AGENDA
County Operations Committee
Tuesday, September 24, 2019
@ 1:00 PM
Peoria County Courthouse, Room 402

1. Call to Order

2. Approval of Minutes
   - May 28, 2019 (Executive Session)
   - June 25, 2019 (Executive Session)
   - August 27, 2019 (Regular Session)

3. Informational Items/Reports/Other Minutes/Updates
   - Workforce Report

4. Resolutions
   - Employee Health Plan Summary Plan Document Update
   - Employee Health Plan Premiums and Health Savings Account

5. Executive Session
   - Labor Relations

6. Miscellaneous

7. Adjournment
Call to Order
Vice-Chairperson Groves Allison called the meeting to order at 1:00 p.m.

Approval of Minutes
A motion to approve minutes of July 23, 2019 was made by Mr. Watkins and seconded by Ms. Daley. The motion to approve carried unanimously.

Discussion
- Workforce Report
Mr. Sorrel advised that the current report covers applicants, new hires and separations for July 2019 and a comparison of July 2018 and July 2019 figures. He commented that the report details demographics of both female and male employees, and remarked that the African American portion of the payroll for females and males combined is proportionate to the racial composition of the community. He noted that July saw 18 new hires of a total 22 positions posted, as compared to 16 new hires of a total 29 positions posted in July 2018. He stated that for the month of July, the majority of new hires were white/Caucasian females. He also advised that the county saw 21 separations in July as compared to 14 separations in July 2018, with Heddington Oaks being the top department seeing separations in both years.

Resolution
- Addendum #1 to health plan consultant services contract
A motion to approve was made by Mr. Watkins and seconded by Mr. Rieker. Ms. Musselman advised that the county is currently under contract with Unland & Company for the health plan consultant services bid process as well as annual plan updates to keep in compliance with state and federal regulations. She stated that during the health plan RFP process, a number of employee educational tools were identified and after reviewing the current market, it was determined that Unland & Company was able to offer the tools at a significant discount, as well as assisting with the modeling system. She stated that it is necessary to update the contract with Unland & Company in order to secure the discounted pricing for the system.

Ms. Musselman also advised that the current open enrollment process is completely paper based and stated that, through Unland & Company, the county would have the ability to streamline a more comprehensive online process. She stated that in addition to streamlining the process for employees, the recommended services will be less labor intensive and save the HR team a significant number of staff hours.
Ms. Musselman advised that staff is requesting a contract extension with Unland & Company through December 31, 2020 for the additional services at an approximate cost of $39,500.00.

Mr. Rieker asked if the information that is to be collected from the system will be owned by Peoria County, and would the county lose access to the information in the future if/when the contract with Unland & Company expires. Ms. Musselman assured that the data is owned by Peoria County.

The motion to approve carried unanimously.

**Adjournment**
The meeting was adjourned at 1:12 p.m. upon a motion by Ms. Pastucha and second by Mr. Rieker.

*Recorded and Transcribed by: Jan Kleffman*
August Applicants

Female Employees Race/Ethnicity
(as of 8/31/19)

Male Employees Race/Ethnicity
(as of 8/31/19)

Employee Separations

Top Department Separations

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<tr>
<th>Department</th>
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<th>August 2019</th>
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<tr>
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AGENDA BRIEFING

COMMITTEE: County Operations Committee
MEETING DATE: September 24, 2019
LINE ITEM:
AMOUNT:

ISSUE: Update the Summary Plan Document to incorporate the administrative language changes necessary to implement the previously approved plan design changes.

BACKGROUND/DISCUSSION:
Earlier this year the County Board approved changes to the Employee Plan in order to reduce costs and comply with PPACA (healthcare reform). The Summary Plan Document (SPD) is the actual plan document itself that our third party administrator and insurance carriers use to administer the plan. In order to administratively implement the plan design changes that were previously approved by the board, the plan language in the SPD needs to be updated. In addition, there are a few language changes that “clean up” some of the definitions and titles within the document to represent current and best practices. Attached is a strike-through version of the SPD with the recommended changes. These have all been reviewed by the health plan consultant and are in compliance with state and federal regulations.

COUNTY BOARD GOALS:

HEALTHY VIBRANT COMMUNITIES

STAFF RECOMMENDATION:
To approve the attached administrative language changes to the Health Plan SPD.

COMMITTEE ACTION:

PREPARED BY: Shauna Musselman, Asst. County Administrator
DEPARTMENT: County Administration
DATE: September 18, 2019
EMPLOYEE HEALTH PLANS
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INTRODUCTION

The County of Peoria Employee’s Healthcare, Dental, Vision and Prescription Plan is a self-funded health benefit plan established to provide medical, dental and prescription benefits for employees of the County of Peoria ("The County"). This Plan represents the efforts of The County to provide its employees and their dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a description of all benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus, we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you may come across terms and phrases that are unfamiliar to you. Please refer to the Definitions Section 29 or you may contact the Claims Administrator, Consociate, at (800) 798-2422 between 8:00 A.M. and 5:00 P.M., Monday through Friday for clarification of these terms and phrases.

If you have difficulty in understanding the booklet or your rights under the Plan, you may contact the County’s HR Generalist-Health & Risk/Healthcare Administrator at (309) 672-6071 between 8:00 A.M. and 5:00 P.M., Monday through Friday.

