as determined by a Participating Provider. Removal of breast implants when the removal of the implants is medically necessary treatment for a sickness or injury and the implants were not implanted solely for cosmetic reasons.

3. **Professional Services in Hospital.** Medically Necessary services by a Participating Provider for visits, examinations and consultations, when such Member is an inpatient receiving covered Inpatient Services in a Participating Hospital or Participating Skilled Nursing Facility.

4. **Services In The Home.** Medically Necessary services in the Member's home by a Participating Provider if the Participating Provider determines that the Member is too ill or disabled to be seen during regular working hours at the Provider's office.

B. **Inpatient Hospital Services**

1. Hospital stays in a semi private room, meals and general nursing care; a private room when Medically Necessary, ordered by a Participating Provider and approved by Health Plan.
2. Special diets and dietitian services when Medically Necessary.
3. Use of operating room and related facilities, and specialized treatment rooms.
4. Intensive care unit and services.
5. Anesthesia and oxygen services.
6. Surgical and anesthetic supplies furnished by the hospital as a regular service.
7. Surgical implant devices and supplies used by a Member while an inpatient.
8. Hospital ancillary services, i.e., laboratory, pathology, radiology, radiation therapy, inhalation and respiratory therapy, whether or not services are provided by a Participating Physician or Participating Provider.
9. Drugs, medications, and biologicals when prescribed for use as an inpatient.
10. Blood transfusion services, including the administration of whole blood, blood products (blood components and derivatives) and blood plasma. Autologous blood collection and storage, if Medically Necessary, for a specific planned hospital admission.
11. Diagnostic and therapeutic services.
12. Coordinated discharge planning services, including the planning of such continuing care as may be Medically Necessary.
13. Organ transplantation procedures using a transplant Provider certified by HFS. The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the Federal Department of Health and Human Services will be consulted to respond to a request for determination within ninety (90) days whether such procedure is experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
14. Post-parturition care of a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery for the mother and newborn or a minimum of ninety-six (96) hours of Inpatient care following a delivery by caesarean section for the mother and newborn; provided that a shorter length of Hospital Inpatient stay may be provided if the Member's Participating Provider determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and newborn meet the appropriate guidelines for a shorter length of stay based on evaluation of the mother and newborn. In the event a shorter length of stay occurs, a post-discharge Physician office visit or in-home nurse visit within the first forty-eight (48) hours of discharge will be covered.
15. Inpatient coverage for post-mastectomy care for a length of stay determined by the Member's Participating Provider to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Member. If Medically Necessary, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the Member within the first forty-eight (48) hours of discharge will also be covered.

C. **Diagnostic Testing and Laboratory Services**

Diagnostic services, including diagnostic laboratory services, imaging and diagnostic and therapeutic radiological services.

D. **Short-Term Rehabilitation Therapy**

For each acute condition or complex of acute interrelated conditions (multiple problems and/or sites in the same body region) which are related to the same acute causal event but not including conditions for which rehabilitative services have previously been provided, Medically Necessary Short-Term Rehabilitation Therapy services (as defined in Section I-CC) limited to speech, physical, and occupational rehabilitative therapy for acute conditions which are directed at improving the physical functioning of Member will be provided when ordered by Member's Primary Care Provider and authorized by Health Plan's Medical Director in advance and on a timely basis.

E. **Home Health Services**

Medically Necessary part-time, intermittent home health services provided by a Participating Provider, when the Member is homebound for medical reasons, when and to the extent prescribed by a Participating Provider in accordance with a home health treatment plan and authorized by Health Plan. Such home health services include:

1. Skilled nursing services provided by a registered nurse or licensed vocational nurse.
2. Home health aide services under the supervision of a registered nurse, excluding meals, child care, in-home day care, and housekeeping services.
3. Physical, occupational or speech therapy, subject to the limitations of Section II-D, Short-Term Rehabilitation, Attachment A.
4. Laboratory services prescribed by a Participating Provider and administered by a Participating Provider, to the extent the same would have been Covered Services if the Member had remained in the Hospital or Skilled Nursing Facility.

