This document is an Amendment to your Plan's Summary Plan Description.

An amendment adds, modifies, deletes or otherwise changes a benefit listed in your Summary Plan Description. You can make the most of your coverage by reading your amendments and keeping them with your Summary Plan Description for future reference.

Regarding:

1. **Benefits—Medical Benefits—("Fertility Preservation Services", "Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)", "Physician Services" (telehealth services), "Telehealth Services")**
2. **Services Requiring Preauthorization**
3. **Plan Exclusions—"Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)"**
4. **Prescription Drug Benefits—Eligible Prescription Drug Expenses (All FDA-approved drugs for the treatment of stage 4, advanced metastatic cancer)**
5. **Exhibit 1: Be Healthy—Using Your Preventive Care Benefits, Effective 1/1/2019**
6. **Exhibit 2: Enhanced Infertility Services**

AMENDMENT TO THE ILLINOIS EDUCATORS RISK MANAGEMENT PROGRAM ASSOCIATION GROUP HEALTH PLAN

The following is an amendment to your **January 2018** Plan Document/Summary Plan Description. Please review this document carefully and keep it with your Plan Document/Summary Plan Description for future reference.

AMENDMENT #1, effective January 1, 2019:

*On page 62, under the section "**MEDICAL BENEFITS**", a new subsection "**Fertility Preservation Services**" has been added. This section reads as follows:*

Fertility Preservation Services
Expenses incurred for standard fertility preservation services are considered Eligible Expenses for Covered Persons when treatment may directly or indirectly result in impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting the reproductive organs or processes.

*On pages 64-65, under the section "**MEDICAL BENEFITS**", the subsection "**Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)**" has been deleted in its entirety and replaced. This section now reads as follows:*

Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
See the "EXHIBIT 2: ENHANCED INFERTILITY SERVICES BENEFIT" section of this document for the Infertility services that are considered Eligible Expenses under the Plan.

*On page 67, under the section "**MEDICAL BENEFITS**", the subsection "**Physician Services**" has been revised to delete the second paragraph. This section now reads as follows:*

Physician Services
Diagnostic and treatment services and preventive medical services provided by a Physician or under the supervision of a Physician, including recommended periodic healthcare examinations, are considered Eligible Expenses.

*On page 73, under the section "**MEDICAL BENEFITS**", a new subsection "**Telehealth Services**" has been added. This section reads as follows:*

Telehealth Services
Telehealth services, including telehealth Physician's charges and telehealth facility fees. Telehealth services include medical exams, consultations, and behavioral health (including Substance Use Disorder evaluations and treatment). For purposes of this subsection, "telehealth services" means the delivery of eligible healthcare services between the patient and healthcare Provider over the phone, via the Internet or by way of an interactive telecommunications system (e.g., an audio and video system permitting two-way, live interactive communication).

*On pages 75-78, under the section "**PREAUTHORIZATION**", the subsection "**Services Requiring Preauthorization**" has been deleted in its entirety and replaced. This section now reads as follows:*

SERVICES REQUIRING PREAUTHORIZATION

The Plan requires Preauthorization of the following Listed Services:

- abdominoplasty/panniculectomy
- ambulance—land/air (non-urgent air and non-urgent ground)
- bariatric surgery
- blepharoplasty and eye brow lift/brow-ptosis
- breast reconstruction
  - breast implant surgeries
  - gynecomastia surgery
  - reduction mammoplasty
- cardiac imaging and procedures
  - ECHO
  - ECHO stress
  - cardiac rhythm implantable devices
  - myocardial perfusion imaging
  - nuclear medicine
  - diagnostic heart catheterization
- chiropractic and massage therapy (NOTE: If chiropractic services are subject to a dollar or visit benefit limitation, Preauthorization is not required. See the "SCHEDULE OF BENEFITS" section.)
- clinical trials—Phase I, II, III and IV
- cosmetic and reconstructive surgery
- dental services (if done in a facility rather than in a Provider's office)
- Durable Medical Equipment (select)
- electrical stimulation for gastroparesis
- endothelial keratoplasty
- experimental and investigational services
- genetic testing—all (including molecular diagnostics)
- gynecomastia surgery
- hyperbaric oxygen therapy
- Imaging
  - CT
  - CTA
  - MRI
  - MRA