Any information that you obtain concerning your rights and benefits may not be relied upon as a guarantee of your rights or that benefits will be paid in that manner. The availability of benefits is determined solely from the terms of the Plan as contained in the Plan document. A determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Third Party Administrator and they fully adjudicate your claim. Final determination of any claim rests with the Plan Administrator.

PLEASE BE ADVISED...If you have any changes in your status, such as a birth, death, marriage, divorce, address changes or any other information that may affect your benefits, it is mandatory that you contact the HR Generalist-Health & Risk at (309) 672-6071 with this information, within thirty-one (31) days of the eligibility event.

FAILURE TO NOTIFY PERSONNEL OF ANY CHANGE IN STATUS MAY RESULT IN A DELAY OR DENIAL OF HEALTHCARE BENEFITS.

Unity Point Health Plus (Methodist, Proctor and Pekin) is the Preferred Physician Hospital Network. The Preferred Hospital is METHODIST MEDICAL CENTER which provides free parking.
Quick Reference List
Listed below are a few numbers of importance.
These numbers are listed here for your quick reference and convenience.

County Administration ..............................................................................(309) 672-6056
..............................................................................................................(309) 672-6054 – Fax

HR Generalist-Health & Risk ......................................................................(309) 672-6071

Assistant Director of Human Resources .......................................................(309) 672-6941

Pharmacy Benefit Manager
MEDTRAK ....................................................................................................(800) 771-4648
7101 College Blvd., Suite 1000
Overland Park KS  66210

Third Party Administrator (Claim Administration and Customer Service of Benefits)
Consociate ....................................................................................................(800) 798-2422
151 E. Decatur Street ......................................................................................(217) 233-7252 – Fax
PO Box 1068
Decatur, IL  62525-1068
Payer ID# 37135

Pre-Certification/Utilization Review
Hines & Associates, Inc. ...................................................................................(800) 944-9401
Name of Plan:
County of Peoria Employee’s Healthcare, Dental, Vision, and Prescription Plan.

Plan Sponsor/Administrator:
Assistant County Administrator-Health and Human Services in coordination with the Third Party Administrator.

County of Peoria
324 Main Street, Room 502
Peoria, IL 61602
(309) 672-6056

Plan Sponsor Employer Identification Number ("EIN"): 37-6001763

Health Plan Identification Number (HPID): 7003819456

Type of Plan:
Healthcare benefit plan providing medical, dental, vision and prescription benefits.

Funding and Sources of Contribution to the Plan:
The Plan is self-insured and the cost of providing benefits under the Plan is shared by the Employer, Outside Groups and Employees. A schedule of premiums will be distributed periodically setting forth the current cost of benefits and the amount of those costs that are paid by the Employer, Outside Groups and Employees.

Claims Administrator:
Consociate
151 E. Decatur Street
PO Box 1068
Decatur, IL 62525-1068
(800) 798-2422
FAX (217) 233-7252

Medical Utilization Review:
Hines & Associates, Inc.
(800) 944-9401

Agent for Service of Legal Process:
Note: Service of legal process may be made upon the Employer/Plan Administrator.

Fiscal Year of the Plan:
January 1 through December 31.

Effective Date of the Plan:
September 1, 1983

Effective Date of Restated Plan:
July 1, 2015
January 1, 2020

HR Generalist-Health & Risk:
Peoria County Courthouse, Room 502
324 Main Street
Peoria, IL 61602
(309) 672-6071
ELIGIBILITY & PARTICIPATION REQUIREMENTS

To be considered a Primary Participant or Eligible Dependent, one or more of the following criteria must be met and maintained:

1.01 Primary Participant includes:
   a) Full-time Regular Active Employees of the County of Peoria;
   b) Qualified Retirees (see Section 25);
   c) Survivors (see Section 25);
   d) Active Elected Officials;
   e) COBRA Participants (including those covered by the extended COBRA period through the Voluntary Separation Program); and

1.02 Eligible Dependent includes:
   a) the Primary Participant’s lawful spouse/civil union partner;
   b) any natural or legally adopted child under age twenty-six (26).
   c) Also, unmarried child from birth to the end of the month in which the child reaches age thirty (30) if such child is an Illinois resident, served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and has received a release or discharge other than a dishonorable discharge. The eligible dependent must submit to the Third Party Administrator a form approved by the Illinois Department of Veterans’ Affairs stating the date on which the dependent was released from service;
   d) a stepchild or other child for whom you or your covered spouse/civil union partner have assumed a legal responsibility, such as legal guardianship or a foster child, or responsibility has been determined by court order, and is a dependent, as defined by the United States Internal Revenue Code Section 152 (26 U.S.C. § 152);
   f) any unmarried child twenty-six (26) years or over who is incapable of self-sustaining employment by reason of a mental condition or physical handicap and who is dependent upon the Primary Participant for support and maintenance, provided the dependent is suffering from a documented disability on the date he or she otherwise ceases to be eligible for benefits under the Plan. Such disability must be verified during each annual open enrollment period or at such times as the Employer may reasonably require.

1.03 But, excludes the following:
   a) any person who is not a resident within the United States of America or Canada;
   b) any person who is already covered under this Plan as a primary Participant;
   c) any person who is on active duty in any military, naval, or air force of any country;
   d) any spouse/civil union partner of a Primary Participant who is legally divorced from the Primary Participant.