F. **Skilled Nursing and Intermediate Care Facilities**

Medically Necessary non-acute care skilled nursing or immediate care services in a Skilled Nursing Facility or an immediate care facility (or equivalent care provided at home because a skilled nursing facility is not available) which is a Participating Provider up to a

maximum of ninety (90) days in any Contract year, to the extent prescribed by a Participating Provider and authorized by Health Plan, including room and board in semi-private accommodations, general nursing care and Medically Necessary Short-Term Rehabilitation Therapy subject to Section II-D of Attachment A. Periods in excess of ninety (90) days per contract year will be covered by the Department according to its prevailing reimbursement system and applicable laws and regulations. However, custodial or domiciliary care in a Skilled Nursing Facility or any other facility is not covered.

G. **Preventive Health Services**

1. **Periodic Health Appraisals.** Health appraisals from birth by the Member's Primary Care Provider including:
   a. periodic physical examinations;
   b. hearing and vision screening as set forth in Attachment A, Section II-G(5), below;
   c. routine laboratory testing and screening as set forth in Section C of this Attachment A;
   d. blood pressure testing;
   e. pelvic examination as set forth in Attachment A, Section II-G(2), below;
   f. mammography testing as set forth in Attachment A, Section II-G(4), below; and
   g. EPSDT Services as set forth in Attachment A, Section II-G(9), below.

2. **Periodic PAP Smear, Breast And Pelvic Examination**. Female Members may receive an annual PAP smear, breast and pelvic examination, including cervical-cytological testing. This examination may be performed by the Member's Primary Care Provider or WHCP, at the option of the Member, and does not require a referral from Health Plan.

3. **Immunizations**. Adult Members may receive immunizations as recommended by the U.S. Public Health Service and prescribed by the Member's Primary Care Provider. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics and prescribed by the child Member's Primary Care Provider. Immunizations primarily for the Member's personal convenience including but not limited to, travel, school (for adult Members), work (for adult Members) and recreational purpose are not covered.

4. **Mammography**. Female Members may receive mammography for screening or diagnostic purposes upon referral by the Member's Primary Care Provider or WHCP and as set forth herein. Low-dose mammography for female Members 35 years or older for the detection of occult breast cancer is covered as follows:

   a. A baseline mammogram for women 35 to 39 years of age.

   b. An annual mammogram for women 40 years of age or older.

   c. As indicated for women with personal or family history.

   For the purposes of this Section only, the term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one (1) rad per breast for two (2) views of an average size breast.

5. **Vision And Hearing Screening.** Vision and hearing screening for Members to determine the need for vision and hearing correction as determined by the Member's Primary Care Provider.

6. **Sexually Transmitted Diseases.** Testing for sexually transmitted diseases through the Member's Primary Care Provider.

7. **Health Education Services.** Members may receive from Health Plan or the Member's Primary Care Provider health education services and/or materials, including:

   a. information regarding personal health behavior and health care, and instructions on achieving and maintaining physical and mental health and preventing illness and injury;

   b. information and recommendations regarding the optimal use of health care services provided by Health Plan or health care organizations affiliated with Health Plan; and

   c. information regarding service agencies (but services of such agencies are not Covered Services), including adoption agencies, medical social services, ancillary services for the treatment for abuse of, or addiction to, alcohol and drugs.

8. **Circumcisions** performed within the first six (6) weeks of birth and circumcisions performed thereafter if Medically Necessary.

9. **EPSDT Services.** Members who are under twenty-one (21) years of age are eligible to receive EPSDT Services, including screening examinations and immunizations that are consistent with the Medical Assistance Program. Child Members may receive Covered Services to treat a covered condition detected pursuant to such EPSDT Services in accordance with Health Plan's UM/QA Protocols. Psychological testing by Participating Provider for a child Member is a Covered Service when ordered by Member's Primary Care Provider and authorized by Health Plan pursuant to its UM/QA Protocols.

10. **Prostate-Specific Antigen Tests.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, male Members age fifty (50) and over, African-American male Members age forty (40) and over and male Members with a family history of prostate cancer age forty (40) and over may receive an annual digital rectal examination and a prostate-specific antigen test upon the recommendation of the Member's Primary Care Provider.