  - PET
  - 3D (3D mammography does not require Preauthorization)
  - obstetrical and diagnostic ultrasound (NOTE: Breast ultrasounds and venous duplex (Doppler) scans do not require Preauthorization.)
- Infertility services (all diagnostic tests, medications, treatments, etc.)
- inpatient rehabilitative services
- interstim: implantable sacral nerve stimulation for urinary dysfunction
- Interventional Pain Management (including, but not limited, to radiofrequency denervation procedures)
- joint surgery (select) (visit HealthAlliance.org for specific CPT/HCPCs codes)
- laser treatment of psoriasis
- observation stays (notification is required for observation stays beyond 24 hours)
- oncology pathways (inpatient chemotherapy does not require Preauthorization)
- out-of-network referral for HMO
- port wine stain removal
- radiation therapy, including but not limited to:
  - proton beam therapy
  - stereotactic radiosurgery
- rehabilitative therapies
  - occupational therapy
  - physical therapy
  - speech therapy
- select surgical procedures requiring an elective inpatient stay may require Preauthorization (visit HealthAlliance.org for specific CPT/HCPCs codes)
- Skilled Nursing Facility
- sleep diagnostics, evaluations and supplies
- Specialty Pharmacy—select (including home infusion drugs) (visit HealthAlliance.org for specific CPT/HCPCs codes)
- spinal surgery (select) (visit HealthAlliance.org for specific CPT/HCPCs codes)
- transcranial magnetic stimulation (TMS) treatment
- transmyocardial laser revascularization
- transplant services
- urgent inpatient stays (medical/surgical, Substance Use Disorder) (notification required; no review)
- uvulopalatopharyngoplasty (UPPP)
- vision therapy

*On page 89, under the section "**PLAN EXCLUSIONS**", the subsection "**Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)**" has been deleted in its entirety and replaced. This section now reads as follows:*

Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
See the "EXHIBIT 2: ENHANCED INFERTILITY SERVICES BENEFIT" section of this document for the Infertility services that are considered Eligible Expenses under the Plan.

*On page 93, under the section "**PRESCRIPTION DRUG BENEFITS—ELIGIBLE PRESCRIPTION DRUG EXPENSES**", a new item has been added. This item reads as follows:*

- All FDA-approved drugs for the treatment of stage 4, advanced metastatic cancer are available without limitation, exclusion, or step therapy requirement, if use of the drug(s) is consistent with best practices, and supported by peer-reviewed medical literature.

*On page 145, at the end of the "**EXHIBIT 1: BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS, EFFECTIVE 5/1/2018 THROUGH 12/31/2018**" section, a new section "**EXHIBIT 1: BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS, EFFECTIVE 1/1/2019**" has been added to read as follows:*

EXHIBIT 1: BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS EFFECTIVE 1/1/2019

The information included in this section is intended to be used in conjunction with the "Preventive Care Services" subsection of the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section of this Plan. Covered Persons may also receive a hard copy of this information in a brochure-type format.

For questions related to this ADDENDUM section, contact the Third Party Administrator's Customer Service Department at the phone number listed in the "GENERAL PLAN INFORMATION" section of this document.

Following is a partial list of the services included in your comprehensive preventive care services benefit:*****

- One preventive care exam per Covered Person (no age limitations) per Benefit Period
- One preventive care visit to an OB/GYN Principal Healthcare Provider per year
- Well-child care
- The screenings, procedures and immunizations listed below, within the applicable preventive care services benefit:
  - Blood sugar screening
  - Cervical cancer screening (Pap smear)
  - Cervical cancer vaccine
  - Childhood immunizations
  - Chlamydia screening
  - Cholesterol screening
  - Colorectal cancer screening (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test)

*****Office visit Copayment or Coinsurance may apply and/or be subject to a Deductible. Age limitations and frequencies may apply.