The term “child” means any child of the Primary Participant, including a stepchild, adopted child, or child in the custody of a Primary Participant while adoption proceedings with respect to that child by the Primary Participant are pending, a grandchild who resides with the Primary Participant, and a child for whom the Primary Participant has obtained legal guardianship.

In the case of a grandchild, a child for whom the Employee has legal guardianship and a child who qualifies as an eligible dependent under Section 1.02(c) above, the child must be fully dependent upon the primary participant for support and maintenance and qualify as a dependent as defined by the Internal Revenue Service Code Section 152 (26 U.S.C. § 152).

Coverage for grandchildren, persons with disabilities, and legal guardianship children is secondary to any other source of coverage, except as provided by State or Federal laws and regulations.
1.04  **Rehiring a Terminated Employee:**
A terminated employee who is rehired must satisfy the Eligibility Requirements of a new hire. However, an employee returning to work directly from coverage under the Plan’s COBRA continuation option need not satisfy the new employment waiting period.

1.05  **Reinstatement of Coverage:**
An employee whose coverage has terminated must satisfy the Eligibility Requirements of a new hire upon reinstatement. However, an employee returning to coverage directly from coverage under the Plan’s COBRA continuation option need not satisfy the new employment waiting period.
2.01 Eligibility to be enrolled as a participant in the Plan

2.02 New Employee and Dependents

New employees and dependents are eligible to apply for enrollment during the first thirty days of continuous regular full-time employment. An employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage becoming effective.

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Waiting period: New employee and dependents become enrolled as plan participants on the first day of the next month following completion of one calendar month of continuous regular full-time employment.

2.03 Full-time Employee, 31+ Days of Employment

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Eligibility: Only during the annual open enrollment period.
Dependents (Same).

Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of January following enrollment during open enrollment period;

2.031 Full-time Employee, 31+ Days of Employment/Loss of Other Coverage

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Eligibility: Within thirty (30) days of the loss of other coverage; or sixty (60) days of losing eligibility status through Medicaid or CHIP.
Dependents (Same).

Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of the month following the month in which application for enrollment is made;

b) The date that other coverage is terminated;

2.032 Full-time Employee, 31+ Days of Employment/Eligible for Employment assistance under Medicaid or CHIP

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Eligibility: Within sixty (60) days of becoming eligible for Employment assistance under Medicaid or CHIP.
Dependents (Same).
Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of the month following the month in which application for enrollment is made;

2.04 Newly Acquired Dependent of Participating Employee (Primary participant without dependent coverage).

Eligibility: Eligible to obtain dependent coverage and enroll new dependent when acquired by:

2.041. Newborn or adoption

Requirements: Enroll within thirty-one (31) days of birth or placement for adoption.

Waiting period: None

2.042 New Spouse/Civil Union Partner/Other Eligible Dependents:

Requirements: Enroll within thirty-one (31) days of date when new dependent acquired.

Waiting Period: None

2.043 Newly Acquired Dependent of Primary Participant with Dependent Coverage

Requirements: Enroll within thirty-one (31) days of date when new dependent acquired*.

Waiting Period: None

2.05 Variable Employees and Eligible Dependents:

As required by Employer Shared Responsibility Provisions of the PPACA, new variable employees and dependents are eligible to apply for enrollment upon meeting the requirements of and completing their Initial Measurement Period. Ongoing variable employees and dependents are eligible to apply for enrollment upon meeting the requirements of and completing their Standard Measurement Period. An employee must make written application for coverage and sign a payroll deduction order form within thirty-one (31) days of becoming eligible.

Initial Measurement Period: Begins on the first day of the next month following completion of one calendar month of continuous employment and ends twelve (12) months later.

Requirement: During the Initial Measurement Period the employee must average thirty (30) hours per week or average one hundred thirty (130) hours per month, also known as the "minimum hours threshold".

Effective Date: After meeting the minimum hours threshold requirement during the Initial Measurement Period coverage is effective no later than thirteen (13) months from the employee’s start date plus time remaining until the 1st day of the next calendar month.

Initial Stability Period: Coverage begins with the Effective Date of coverage as described above and continues for a period of twelve (12) consecutive months, regardless of actual hours worked during this subsequent Stability Period, provided the employee remains employed.
Standard Measurement Period: Begins on November 1st and ends twelve (12) months later on October 31st.

Requirement: During the Standard Measurement Period the employee must average thirty (30) hours per week or average one hundred thirty (130) hours per month, also known as the “minimum hours threshold”.

Effective Date: After meeting the minimum hours threshold requirement during the Standard Measurement Period coverage is effective the 1st day of January.

Standard Stability Period: Coverage begins the first 1st day of January and continues for a period of twelve (12) consecutive months, regardless of actual hours worked during this subsequent Stability Period, provided the employee remains employed.

2.06 Annual Enrollment
The Primary Participant must submit an enrollment/waiver form each calendar year during the Open Enrollment Period. The Plan selected during the Open Enrollment Period will remain in effect for the entire Plan year with the following exceptions:

a) A Primary Participant enrolled in the Standard Plan will have the opportunity to switch to the Qualified High Deductible or Indemnity–IMRF Medicare Eligible Retiree Plan at the time of Retirement.

b) A Participating Retiree will have the opportunity to switch—automatically be enrolled to—in the Indemnity–IMRF Medicare Eligible Retiree Plan at the time they (and their applicable dependents) become eligible for Medicare. It is the Retiree’s responsibility to notify the Plan Sponsor of the intention to switch Plans within 31 days of becoming Medicare eligible.