11. **Colorectal Cancer Screening.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, Members who are at least fifty (50) years old or Members classified as high risk for colorectal cancer because the Member or a first-degree family member of the Member has a history of colorectal cancer who are at least thirty (30) years old are eligible to receive colorectal cancer screening with sigmoidoscopy or fecal occult blood testing every three (3) years.

12. **Diabetes Self-Management and Training.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, Members diagnosed with Type 1 Diabetes, Type 2 Diabetes or gestational diabetes mellitus are eligible to receive diabetes self-management training and education. "Diabetes self-management training" means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

    Coverage shall be provided for the following equipment when Medically Necessary and prescribed by the Member's Primary Care Provider:
    a. blood glucose monitors
    b. blood glucose monitors for the legally blind
    c. cartridges for the legally blind
    d. lancets and lancing devices

    Coverage shall be provided for the following pharmaceuticals and supplies when Medically Necessary and prescribed by the Member's Primary Care Provider:
    a. insulin
    b. syringes and needles
    c. test strips for glucose monitors
    d. FDA approved oral agents used to control blood sugar
    e. glucagon emergency kits

    Coverage shall be provided for regular foot care exams by a Participating Provider.

    If authorized by a Participating Provider, diabetes self-management training may be provided as a part of an office visit, group setting, or home visit.

H. **Pregnancy, Maternity, and Newborn Care**
Prenatal care, prenatal HIV testing, prenatal diagnostic procedures in cases of high risk pregnancy, labor and delivery rooms, delivery, special procedures such as Cesarean section, anesthesia, antepartum and postpartum care, post-natal care for newborn infants and services for any conditions resulting from pregnancy or from childbirth and any complications thereof. The coverage, benefits and services for newborn infants shall include illness, injury, congenital defects, birth abnormalities and premature birth.

I. **Family Planning Services**
Family Planning Services and counseling are covered and available as outlined below if prescribed by Member's Primary Care Provider or WHCP and authorized, if applicable. These services include information, physical exam and counseling during a visit, annual physical exam for family planning purposes, pregnancy testing, voluntary sterilization, related laboratory and diagnostic testing, instruction and medical counseling services on family planning issues, including the use of contraceptive devices and birth control medication. Birth Control medication, contraception devices and physician services for the insertion and removal of an intra-uterine device (IUD) are covered. Family planning services may also be obtained out of network, without a referral.

J. **Emergency Services**
1. **Medical Care and Notification.** Medical care is available through Participating Providers seven (7) days a week, twenty-four (24) hours a day. If injury or illness requires Emergency Services, the Member must notify his or her Primary Care Physician or Health Plan within twenty-four (24) hours of an emergency admission or within twenty-four (24) hours of when the Member is able to notify the Health Plan. The definition of an Emergency is set forth in Section I-J of the handbook. When appropriate, Emergency Services will include such inpatient services as necessary to stabilize the Member. If an Emergency occurs, the Member should go to the nearest hospital emergency department immediately and notify his or her Primary Care Provider as soon as possible. Medical care for Emergencies includes services of a hospital emergency department, inpatient services, outpatient visits and referrals for Emergency mental health problems.

2. **Post-Stabilization Medical Services.** Post-Stabilization Medical Services, which would be otherwise covered if provided by a Participating Provider, will be covered when provided by a non-Participating Provider when the following conditions are met:

    a. the non-Participating Provider has obtained approval to provide such services from Health Plan; or
    b. the non-Participating Provider made two (2) good faith attempts to contact the Health Plan and Health Plan did not respond or deny such services within one (1) hour of the non-Participating Provider's attempt to contact Health Plan

3. **Emergency Ambulance Service.** Members may receive Medically Necessary ambulance services in an emergency to transport the Member to the nearest hospital emergency department without an order from their Primary Care Provider or authorization of Health Plan. Services of an air ambulance are covered up to the cost of ground ambulance services for a similar level of care and similar distance of travel.

4. **Payment.** Payment for services of non-Participating Providers shall be subject to Usual and Customary Charges for such services

as defined herein. Except for extenuating circumstances, all claims which may have been paid by Member for Emergency Services or Post-Stabilization Medical Services, whether for Provider or Hospital, must be submitted to Health Plan within ninety (90) days of the date of service in order for such expenses to be considered for reimbursement.