A detailed listing of eligible procedures and services follows.

Procedure Codes	**Descriptions**
Immunizations	
90460–90461, 90471–90474	Immunization administration
90632-90634	Hepatitis A
90636	HepA-HepB adult
90644, 90733–90734	Meningococcal
90620–90621	MenB ages 16-23
90647–90648	Hib

Procedure Codes	Descriptions	
90649 90650–90651	HPV quadrivalent 3 dose ages 9-26 HPV bivalent 3 dose ages 9-26	
90630, 90653–90658, 90660–90662, 90664, 90666–90668, 90672, 90673, 90674, 90682, 90685–90688, 90756, Q2034–Q2039	Influenza	
90670, 90732	Pneumococcal	
90680–90681	Rotavirus	
90696	DTaP-IPV ages 4-6	
90697	DTap-IPV-Hib-HepB	
90698	DTaP-Hib-IPV	
90700	DTaP < 7 years	
90702	DT < 7 years	
90707	Measles, mumps and rubella (MMR)	
90710	Measles, mumps, rubella and varicella vaccine (MMRV)	
90713	Poliovirus (IPV)	
90714	Td 7 years and older	
90715	Tdap 7 years and older	
90716	Varicella (VZV) – chicken pox	
90723	DTaP-HepB-IPV	
90750	Herpes Zoster (shingles) ages 50 and older	
90739, 90740, 90743, 90744, 90746, 90747	Hepatitis B	
90748	HepB-Hib	
G0008	Administration of influenza virus vaccine	
G0009	Administration of pneumococcal vaccine	
G0010	Administration of hepatitis B vaccine	
Alcohol Screenings		
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention (SBI) services; 15 to 30 minutes)	Four visits per year
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Four visits per year
G0442	Annual alcohol misuse screening, 15 minutes	
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	Four visits per year

Procedure Codes	Descriptions	
Osteoporosis Screening		
76977, 77078, 77080, 77081, G0130	DXA, bone density study	
Cholesterol		
80061	Lipid profile	Once every 5 years ages 20 and older, and children at high risk
82465	Cholesterol, serum or whole blood, total	Once every 5 years ages 20 and older, and children at high risk
83718	Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	Once every 5 years ages 20 and older, and children at high risk
83721	Lipoprotein, direct measurement; LDL cholesterol	Once every 5 years ages 20 and older, and children at high risk
84478	Triglycerides	Once every 5 years ages 20 and older, and children at high risk
Colorectal		
G0104	Colorectal cancer screening, flexible sigmoidoscopy	Once every 5 years ages 50–75
G0105	Colorectal cancer screening, colonoscopy	Once every 10 years ages 50–75
G0106	Colorectal cancer screening, alternative to G0104, screening sigmoidoscopy, barium enema	Once every 5 years ages 50–75
G0120	Colorectal cancer screening, alternative to G0105, screening colonoscopy, barium enema	Once every 10 years ages 50–75
G0121	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk	Once every 10 years ages 50–75
G0328	Colorectal cancer screening, fecal occult blood test, immunoassay, 1-3 simultaneous determinations	Annually starting at age 50
45330, 45331-PT, 45338-PT	Flexible sigmoidoscopy	Once every 5 years ages 50–75
45378-PT, 45380-PT, 45384-PT, 45385-PT, 45388-PT	Colonoscopy, flexible	Once every 10 years ages 50–75
81528	Cologuard (Service only covered when screening; diagnostic services are not considered eligible expenses for cologuard)	Once every 3 years with diagnosis code Z12.11 or Z12.12; ages 50–75
82270, 82274	Blood occult screening	Annually starting at age 50
Diabetes		
82947, 89250–89251	Abnormal blood glucose and Type 2 Diabetes Mellitus screening	
83036	Hemoglobin A1C	Once per year with diagnosis code Z00.00, Z00.01 or Z13.1