(Subject to Federal and State Laws as they become applicable.)

*The Primary Participant’s failure to timely enroll new dependent under this section will result in two consequences:

a) Dependent will have no prescription plan coverage and will not be able to recover prescription expenses that occur prior to enrollment date.

b) Payment of claims for benefits incurred prior to enrollment will be delayed.

2.07 Automatic Enrollment
Unless a waiver of coverage or a health insurance enrollment form is received within 31 days of becoming eligible, a full-time employee will be automatically enrolled in the lowest cost health plan available with employee only coverage.
All primary participants in the County of Peoria Health Plan are required to make premium payments, either by active payroll deduction, pension deductions, or self-pay. At such time that the primary participant is required to self-pay their premiums, due to retirement, disability, unpaid leave of absence or any other interruption of active employment, that primary participant is required to do so by the first day of the month. Courtesy invoices will be issued twelve to fifteen (12-15) days prior to the due date. Failure to pay within thirty (30) days of the due date will result in immediate termination from the Plan. **IF YOU ARE TERMINATED FROM THE PLAN FOR NON-PAYMENT OF PREMIUMS, YOU MAY APPEAL THAT TERMINATION TO THE HR GENERALIST-HEALTH & RISK/HEALTHCARE ADMINISTRATOR’S OFFICE.**
4.01 INDIVIDUAL ANNUAL MAXIMUM: Unlimited

4.02 Deductibles: (per calendar year)
   (Applies to all Benefits of Plan except where specifically indicated otherwise)

   Single Coverage
   $1,500 of the first eligible charges. $4,500 for non-PPO costs. And, effective January 1, 2021 this changes to $2,000 of the first eligible charges. $6,000 for non-PPO costs.

   Family Coverage
   $3,500 of the first eligible charges of all participants. $10,500 for non-PPO costs. And, effective January 1, 2021 this changes to $6,000 of the first eligible charges of all participants. $18,000 for non-PPO costs.

4.03 Co-insurance:
   (Applies to all Benefits of Plan except where specifically indicated otherwise)

   80% after the deductible up to maximum out-of-pocket. 50% after the deductible up to maximum out-of-pocket for non-PPO costs.

4.04 Maximum Out-of-Pocket:
   (Applies to all Benefits of Plan except where specifically indicated otherwise)

   $3,000 per participant and $5,000 per family in a calendar year. For non-PPO costs, the maximum out-of-pocket is $4,000 per participant and $8,000 per family in a calendar year. This limit does not apply to prescriptions filled through the drug card program, dental benefits, deductibles, amounts over reasonable and customary, non-covered expenses, or to penalties.

   No deductible or co-insurance will be charged after reaching Maximum out-of-pocket.

4.041 PPACA and IRS In-Network
   Maximum Out-of-Pocket:

   Standard Plan $8,150 per participant and $16,300 per family in calendar year 2020. QHDHP $6,900 per participant and $13,280 per family in calendar year 2020. This limit applies to deductibles, coinsurance, and co-pays for covered PPACA Essential Health Benefit expenses including the drug card program, and “Up to Age 21” dental and vision benefits. This limit does not apply to out-of-network expenses, amounts over reasonable and customary, non-covered expenses, or penalties.

   Beginning with calendar year 2021 and each calendar year thereafter this In-Network Maximum Out-of-Pocket amount shall be adjusted as required under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto.
4.05 MEDICAL BENEFITS

4.051 Hospital Coverage:
Preferred provider (in-patient): 80% of hospital room and board charges up to a hospital’s semi-private rate, subject to reasonable and customary, Deductible and Co-insurance. 80% of charges for intensive care, coronary care or special care units. 80% inpatient or outpatient miscellaneous services and supplies provided by a hospital and necessary to diagnose and treat a condition of illness or injury, including diagnostic tests.

Preferred provider (out-patient): 100% of charges for outpatient medical emergency care; 80% of charges for diagnostic tests or outpatient surgery. Subject to Reasonable and Customary Allowance.

Non-Preferred Provider (in-patient): 50% of hospital room and board charges up to a hospital’s semi-private rate, subject to reasonable and customary, Deductible and Co-insurance. 50% of charges for intensive care, coronary care, or special care units. 50% inpatient or outpatient miscellaneous services and supplies provided by a hospital and necessary to diagnose and treat a condition of illness or injury, including diagnostic tests. **PENALTIES ARE ASSESSED.** (See Penalties, Section 13).

Non-Preferred Provider (out-patient): 100% of charges for outpatient medical emergency care; 50% of charges for diagnostic tests or outpatient surgery. Subject to Reasonable & Customary Allowance. **PENALTIES ARE ASSESSED.** (See Penalties, Section 13).

4.06 DENTAL BENEFITS
Effective 01/01/14

Up to Age 21 Co-insurance Out-of-Pockets will accumulate toward the PPACA In-Network Maximum Out-of-Pocket under Sec. 4.041. Payment up to Reasonable and Customary Allowance, subject to:

Deductibles: (per calendar year)

Single Coverage
$100 of the first eligible charges

Family Coverage
$200 of the first eligible charges of all participants. (Under family coverage each Participant’s deductible is calculated toward $200 max.)