5. **Follow-Up Care.** Follow-up care will be covered only when (a) provided to the Member by a Participating Provider; (b) when determined to be Medically Necessary; and (c) ordered by Member's Primary Care Provider.

K. **Non-Emergency Ambulance or Medical Transport Services**
In accordance with Health Plan's transportation policy, non-medically necessary ambulance or medical transport services, for members, from a Participating Provider or Non-Participating Provider between medical facilities when medically necessary, prescribed by a participating provider and authorized by Health Plan.

L. **Allergy Testing**
Allergy testing when medically necessary, prescribed by a participating provider and authorized by Health Plan.

M. **Oral Surgery Services**
Medically necessary oral surgery services from an oral surgeon who is a participating provider, upon referral by a participating physician and authorized by Health Plan, but limited to non-dental oral surgical procedures for the treatment of acute injuries or fractures of the facial bones (including bones of the jaw but not including treatment to or replacement of teeth or other excluded dental care) and treatment of neoplasms of the face, facial bones or mouth. Treatment of Temporomandibular Joint Dysfunction is not a covered service except where medically necessary to treat trauma or tumor of the Temporomandibular Joint.

N. **Orthopedic and Prosthetic Devices**
1. Medically necessary orthopedic devices are limited to:
   a. braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays
   b. splints
   c. devices for congenital disorders
   d. post and peri-operative devices

when ordered by Member's Participating Provider and authorized by Health Plan. All other orthopedic devices are specifically excluded, otherwise expressly provided in this Certificate.

2. Medically Necessary prosthetic devices, i.e., devices required to substitute for missing or non-functioning body parts or organs, except as specifically excluded in this Attachment, are limited to the initial non-experimental and non-investigational devices and/or appliances provided in connection with an illness or injury to the member as well as adjustment of initial Prosthetic Device when ordered by member's attending participating physician

O. **Out-of-Area Services**
Medically Necessary Covered Services from non-Participating Providers outside the Service Area of Health Plan, but only as specified below. Payments by Health Plan for such services are limited to charges which do not exceed the Department's reimbursement rates.

If an injury or sudden illness requiring Emergency care occurs when a member is temporarily outside the Service Area, the Member should obtain Emergency care at the nearest medical facility or emergency department. Covered Emergency services include Medically Necessary ambulance services and Emergency Hospital Services. If the Member is admitted as an inpatient, the Member should ask the hospital to notify Health Plan as soon as possible but no longer than twenty-four (24) hours. Continuing or follow-up treatment by non-Participating Providers for accidental injury or emergency illness is limited to medically necessary services required before the Member can, when it is medically appropriate, return to the service area.

If Member is required by the provider of service to pay for medically necessary Out-of-Area services, member must, except for extenuating circumstances, submit all receipts for out-of-pocket expenses to Health Plan within ninety (90) days of the date of service in order for such expenses to be considered for reimbursement.

The need for pregnancy-related medical services, including routine prenatal care or delivery, received by a Member traveling outside the Service Area during the third-trimester of pregnancy against medical advice will not be deemed an Emergency, except when Member is outside the Service Area due to circumstance beyond her control.

P. **Mental Health Services**
1. **Inpatient Mental Health and Substance Abuse Services.** Medically necessary non-emergent Inpatient mental health and substance abuse services are covered when authorized in advance by Health Plan and Health Plan requires participating providers to complete a behavioral health assessment

2. **Outpatient Mental Health Services.** Medically necessary individual outpatient non-emergent Mental Health Services for evaluation, short-term treatment or crisis intervention are covered when authorized in advance by Health Plan and Health Plan requires participating providers to complete a behavioral health assessment.

In addition, medically necessary Emergency Services do not require authorization in advance by Health Plan.

Q. **Detoxification and Treatment of Alcoholism and Drug Abuse**
1. **Inpatient Care.** Medical treatment for detoxification or medical complications of drug and alcohol abuse on an inpatient basis

when determined to be medically necessary by Member's Primary Care Provider and approved in advance by Health Plan is a covered benefit. In addition, Inpatient rehabilitative services for alcohol or drug abuse are limited to thirty (30) days per calendar year for adults. There is no limitation for Inpatient rehabilitation services for alcohol or drug abuse for Members under the age of twenty-one (21), Members under the age of twenty-one (21) as an EPSDT benefit or pregnant Members. Care in a day hospital, residential non-hospital or intensive outpatient treatment mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by Member's Primary Care Provider. Thus, the number of remaining annual inpatient days a Member is eligible for will be reduced by one-half day for each day the Member is enrolled in a day hospital, residential non-hospital or intensive outpatient environment pursuant to a determination of appropriateness by Member's Primary Care Provider.