Procedure Codes	Descriptions	
G0108	Diabetes self-management training, individual session (two or more), 30 minutes	
G0109	Diabetes self-management training, group session (two or more), 30 minutes	
HIV		
86689	Antibody, HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	
86703	Antibody, HIV-1 and HIV-2, single assay	
87389	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87806	HIV-1 antigen with HIV-1 HIV-2 antibodies	
G0432, G0433, G0435	Infection agent antibody detection	
G0475	HIV antigen/antibody, combination assay, screening	
Men's Health		
55250, 55450	Vasectomy	With diagnosis code Z30.2
76706	Ultrasound AAA screening	One per lifetime for men ages 65-75
89320	Semen analysis post vasectomy	2 tests post vasectomy with diagnosis code Z30.8
G0102	Digital rectal exam	
Newborn		
84030	Phenylalanine (PKU)	Ages 0–28 days
84437, 84443	Congenital hypothyroidism screening	Ages 0–90 days
85660	Sickling cell screening	
85014, 85018	Anemia test	Age 21 and younger With diagnosis code Z00.121–Z00.129
83655	Lead screening	Age 21 and younger With diagnosis code Z00.121–Z00.129
80061, 82465, 83721, 84478	Dyslipidemia screening	Age 21 and younger With diagnosis code Z00.121–Z00.129, Z13.220
S3620	Newborn metabolic screening panel	Ages 0–28 days
Sexually Transmitted Diseases		
G0445	Semiannual high-intensity behavioral counseling to prevent STIs. Includes education, skills training and guidance on how to change sexual behavior.	Two every 12 months
86592–86593	Syphilis test	With diagnosis code Z00.00, Z00.01, Z00.121, Z00.129. Z11.3, or Z20.2
87270, 87320, 87490–87492, 87810	Chlamydia	

Procedure Codes	Descriptions	
87850, 87590–87592	Gonorrhea	
87623–87625, G0476	Papillomavirus (HPV)	Screening should begin at 30 years of age and should occur no more frequently than every three years.
Women's Health		
P3000–P3001, Q0091, R923	Pap smear	
G0101	Cervical or vaginal cancer screening, pelvic and breast exam	
G0123, G0124, G0141, G0143–G0145, G0147–G0148	Screening cytopathology, cervical or vaginal	
88141–88143, 88147, 88148, 88150, 88152–88155, 88164–88167, 88174–88175	Cytopathology, cervical or vaginal	
E0602	Breast pump, manual	
Women's Health—Contraceptive Management * (with Diagnosis) *For Covered Persons with Prescription Drug benefits, a listing of Contraceptives that are considered Eligible Expenses at the Pharmacy can be found at HealthAlliance.org.		
A4261	Cervical cap for contraceptive use	
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	
A4266	Diaphragm for contraceptive use	
S4989, J7296–J7298, J7301	Contraceptive intrauterine device (IUD), including implants and supplies	
J7307	Contraceptive non-biodegradable drug implant and supplies	
J1050, 96372	Medroxyprogesterone acetate and administration	
11982, 11983	Insertion and removal of non-biodegradable implant	
57170	Diaphragm or cervical cap fitting with instructions	
58300, 58301	Insertion and removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600, 58605, 58611	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip or Falope ring)	
Women's Health—Breast Cancer Screening		
77058–77059, 77641	Ultrasound and MRI	Once per year ages 35 and up with diagnosis code Z12.39
77067, 77063, G0202, R403	Screening mammography	Once per year ages 35 and up