Orthodontics:
Up to Age 21 (no orthodontics for age 21+). Are paid quarterly, subject to the limitations set forth in Section 10.01.

4.061 Co-insurance:

Preventative Dental Services: 100% Deductibles & Co-insurance waived.

Primary Dental Services: Up to Age 21 – 80% no deductible. Age 21+ 80% after the deductible.
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Dental Services:</td>
<td>Up to Age 21 – 80% no deductible. Age 21+ 50% after the deductible.</td>
</tr>
<tr>
<td>Orthodontics:</td>
<td>Up to Age 21 - 80% no deductible.</td>
</tr>
<tr>
<td>Orthodontics:</td>
<td>Benefits are paid quarterly.</td>
</tr>
</tbody>
</table>

4.07 PRESCRIPTION DRUG CARD AND MAIL ORDER PROGRAM

(Please refer to "Exhibit A" for a summary of covered drugs.)

Deductibles:

Charges do not apply to the medical or dental deductible and do not apply to meeting the medical out-of-pocket maximum. Effective 01/01/15 drug card program deductibles, coinsurance and copays will accumulate toward the PPACA In-Network Maximum Out-of-Pocket under Section 4.041. **If the brand name drug is selected when a generic available, there will be an additional cost to the participant. (See "Exhibit A" for specific coverage benefits).**
5.01 This is a special program designed to assist you in determining the course of treatment that will maximize your benefits under this Plan. There are several components of Utilization Review that are described below (e.g. pre-certification, continued stay review, discharge planning, second surgical opinion, case management, etc.)

5.02 **Pre-Certification:** Whenever a non-emergency inpatient admission or out-patient service is required by your Physician, it is your responsibility to call Utilization Review for pre-certification prior to the admission or service. In the event of an emergency admission, you, or someone calling on your behalf, must notify Utilization Review within seventy-two (72) hours from the date of admission. **However, it is your ultimate responsibility to make sure the call is made.**

5.03 ******NOTE: FAILURE TO NOTIFY UTILIZATION REVIEW PRIOR TO AN INPATIENT ADMISSION, OUT-PATIENT SERVICE OVER $500, OR WITHIN SEVENTY-TWO (72) HOURS OF AN EMERGENCY ADMISSION WILL RESULT IN A $250 PENALTY PER ADMISSION OR SERVICE. THIS AMOUNT WILL NOT BE APPLIED TO ANY OUT-OF-POCKET EXPENSE LIMITATION OF THIS PLAN. THIS PENALTY WILL NOT APPLY IF THIS PLAN IS THE SECONDARY PAYOR.******

When you call Utilization Review, be sure to identify yourself as a County of Peoria employee or healthcare participant.

When you contact Utilization Review, you should be prepared to provide the following:

a) Primary Participant name, address, phone number, social security number;
b) Name of employer;
c) Patient name and date of birth;
d) Date of admission;
e) Hospital name and address;
f) Name and address of admitting Physician; and
g) Admitting diagnosis, procedure and expected length of stay if known.

Once the pre-certification call has been received, make a note of the date, time and person you spoke to. This is your verification that you met your portion of the pre-certification requirement. The Utilization Review Administrator will contact the attending Physician for medical information, comparing that with pre-established medical criteria, an anticipated length of stay will be determined. After the admission, confirmation will be sent to the Participant and the attending Physician.

5.04 **IF THE ADMISSION OR OUT-PATIENT SERVICE HAS NOT BEEN PRE-CERTIFIED AND APPROVED, AND YOU CHOOSE TO BE ADMITTED TO THE HOSPITAL OR TO PROCEED WITH THE SERVICE, YOUR BENEFIT LEVEL MAY BE REDUCED OR DENIED FOR THE CHARGES INCURRED.**

During the pre-certification process, the Utilization Review Administrator may also review for:

a) Surgery that may be performed on an outpatient basis. The Utilization Review Administrator will review procedures for recommendation of outpatient surgical setting; and/or
b) Second Surgical Opinion. The Utilization Review Administrator may recommend a second opinion for certain surgical procedures.
c) Pre-admission testing. The Utilization Review Administrator may recommend that pre-surgical testing be done prior to admission.
5.05 Continued Stay Review: Continued Stay Review occurs when the patient remains hospitalized beyond the original length of stay. The attending Physician may contact the Utilization Review Administrator during the hospital stay to request additional days or the Utilization Review Administrator will contact the Physician prior to or on the expected discharge date. Additional days will be assigned based upon the patient’s continued need for hospitalization. Letters of recertification for the continued stay will be sent to the Participant, the Physician and the Hospital.

If the additional Hospital days are not approved and you choose to remain hospitalized after adequate notification, there will be no benefits paid by the Plan.

5.06 Discharge Planning: Discharge planning is designed to identify individuals who will require care after discharge from the Hospital. The Utilization Review Administrator may identify a certain diagnosis or procedure that usually has potential for discharge planning. Contact will then be made with the Hospital’s social service/discharge planning department to determine the need for post discharge care. The Utilization Review Administrator will also work with the Physician and family as indicated to ensure that all discharge plans and home health treatment plans are appropriate to the patient’s condition and home setting.