2. **Outpatient Treatment.** Medical treatment for detoxification or medical complications of drug and alcohol abuse on an outpatient basis when determined to be medically necessary by Member's Primary Care Provider and approved in advance by Health Plan is a covered benefit. In addition, Medically Necessary outpatient counseling for alcohol and drug abuse as appropriate for evaluation, crisis intervention, and short-term treatment is a covered benefit and is limited to twenty-five (25) hours per calendar year. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by Member's Primary Care Provider. Thus, the number of remaining annual individual outpatient counseling visits a Member is eligible for will be reduced by one-half visit for each group outpatient visit received by Member pursuant to a determination of appropriateness by Member's Primary Care Provider. There is no limit for counseling for Members under the age of twenty-one (21) as an EPSDT benefit or for pregnant Members. Outpatient services must be rendered by a Participating Provider.

R. **Sexual Assault or Abuse**
Any examination, treatment or testing of a victim of Sexual Assault or Abuse, or any attempt to commit Sexual Assault or Abuse, shall be covered in full. Sexual Assault or Abuse means any offense as defined in Section 12-13 through 12-16 of the Illinois Criminal Code, as amended from time to time.

S. **Durable Medical Equipment**
Durable and non-durable medical equipment is covered when authorized by a Primary Care Provider and approved by Health Plan. Equipment includes, but is not limited to, standard wheelchairs, walkers, crutches, traction equipment, standard hospital beds, oxygen, and oxygen administration equipment. Also includes amino acid based elemental formulas, regardless of delivery method for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

T. **Enumerated Covered Services**
To the extent not identified above, the following enumerated services shall be included as Covered Services under this Certificate and will be provided to Members whenever Medically Necessary:

- Assistive/augmentative communication
- Audiology services, physical therapy, occupational therapy and speech therapy
- Behavioral health services, (inpatient and outpatient)including subacute alcohol and substance abuse services and mental health service;
- Blood, blood components and the administration thereof
- Bone mass measurement and diagnosis and treatment of osteoporosis
- Certified hospice services
- Chiropractic Services
- Clinic Services (as described in 89I11. Adm. Code, Part 140.460);
- Diagnosis and treatment of medical conditions of the eye provided by a physician;
- Durable and nondurable medical equipment and supplies
- Emergency Services
- Family Planning Services
- Home Health Care Services
- Inpatient hospital services (including dental hospitalization in case of trauma or when related to a medical condition including medical detoxification)
- Laboratory and x-ray services
- Medical procedures performed by a dentist
- Nurse midwife services
- Nursing facility services for the first 90 (ninety) days
- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incident to mastectomy
- Outpatient hospital services
- Physicians' services, including psychiatric care
- Podiatric services
- Pharmaceutical products provided by an entity other than pharmacy
- EPSDT
-
- Services to Prevent Illness and Promote Health in accordance with subsection (c) hereof;
- Transportation to secure Covered Services.
- Transplants covered under 89 Ill. Adm. Code 148.82 (using transplant providers certified by the Department, if the procedure is performed in the State).

The drawing of blood for lead screening shall take place within the Contractor's Affiliated facilities or elsewhere at the Contractor's expense. All laboratory tests for children being screened for lead shall be sent for analysis to the Illinois Department of Public Health, or if

performed by the Contractor's Affiliated facility, the results shall be reported to the Illinois Department of Public Health in compliance with the requirements of the Illinois Lead Poisoning Prevention Act (410 ILCS 45/) and the Lead Poisoning Prevention Code (Administrative Code, Title 77, Chapter 1, Subchapter p, Part 845). Contractor shall have policies and procedures in place to ensure its contracted providers are educated on the these requirements.