Procedure Codes	Descriptions	
96040	Medical genetics counseling (for BRCA)	With diagnosis code Z80.3
Women's Health—Obstetric Exams and Screening With Maternity Diagnosis		
80055, 80081	Obstetric profile	
81000–81002	Urinalysis	
82950–82951	Gestational Diabetes Mellitus screening	
83540	Iron	
85007, 85009	Differential WBC count	
85025, 85027	Automated hemogram	
86762	Antibody, rubella	
86850, 86900–86901	Rh(D) Incompatibility screening	
87086, 87088	Urine culture/colony count; urine bacteria	
87340–87341	Hepatitis B surface antigen detection	
85004	Blood count; automated differential WBC	
Smoking Cessation		
99406, 99407	Smoking and tobacco use cessation counseling visit	
Miscellaneous		
G0117, G0118	Glaucoma screening	
86480–86481, 86580	Tuberculosis (TB) screening	With diagnosis code Z00.00, Z00.129, or Z11.1
92551	Hearing screening, pure tone	Age 21 and younger
G0444	Annual depression screening; 15 minutes	
96127	Behavioral assessment	With diagnosis code Z13.89
G0446	Annual face-to-face intensive behavioral therapy to reduce CVD risk; 15 minutes	
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	26 every 12 months with diagnosis codes Z68.30–Z68.45
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	
G0499	Hepatitis B screening	
G0472, 86803	Hepatitis C screening	Annually for high risk. Once per lifetime for adults born between 1945 and 1965.
99173	Vision screening test	Age 21 and younger
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	
96110	Developmental testing	
99188	Application of fluoride varnish	Ages 0–6
G0296	Visit to determine low dose CT eligibility	With diagnosis code Z87.891

Procedure Codes	Descriptions	
G0297	Low dose CT for lung cancer screening	Annually ages 55–80
Preventive Care Exams		
99381–99387, 99391–99397	Preventive medicine services	
99401–99404, 99411, 99412	Preventive counseling	
R770	Preventive care services	
R771	Preventive care services vaccine administration	
R779	Other preventive services	

qm-commILbehealthybroch-0518
(H2)

*After the section "**EXHIBIT 1: BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS, EFFECTIVE 1/1/2019**", a new section "**EXHIBIT 2: ENHANCED INFERTILITY SERVICES**" has been added to read as follows:*

EXHIBIT 2: ENHANCED INFERTILITY SERVICES

ELIGIBLE INFERTILITY SERVICES EXPENSES

IMPORTANT: Your employer-sponsored group health Plan considers ENHANCED Infertility services to be Eligible Expenses. See the subsection titled "DEFINITIONS FOR PURPOSES OF INFERTILITY SERVICES" for important definitions.

- Benefits for Infertility services are subject to the Plan's deductible, coinsurance and copayment, as applicable.
- Infertility services, combined, are subject to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS" section of the Plan.
- Infertility services require Preauthorization.

Benefits for Eligible Expenses related to enhanced Infertility services are limited to the following when performed by a Provider:

- Testing and diagnosis of a suspected medical condition;
- Artificial insemination when related to the diagnosis of Infertility;
- Assisted reproductive technology (ART) procedures when related to the diagnosis of Infertility;
- Medications associated with eligible Infertility service expenses are considered Eligible Expenses under the "PRESCRIPTION DRUG BENEFITS" section of the Plan.

The term "Infertility" means:

- the inability to conceive after one year of unprotected sexual intercourse (documentation of regular unprotected sexual intercourse (union between a male and female) of at least one year's duration is required for a woman who is not in natural menopause);
- the inability to conceive after an individual is diagnosed with a condition affecting fertility; or
- the inability to sustain a successful Pregnancy.

A woman shall be considered infertile without having to engage in one year of unprotected sexual intercourse if there is inability to conceive after an individual is diagnosed with a condition affecting fertility. This includes, but is not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal for a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

A woman shall be considered infertile after one year of attempts to produce conception with medically based and supervised methods of conception, including three artificial inseminations, provided in a Physician's office, which a

Physician has determined to have failed and is unlikely to lead to a successful Pregnancy.

Infertility services, including but not limited to, the following, are considered Eligible Expenses when medical criteria has been met. The Health Alliance Medical Policy is used as a guide for determining Medical Necessity.

- **Diagnostic Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS" section of the Plan.)