5.07 Second Surgical Opinion A second surgical opinion may be required by Utilization Review. If your Physician has recommended surgery, either you or the Utilization Review Administrator may request a second surgical opinion. The Utilization Review Administrator will give you instructions on obtaining that second opinion. If a second surgical opinion is arranged by the Utilization Review Administrator, expenses for the second surgical opinion will be paid at 100% with no deductible.

If the second surgical opinion does not confirm the first opinion, a third opinion may be approved. If the third opinion is approved or arranged by the Utilization Review Administrator, it too, will be paid at 100% with no deductible.

5.08 Large Case Management: A large case management approach may be indicated at no charge to the patient. This may involve the exploration of alternative means of care. The Utilization Review Administrator may arrange for review and/or case management services from a professional who is qualified to perform such services. Upon the advice of such professional, and agreement of the patient, the Utilization Review Administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect that a cost-effective result can be achieved without a sacrifice to quality of patient care.

5.09 Retrospective Review: In the event you fail to call Utilization Review prior to your admission, outpatient service, or within seventy-two hours following an emergency admission, the penalty will apply. In addition, the entire medical record relating to this admission may be reviewed by the Utilization Review Administrator on a retrospective basis.

Payments for days of care that were not medically necessary will be denied. You will be held responsible for these charges. Written notification of the denial will be sent by the Utilization Review firm to you, the attending Physician and the Hospital.

5.10 Right of Appeal: Should you choose to appeal a Utilization Review denial decision, you may do so by written request within sixty (60) days from the date of notification.
5.11 Mothers/Newborn Benefits:

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable).

5.12 Outpatient Mental Illness Health and Substance Abuse:

Preauthorize the following outpatient service(s) by calling the Mental Illness Health Unit: psychological testing, neuropsychological testing, electroconvulsive therapy, and intensive outpatient programs.

5.13 Substance Abuse:

Preauthorize Substance Abuse Services. Pre-Certification / Utilization Review Manager will continue to be responsible for making determinations of medical necessity; providing medically necessary criteria to participants upon request; and determining prior authorizations in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including the appeals process. The criteria established by the American Society of Addiction Medicine including the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions will be used for substance use disorders; and to determine medically necessary acute treatment services and stabilization services. Primary Participants and their covered dependents shall continue to be free to select any willing licensed or certified professional at a program licensed pursuant to the Illinois Alcoholism and Other Drug Abuse and Dependency Act.

5.1314 Dialysis Cost Management Program

For dialysis treatments, please contact Ethicare Advisors Hines & Associates, Inc. at 877-218-4955—1-800-944-9401 before treatment begins.
HEALTHCARE BENEFITS – ELIGIBLE CHARGES
Hospital Services at Preferred (PPO) Hospitals
(Refer to front of Plan for Qualified High Deductible Benefit Highlights)

***NOTE: PRE-CERTIFICATION IS REQUIRED FOR IN-PATIENT AND OUT-PATIENT SERVICES. SEE PENALTIES (SECTION 13) AND UTILIZATION REVIEW (SECTION 5) FOR EXPLANATIONS AND PROCEDURES***

6.01 IN-PATIENT SERVICES:

Hospital Coverage: ($250 Penalty will apply for failure to pre-certify hospital admission)
80% Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance. Applies to facility fees only. Physician charges under separate benefit. (See Section 8).

Room and Board Daily Limit: Semi-private (Upgrade to private room at semi-private rate if available).

Diagnostic Services:
- Lab, X-Ray, and Anesthesiology: 80% Payment up to Reasonable and Customary Allowance. Deductible and Co-insurance applies.
- Psychiatric, Mental/Nervous Illness, Substance Abuse: 80% payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

6.02 OUT-PATIENT SERVICES:

Hospital Coverage: 80% Payment up to Reasonable and Customary Allowance. Deductible and Co-insurance applies. UTILIZATION REVIEW APPROVAL REQUIRED IF PROCEDURE IS OVER $500.

Diagnostic Services:
- Lab, X-Ray, and Anesthesiology: 80% Payment up to Reasonable and Customary Allowance. Deductible and Co-insurance applies. UTILIZATION REVIEW APPROVAL REQUIRED FOR MRI, CT (CAT) & PET TESTING, EXCEPT IN AN EMERGENCY. PENALTY WILL BE ASSESSED FOR FAILURE TO PRE-CERTIFY MRI, CT (CAT) & PET TESTING. SEE PENALTIES, SECTION 13.
- Emergency Room Provision: 100% Payment up to Reasonable and Customary Allowance. Deductible and Co-insurance waived. SEE SECTION 13, $150 PENALTY WILL BE ASSESSED FOR INAPPROPRIATE USE. SEE SECTION 15 FOR GUIDELINES ON APPROPRIATE USE.
- Psychiatric, Mental/Nervous Illness, Substance Abuse: 100% (including partial hospitalization), Payment up to Reasonable and Customary Allowance.