** Contractors will be responsible for covering up to a maximum of ninety (90) days nursing facility care (or equivalent care provided at home because a skilled nursing facility is not available) annually per Enrollee. Periods in excess of ninety (90) days annually will be paid by the Department according to its prevailing reimbursement system.

(c) Services to Prevent Illness and Promote Health. The Contractor shall make documented efforts to provide initial health screenings and preventive care to all Enrollees. The Contractor shall provide, or arrange to provide, the following Covered Services to all Enrollees, as appropriate, to prevent illness and promote health:

(1) EPSDT services in accordance with 89 Ill. Adm. Code 140.485 and described in this Article V, Section 5.13(a);

(2) Preventive Medicine Schedule which shall address preventive health care issues for Enrollees twenty-one (21) years of age or older (Article V, Section 5.13(b));

(3) Maternity care for pregnant Enrollees (Article V, Section 5.13(c)); and

(4) Family planning services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, voluntary sterilization, insertion or injection of contraceptive drugs or devices, and related laboratory and diagnostic testing (except to the extent an Enrollee has chosen to obtain such services and supplies from a non-Affiliated Provider, in which case the Department shall be responsible for providing payment for such services).

(5) The Contractor's providers shall screen Enrollees who are children 6 months through 6 years of age for lead poisoning. These children must be tested as required in the Healthy Kids Early and Periodic Screening, Diagnosis and Treatment Program (89 Ill. Adm. Code 140), as defined in the Handbook for Providers of Healthcare Services. Every provider who diagnoses, or health care provider, nurse, hospital administrator or public health officer who has verified information of any person who has a level of lead in the blood, starting with a confirmed lead level of 10 mcg/dL is required to report. Children who have elevated screening results shall have follow-up testing. Elevated capillary results 10 mcg/dL and above shall be confirmed by a venous sample.

Any services which have been paid or are payable under any other health plan or health insurance under which a Member is covered is always primary to this coverage and, like the Medical Assistance Program, is always the coverage of last resort.

SECTION III. EXCLUSIONS AND LIMITATIONS

A. **Exclusions**

The benefits under this Certificate are intended to be equal to those covered under the Medical Assistance Program unless otherwise expressly provided, consistent with the Contract. Exclusions and benefits are consistent with the Medical Assistance Program fee schedule provided by the Medical Assistance Program for the State of Illinois' Healthcare and Family Services.

The following services and benefits shall not be included as covered services:

(1) Dental services;

(2) Pharmacy services provided by a pharmacy;

(3) All services provided by an Optometrist;

(4) Mental health clinic services as provided through a community behavioral

health provider as identified in 89 Ill. Adm. Code 140.452 and 140.454 and further defined in 59 Ill. Adm. Code, Part 132 "Medicaid Community Mental Health Services Program."

(5) Subacute alcoholism and substance abuse treatment services as provided through a community behavioral health provider as identified in 89 Ill. Adm. Code 148.340(a) and further defined in 77 Ill. Adm. Code 2090.

(6) Routine examinations to determine visual acuity and the refractive state of the eye, eyeglasses, other devices to correct vision, and any associated supplies and equipment. The Contractor shall refer Enrollees needing such services to Providers participating in the HFS Medical Programs who are able to provide such services, or to a central referral entity that maintains a list of such Providers;

(7) Nursing facility services, or equivalent care provided at home because a skilled nursing facility is unavailable, beginning on the ninety-first (91st) day of service in a calendar year;

(8) Services provided in an Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled and services provided in a nursing facility to mentally retarded or developmentally disabled Participants;

(9) Early intervention services, including case management, provided pursuant to the Early Intervention Services System Act (325 ILCS 20 et seq.);

(10) Services provided through school-based clinics;

(11) Services provided through local education agencies that are enrolled with the Department under an approved individual education plan (IEP);

(12) Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund;

(13) Services that are experimental and/or investigational in nature; 29

(14) Services provided by a non-Affiliated Provider and not authorized by the Contractor, unless this Contract specifically requires that such services be covered;

(15) Services that are provided without first obtaining a required referral or prior authorization as set forth in the Enrollee handbook;

(16) Medical and/or surgical services provided solely for cosmetic purposes; and
(17) Diagnostic and/or therapeutic procedures related to infertility/sterility

Health Plan shall refer Members to HFS for such services.