  (1) Infertility evaluation and subsequent office visits with a Provider, including history and physical examination, for the eligible services listed below as part of the diagnostic work-up;

  (2) Laboratory services:

  (a) Blood type and Rhesus factor (RH);

  (b) Endocrine evaluation/Serum hormonal levels (e.g., gonadotropins: follicle stimulating hormone (FSH) and luteinizing hormone (LH); thyroid stimulating hormone (TSH); cycle day 3 FSH and the clomiphene citrate challenge test (CCCT); androgens (testosterone dehydroepiandrosterone sulfate (DHEA-S)); human chorionic gonadotropin hCG; prolactin; progesterone; estrogens; adrenocortitrophic hormone (ACTH); anti-müllerian hormone (AMH); day 3 inhibin B);

  (c) Human immunodeficiency virus (HIV);

  (d) Rapid plasma regain (RPR);

  (e) Microscopic post-coital cervical mucus examination;

  (f) Karyotype testing;

  (g) Chlamydia trachomatis screening;

  (h) Fasting and two hours post-75 gram glucose challenge levels;

  (i) Lipid panel (i.e., total cholesterol; HDL; cholesterol; triglycerides);

  (j) Cultures (i.e.; chlamydia; gonococcal culture (GC); mycoplasma; urine; semen; prostatic secretion; urological evaluation);

  (k) Rubella and varicella serology;

  (l) Hepatitis B and C testing;

  (m) Semen analysis;

  (n) Sperm function tests (e.g.; acrosome reaction test; sperm penetration assay);

  (o) Sperm antibody;

  (p) Genetic screening;

  (q) Post-ejaculatory urinalysis; and

  (r) Sperm-cervical mucus interaction microscopic studies.

  (3) Imaging:

  (a) X-ray/Ultrasound (e.g., ovarian; transvaginal; pelvic; transrectal and scrotal);

  (b) Sonohysterography;

  (c) Hysterosalpingogram or hystersalpingo-contrast-ultrasonography;

  (d) CT or MRI of sella turcica (if prolactin is elevated);

  (e) Vasography; and

  (f) Venogram.

  (4) Surgical diagnostic procedures:

  (a) Hysteroscopy;

  (b) Endometrial biopsy;

  (c) Salpingoscopy (falloscopy);

  (d) Hydrotubation;

  (e) Laparoscopy and chromotubation;

(f) Scrotal exploration; and

(g) Testicular biopsy for obstructive azoospermia when gonadotropin levels are normal.

- **Basic Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS" section of the Plan.)

(1) Non-invasive therapies:

(a) Pre-conceptual counseling/teaching;

(b) Outpatient Prescription Drugs and Specialty Prescription Drugs for the treatment of Infertility (see also the "PRESCRIPTION DRUG BENEFITS" section of the Plan).

(2) Surgical treatment:

(a) Laparoscopic or laparotomy treatment of pelvic pathology;

(b) Ovarian wedge resection/ovarian drilling/ovarian diathermy;

(c) Hysteroscopic adhesiolysis;

(d) Tubal ligation (salpingectomy);

(e) Hysteroscopic or fluoroscopic cannulation (salpingostomy, finbrioplasty);

(f) Tubal reconstruction (unilateral or bilateral tuboplasty and tubal anastomosis);

(g) Varicocelectomy (ligation);

(h) Microscopic epididymal sperm aspiration;

(i) Surgical correction of epididymal blockage;

(j) Spermatocelectomy and hydrocelectomy;

(k) Transurethral resection of ejaculatory ducts (TURED); and

(l) Orchipexy.

(3) Artificial insemination (AI), intracervical, intrauterine (IUI) or fallopian tube sperm perfusion (FSP).

- **Enhanced Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS" section of the Plan.)

(1) Assisted reproductive technology (ART) procedures:

(a) In vitro fertilization (IVF) (e.g., gamete intrafallopian tube transfer (GIFT); zygote intrafallopian tube transfer (ZIFT); intracytoplasmic sperm injection (ICSI)) (See also the subsection "EXCLUDED INFERTILITY SERVICES EXPENSES" below);

(b) Uterine embryo lavage;

(c) Embryo transfer;

(d) Low tubal ovum transfer;

(e) Transfer procedures;

(f) Donor sperm and eggs medical costs;