6.03 DENTAL SERVICES:

Hospital charges for dental work or treatment will be covered as Healthcare benefits if:

a) due to an accidental injury to sound natural teeth or to the jaw which occurs while covered; or

b) such work or treatment is done while you are confined in a hospital; in the case of oral dental surgery, such confinement must be ordered by a doctor because your life or health will be placed in danger if such surgery is done while you are not confined to a hospital. Oral dental surgery is limited to charges for cutting procedures for diseases or the extraction of teeth.
HEALTHCARE BENEFITS – ELIGIBLE CHARGES
Hospital Services at NON-Preferred Hospitals (Non-PPO)
(Refer to front of Plan for Qualified High Deductible Benefit Highlights)

***NOTE: SEE SECTION 13 FOR PENALTY EXPLANATIONS***

7.01 IN-PATIENT SERVICES:
Hospital Coverage:
(EFFECTIVE MAY 1, 2001, REASONABLE AND CUSTOMARY ALLOWANCE BASED ON PPO’S DISCOUNTED CHARGES)
(NOTE: The combination of Penalties and Reasonable and Customary Allowance will greatly reduce your benefits.)
PRE-CERTIFICATION REQUIRED, $250 PENALTY FOR FAILURE TO PRE-CERTIFY, SEE SECTIONS 5 & 13

$1,000 PENALTY PER ADMISSION. 50% payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance. Applies to facility fees only. Physician charges under separate benefit. (See Section 8).

Room and Board Daily Limit: Semi-private. Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

Diagnostic Services: 50% Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

Psychiatric, Mental/Nervous/Illness, Substance Abuse:
$1,000 PENALTY PER ADMISSION. $40,000 per participant per calendar year. $30,000 per participant annually. 50% payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

7.02 OUT-PATIENT SERVICES:
Hospital Coverage:
50% payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance applies. PRE-CERTIFICATION REQUIRED, $250 PENALTY FOR FAILURE TO PRE-CERTIFY PROCEDURES OVER $500, SEE SECTIONS 5 & 13, $250 PENALTY FOR OUT OF NETWORK FACILITY.

Diagnostic Services: 50% payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance applies. UTILIZATION REVIEW APPROVAL REQUIRED FOR MRI, CT (CAT) & PET TESTING EXCEPT IN AN EMERGENCY. PENALTY WILL BE ASSESSED FOR FAILURE TO PRE-CERTIFY MRI, CT & PET TESTING. SEE PENALTIES, SECTION 13.

Emergency Room Provision: 100% Payment up to Reasonable and Customary Allowance. Deductible and Co-insurance excluded. $150 PENALTY WILL BE ASSESSED FOR INAPPROPRIATE USE. SEE APPROPRIATE USE GUIDELINES, SECTION 15.

Psychiatric, Mental/Nervous/Illness, Substance Abuse: 50% Payment up to Reasonable and Customary Allowance, deductible and co-insurance applies. Maximum $1,000 per participant per calendar year. Included in $30,000 maximum per participant annually.

7.03 DENTAL SERVICES:
Hospital charges for dental work or treatment will be covered as Healthcare Benefits if:

a) due to an accidental injury to sound natural teeth or to the jaw which occurs while covered; or

b) such work or treatment is done while you are confined to a hospital; in the case of oral dental surgery, such confinement must be ordered by a doctor because your life or health will be placed in danger if such surgery is done while you are not confined to a hospital. Oral dental surgery is limited to charges for cutting procedures for diseases or the extraction of teeth.
Please refer to Definitions and Explanations, Section 29, for clarification of terms.

8.01 Allergy Testing and Serum: Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.02 Ambulance Services: Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance. Transport requires medical necessity.

8.03 Autism: Coverage for the diagnosis and treatment of autism spectrum disorders for dependents under the age of 21; includes coverage for the following treatment:
   a) Psychiatric care;
   b) Psychological care;
   c) Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
   d) Therapeutic care, including behavioral speech, occupational, and physical therapies addressing the following areas:
      • Self-care and feeding
      • Pragmatic, receptive, and expressive language
      • Cognitive functioning
      • Applied behavioral analysis, intervention, and modification
      • Motor planning
      • Sensory processing

8.04 Anesthesiology: Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.05 Blood and other Fluids: The extent charges are not reduced by blood donations; Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.06 Breast Reconstruction: The following are benefits for elective breast reconstruction in connection with a mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications in all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and patient. Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.07 Chemotherapy: Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.08 Chiropractic Care: Payment up to Reasonable and Customary Allowance, up to $1,500 per calendar year. Subject to Deductible and Co-insurance.

8.09 Clinical Trials The Plan will cover routine patient costs for items and services
furnished in association with approved clinical trials with respect to cancer or another life-threatening disease or condition. A participant must be eligible according to the approved trial protocol; and the participating provider has concluded that the individual’s participation would be appropriate or the participant provides medical and scientific information establishing that their participation in the approved trial would be appropriate. Benefit shall be consistent as mandated by PPACA PHS Sec. 2709. Benefits will be paid up to the Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.10 Colo-Rectal Cancer Screening:
Preventive screenings performed by a PPO provider are paid at 100% (see your Wellness Program for details). Non-preventive (diagnostic) services are subject to Deductible and Co-insurance. Subject to Reasonable and Customary.