B. **Limitations**

1. **General Limitations -**In the event that, due to circumstances not within the control of Health Plan, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of Participating Provider's personnel or similar causes, the rendition of professional or hospital services provided under this Certificate is delayed or rendered impractical, Health Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Health Plan and Participating Providers shall render the Hospital and professional services provided under the Contract insofar as practical, and according to their best judgment; but Health Plan and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

2. **Out-of-Area Care -** Out-of-area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. For example, the need for pregnancy-related medical service by a Member traveling outside the Service Area against medical advice during the third-trimester of pregnancy will not be deemed an Emergency, except when the Member is outside the Service Area due to circumstances beyond her control. However, unanticipated complications of pregnancy or premature delivery occurring before the Member had entered the third-trimester of pregnancy are covered outside the Service Area.

   Continuing or follow-up treatment for an Emergency situation is limited to care required before the Member can, without medically harmful or injurious consequences, return to the Service Area. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of this Certificate.

The following services and benefits shall also be limited as Covered Services:

(1) Termination of pregnancy shall be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and Form HFS 2390 must be completed and filed in the Enrollee's medical record. (Termination of pregnancy shall not be provided to Enrollees eligible under the State Children's Health Insurance Program (215 ILCS 106).)

(2) Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a DPA Form 2189 must be completed and filed in the Enrollee's medical record.

(3) If a hysterectomy is provided, a DPA Form 1977 must be completed and filed in the Enrollee's medical record.

Attachment B
Member Administrative Grievance Procedure

Resolutions of appeal issues which impact on a Member's health are addressed in Section X-C and D of this document. All other inquiries and complaints will be handled in a timely manner in accordance with the procedures described in this Attachment B. Health Plan will review these grievance procedures at reasonable intervals for the purpose of amending such procedures. Any amendment to these procedures requires the prior written consent of the Illinois Department of Healthcare and Family Services and the Illinois Division of Insurance. All grievances are to be first submitted to the Health Plan, but later may be appealed to the Illinois Department of Healthcare and Family Services.

The person responsible for the maintenance of records and for the supervision of the complaint/grievance process is the Grievance Coordinator. A specific set of records will be maintained to document grievances filed. Records will include: (1) the reason for grievance; (2) a copy of the grievance and the date it was filed; (3) the date and outcome of all consultations, hearings and hearing findings; (4) the date and decisions of any appeal proceedings; (5) all requests for documents or records necessary for the resolution of the grievance; (6) all relevant support documentation received from the Plan or Member; and (7) the date and proceedings of any litigation. They will be centrally maintained until the grievance is resolved and for three (3) years by the Grievance Coordinator.

Step 1
The Plan encourages any Member who has an inquiry or complaint regarding a matter arising under this Certificate to contact the Health Plan's Member Service Department (see Attachment C) for a resolution. Health Plan's employees handling the grievances have authority to resolve most informal issues. Health Plan has a process to handle both written and verbal grievances. This process requires that the person first receiving the complaint to document the member's concern and attempt a resolution without requesting the Member to write or call again, if reasonably possible. Health Plan must respond to the Member's inquiry/complaint within: (a) thirty (30) days of the receipt of a standard grievance; (b) three (3) business days of the receipt if the inquiry/complaint is urgent. All complaints will be documented and note the general nature of the concern identified.

STEP 2:
In the event the Member's problem has not been settled at the first grievance level and the Member is still dissatisfied, he will be advised to file a second-level written grievance with the Health Plan's Appeals and Grievance Committee. Grievances must be submitted within twelve (12) months of occurrence.

The written grievance shall contain the following information:

1) The Member's name, address, and Member identification number
2) A summary of the grievance, any previous contact made with Health Plan, and a description of relief sought;
3) The Member's signature; and
4) The date the grievance is signed.

The written grievance shall be mailed to the following address:

MeridianHealth
Grievance Coordinator
300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

The Grievance Coordinator will acknowledge the Grievance within five (5) business days of receiving the submission. The Grievance Coordinator will schedule a hearing before the Grievance Committee and notify the Member in writing of the time and place of the hearing. The Appeal and Grievance Committee is comprised of individuals who have been appointed by Health Plan to respond to Grievances. The Illinois Department of Healthcare and Family services may require that one member of the Committee be from the Department. The Committee shall be composed of at least twenty-five percent (25%) Members who are consumers.