(i) Considered an Eligible Expense if Covered Person meets eligibility requirements and has received Preauthorization and approval for Infertility benefits. Covered Persons using known or unknown donors are required to use an in-network Provider, if available, for the collection, processing and billing of the donor sperm and/or eggs. This includes Covered Persons with out-of-network benefits;

(ii) Oocyte donation;

(iii) Donor insemination;

(iv) Sperm retrieval techniques to overcome anejaculation;

(v) Assisted hatching for the following:

1. Two or more failed IVF attempts;

2. Covered Person over age 38;

3. Zona pellucida thickening; or

4. Embryo deficits.

(g) Oocyte retrievals:

(i) Oocyte retrieval limitations:

1. For Infertility services that include oocyte retrievals, benefits for such services are considered Eligible Expenses only if the Covered Person has been unable to attain or sustain a successful Pregnancy through reasonable, less costly medically appropriate Infertility services. This requirement shall be waived in the event that the Covered Person or partner has a medical condition that renders such treatment useless.

2. For Infertility services that include oocyte retrievals, benefits for such services are limited to four completed oocyte retrievals per Covered Person, except that two completed oocyte retrievals are considered Eligible Expenses after a live birth is achieved as a result of an artificial reproductive transfer of oocytes.

For example, if a live birth takes place as a result of the first completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of three are considered Eligible Expenses. If a live birth takes place as a result of the fourth completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of six are considered Eligible Expenses.

The maximum number of completed oocyte retrievals that are considered Eligible Expenses is six per Lifetime of the Covered Person.

NOTE: When the final oocyte retrieval (which is considered an Eligible Expense under the Plan) is completed, one subsequent Infertility procedure for the purpose of transferring the oocytes or sperm is considered an Eligible Expense. Following that transfer, the benefit is exhausted and no further Infertility benefits are available.

NOTE: For purposes of this Infertility services benefit, “per Covered Person” means if a Covered Person completed any number of oocyte retrievals under an Other Plan, without regard to whether or not the expenses for the services were considered eligible for benefits by the Other Plan, those retrievals will not be counted toward the maximum benefit available for oocyte retrievals under this Plan. All self-funded Plans or self-funded Plan options, if applicable, offered by the employer/Plan Sponsor are considered one Plan.

For purposes of this section, “Other Plan” shall mean:

- a policy or plan (insured, uninsured, or alternately funded) that is not offered by or not sponsored by the employer/Plan Sponsor; and
- an insured policy offered by or sponsored by the employer/Plan Sponsor.

See below for services that are considered excluded expenses under the Plan.

EXCLUDED INFERTILITY SERVICES EXPENSES

The following Infertility services are not considered Eligible Expenses under the Plan:

(1) All expenses for surrogate/gestational carrier maternity care for purposes of childbirth, however, costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be considered Eligible Expenses if the individual chooses to use a surrogate.

(2) Cryopreservation and storage of sperm, eggs and embryos; however, costs associated with subsequent procedures of a medical nature necessary to make use of the cryopreserved substance are considered

Eligible Expenses if the procedures are not deemed to be experimental and/or investigational.

(3) Non-medical fees, such as donor fees.

(4) Travel costs associated with Infertility treatment.

(5) Donor embryos.

(6) Selective termination of an embryo.

(7) Drugs associated with excluded Infertility services.

(8) Reversal of a voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits are considered Eligible Expenses if the Covered Person's diagnosis meets the definition of "Infertility" as specified herein. Benefits are not provided for the diagnostic services needed to confirm a successful reversal.

(9) GIFT and ZIFT are not considered Eligible Expenses for female Covered Persons whose male partner has severe male factor Infertility or unexplained Infertility because there is insufficient evidence to recommend either procedure over IVF for these indications.

(10) Experimental or investigational treatments, and procedures performed for research purposes. However, Infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from Infertility treatment considered experimental are considered Eligible Expenses.

(11) Preimplantation genetic screening (PGS).

(12) Infertility services are not considered Eligible Expenses if either partner has had a reversal of a voluntary sterilization.

(13) Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is provided.

(14) Infertility treatments rendered to covered dependents (as defined by the Plan) under the age of 18.

DEFINITIONS FOR PURPOSES OF INFERTILITY SERVICES

"**Covered Person**" means an employee or dependent, as defined in the Plan, who is covered under the Plan. In certain situations, a "Covered Person" also means a former employee or former dependent who is covered under the Plan.

"**Eligible Expense(s)**" mean(s) the expenses for Medically Necessary services or supplies that are eligible under the Plan, subject to all Plan provisions, limitations and requirements.

"**Health Alliance Medical Policy**" means a medical policy developed by Health Alliance for determining Medical Necessity. It is available for use by the Plan Administrator and its designee to assist with the administration of benefits under the Plan, including but not limited to, determinations of Medical Necessity. The Health Alliance Medical Policy provides the criteria that must be met before benefits are provided for certain healthcare services under the Plan. The Health Alliance Medical Policy does not replace or amend the Plan requirements, or in any way affect the discretionary authority of the Plan Administrator.

"**Medically Necessary**" or "**Medical Necessity**" means care, treatment or supply recommended or approved by a Physician or dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. When applied to inpatient care, it further means that the patient's medical symptoms or condition require that the services cannot be safely provided to the patient on an Outpatient basis.

All of the above criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary and appropriate. The Plan Administrator or its designee has the discretionary authority to decide if care or treatment is Medically Necessary and appropriate.

"**Outpatient**" means the care or services received in a Physician's office, the Outpatient department of a hospital, an Ambulatory Surgical Center, a medical center, an X-ray or laboratory facility, a retail pharmacy or the Covered Person's home.

"**Physician**" means a person licensed to practice medicine in all of its branches under the applicable laws of the state within the United States of America where he or she practices.

"**Plan**" means Illinois Educators Risk Management Program Group Health Plan, which is the written document used to communicate benefit provisions, limitations, rights, and obligations to persons covered under the Plan provided by the Plan Sponsor.

"**Plan Administrator**" means Illinois Educators Risk Management Program Association.

"**Plan Sponsor**" means Illinois Educators Risk Management Program Association.

"**Preauthorization**" means the review to determine and authorize the benefit level of Medically Necessary and appropriate services and supplies the Plan will consider eligible if authorized prior to receiving the services/supplies.

"**Pregnancy**" means childbirth and conditions associated with pregnancy, including complications.

"**Provider**" means an individual or organization licensed to provide healthcare services under the applicable laws of the state within the United States of America where they provide services.

Enhanced infertility services (TPAC v.2019-10-31)

IMPORTANT

Section 1557 of PPACA, a federal law, requires that you be provided this notice.

The notice does not change the terms of your coverage and/or benefits under your employer-sponsored health plan.

Please review the information and keep it with your plan materials.

NO FURTHER ACTION IS REQUIRED ON YOUR PART.

DISCRIMINATION IS AGAINST THE LAW

Health Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-851-3379; telephone for members in Washington: 1-877-750-3515 TTY: 711, fax: 217-902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame 1-800-851-3379, WA Llame: 1-877-750-3515 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 1-800-851-3379, WA: 呼叫 1-877-750-3515(TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-851-3379, WA: Zadzwoń 1-877-750-3515 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-851-3379, WA: Gọi 1-877-750-3515 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 IA, IL, IN, OH: 전화 WA: 1-877-750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-851-3379, WA: Вызов 1-877-750-3515 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-851-3379, WA: Tumawag 1-877-750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-851-3379، ولاية واشنطن: اتصل بالرقم: 1-877-750-3515 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-851-3379, WA: Anruf 1-877-750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-851-3379, WA: Appelez 1-877-750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ 1-800-851-3379, WA: કૉલ 1-877-750-3515 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。 1-800-851-3379 IA, IL, IN, OH: コール 1-877-750-3515 WA: コール（TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-851-3379, WA: Bel 1-877-750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-851-3379, WA: Виклик 1-877-750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-851-3379, WA: Chiamare 1-877-750-3515 (TTY: 711).