Review of the initial determination and any additional evidence submitted by the Member at the hearing will result in the rendering of a

decision within thirty (30) days after the Committee hearing. However, the Committee shall have an additional fourteen (14) days to render a decision if there is a delay in obtaining the documents or records necessary for the resolution of the grievance, including but not limited to, the collection of additional information from an out-of-area source.

The Member has the right to attend and participate in the formal Committee proceedings. In addition, the Member has the right to be represented at the formal Committee proceedings by a designated representative of his or her choice. The Committee shall meet at the Health Plan's main office or such other office designated by Health Plan if the main office is not within fifty (50) miles of the Member's home address. To the extent reasonable, Health Plan will assist the Member with transportation to the meeting within the Service Area if the Member would otherwise attend the meeting but cannot do so because of lack of transportation to the meeting. Consideration will be given to a Member's request pertaining to the time and date of such meeting. The Committee shall notify the Member at the time of the formal Committee proceedings of the name and affiliation of those Committee members who are representing Health Plan.

Any documentation furnished to members of the Committee shall also be made available to the Member not less than five (5) days prior to the formal Committee proceeding. Health Plan shall not present any evidence without the Member having been given the opportunity to be present. Health Plan will notify Member in writing of the determination of the Committee within five (5) business days of such determination. The notification will include a statement informing the Member that the decision of the Committee is the final administrative step in the Health Plan's Grievance Procedure. Notification of Health Plan's determination in this Step 2 shall include the following notice:

Notice of Availability of the Department:

> "The Illinois Department of Healthcare and Family Services requires that we inform you that if you are not satisfied with the determination of the Appeals and Grievance Committee you may request review by the Department of Healthcare and Family Services. You may direct your request for review to the HFS Bureau of Administrative Hearings, 401 South Clinton, 6th Floor, Chicago, IL 60607."

The Grievance Committee does not have the authority to hear any Grievance which alleges or indicates possible professional liability, commonly known as "malpractice". Nor does the Grievance Committee have any authority to reverse, set aside, or in any way modify, policies which are established by Health Plan's Board of Directors.

STEP 3:

> If the Member is not satisfied with the Grievance Committee's determination, he or she may ask for a review by the Illinois Department of Healthcare and Family Services. Requests are to be directed to for review to the HFS Bureau of Administrative Hearings, 401 South Clinton, 6th Floor, Chicago, IL 60607.

Health Plan may issue procedures as it deems reasonable for the conduct and operations of the Grievance Procedure. All grievances are to be first submitted to the Health Plan, but later may be appealed to the Illinois Department of Healthcare and Family Services. To the extent required by law, no Member may bring action in court against Health Plan unless he or she has first exhausted the administrative remedies established by this procedure. However, the filing of a grievance shall not preclude Member from filing a complaint with the Illinois Department of Healthcare and Family Services, nor does it preclude the Illinois Department of Healthcare and Family Services from investigating a complaint pursuant to its authority under Illinois law. Any decision from the review of the Illinois Department of Healthcare and Family Services is binding on Health Plan, provided that this will not prevent Health Plan from challenging a decision related to the terms of the Contract to a court of competent jurisdiction.

The member may also file a complaint with the Division of Insurance. In the event that the Health Plan receives a complaint from the Division of Insurance, it will investigate the situation and respond within 21 days or within the time frame that is requested by the Division of Insurance. The Health Plan's report shall include the documents necessary to support the Health Plan's position and any other documents requested by the Division of Insurance. The Health Plan's response will also clearly identify the name, title, address and phone number of the Health Plan staff who reviewed the complaint.

Attachment C
Member Services Department

Health Plan maintains a Member Services Department which is available to respond to your questions or concerns twenty-four (24) hours a day, seven (7) days a week. If you have any questions regarding provisions of this Certificate, how to obtain services under this Certificate, or have other questions, please contact Member Services at 1-866-606-3700. Member Services will:

- Replace identification cards
- Assist in scheduling appointments
- Resolve member complaints
- Assist with referrals to specialists
- Assist with PCP changes and WHCP changes
- Assist in filing grievances and appeals