8.11 Dental Benefits
Impacted or due to accidental injury to the jaw, teeth, mouth or face. Payment up to Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

8.12 Diagnostic, X-ray, Lab:
In physician’s office – payment up to Reasonable and Customary Allowance.

8.13 Dialysis Treatment Cost Management Program:
Subject to guidelines for PPO & NON-PPO Facilities. (See Sections 5.13, 6 & 7). Payment up to Reasonable and Customary Allowance. The dialysis treatment cost management program is a special cost containment program designed for patients requiring dialysis treatments. The Plan has entered into an agreement with EthiCare Advisors, Inc.a specialized cost management company, to manage dialysis costs. EthiCare Advisors Hines & Associates, Inc. must be contacted by your nephrologist and/or the dialysis treatment clinic providing services before the onset of treatment. Unless your nephrologist and/or dialysis treatment clinic has entered into an agreement with EthiCare Advisors the preferred provider, the payment for all drugs and dialysis treatment will be strictly limited to the usual and customary reimbursement rate as defined by the Plan and all other Plan Limitations and Exclusions.

8.14 Durable Medical Equipment:
80% of reasonable and customary charges. Deductible and Co-insurance apply. If not Utilization Review approved, there are no benefits paid by the Plan. Includes charges for prosthetic appliances to replace a limb or organ, if the appliance is the first one or a replacement due to pathological changes or normal growth; casts, splints, trusses, braces, crutches, rental of wheel chairs, hospital-type beds and equipment to give oxygen; rental of an iron lung or other mechanical equipment required to treat respiratory paralysis, certain prescription medications not covered by the prescription card program, or other durable medical equipment. Utilization Review Approval Required for all Outpatient DME Purchases, in excess of $500.00.

8.15 Health/Fitness Activities:
This benefit is offered to an employee who is a member of the Health Care Plan and it is also available for such employees’ spouse/civil union partners who are also County employees. Benefit is half of the single membership cost when the employee or a spouse/civil union partner employed by the County attends the health club eight (8) times a month. Benefit is 100% of the single membership cost when the employee or a spouse/civil union partner employed by the County...
attends the health club twelve (12) times a month. When the employee or a spouse/civil union partner employed by the County is on vacation the prorated number for attendance will be used. **This benefit is separate from benefits processed and paid by the Third Party Administrator. Check with HR Generalist-Health & Risk.**

8.16 **Home Health Care:**

80% Payment up to Reasonable and Customary Allowance if prescribed by a physician and Utilization Review approved. Deductible applies. The home health care must commence within seven days of hospital confinement and is limited to sixty (60) visits (note that four (4) hours counts as one (1) visit). Additional visits may be covered with Utilization Review approval when it is determined to be the most cost effective method to provide medically necessary health care with or without prior hospitalization. If not Utilization Review approved, then there are no benefits paid by this Plan. Coverage is for private duty nursing and hospice or home health care services by an R.N., L.P.N. or other service provider, but only when prescribed by a physician and pre-approved by the Claim Administrator. Home health care provided by a relative as defined in Section 29 or by a person residing in the Participant's household, is not covered by this Plan.

8.17 **Hospice Care:**

Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six (6) months, limited as follows:

(a) Room and Board;
(b) Necessary services and supplies at a facility or in home;
(c) Part-time nursing care;
(d) Consultation and case management services by a Physician;
(e) Physical therapy; and
(f) Medical supplies and prescription drugs otherwise covered by the Plan.

8.18 **Immunizations (childhood and adult):**

Immunizations (vaccines) performed by a PPO provider, a PPO pharmacist, or your local Health Department are paid at 100% (see your Wellness Program for details). Subject to Reasonable and Customary.

PLEASE NOTE: Once the child(ren) has been born, the participant must notify the Personnel Department within thirty-one (31) days of the birth and add the child(ren) to the Plan. Calling the Third Party Administrator does not automatically add the dependent to the Plan. Failure to add the child(ren) within the thirty-one (31) day limit may result in a delay or denial of benefits. If you fail to add a new dependent as described above and your coverage level would have increased (single to family) as a result of adding the dependent, a late entrant can only be added during the open enrollment period.

8.19 **Mammogram**

Preventive breast cancer screenings performed by a PPO provider are paid at 100% (see your Wellness Program for details). Non-preventive (diagnostic) services are subject to Deductible and Co-insurance. Subject to Reasonable and Customary Allowance.
8.20 **Implants**

Refer to 8.06 Breast Reconstruction. Penile implants are covered if deemed medically necessary and all other FDA approved treatments have failed. Subject to reasonable and customary allowance. Subject to deductible and co-insurance.

8.21 **Mental/Nervous Illness**

**Treatment including “Partial Hospitalization/Substance Abuse**

Individual or group psychotherapeutic treatment by licensed providers under the supervision of a physician or referred through the County Employee Assistance Program Provider. **EAP 100% payment up to Reasonable and Customary Allowance and 50% payment at non-preferred provider.**

The Peoria County Employee Assistance Program (EAP) provides three free visits per issue per year for Peoria County Employees and family members. For EAP services call (800) 333-2095 or (309) 681-5652.

8.22 **Morbid Obesity/Weight Reduction**

Expenses Incurred for weight loss programs including office visits, x-ray and laboratory expenses, and prescription drugs, for Morbid Obesity, limited to two (2) programs per person per lifetime. No benefits are payable for Expenses Incurred for Weight Watchers, TOPS, special diets; dietary supplements; and weight control meetings unless under the supervision of a Physician.

Diagnostic services, surgical procedures and prescription drugs for the treatment of Morbid Obesity. A surgical treatment plan must be provided to the Plan Administrator by the patient’s attending Physician prior to Surgery. Surgical treatment, including but not limited to gastric restrictive procedures and gastric bypass, whether or not it is, in any case, a part of the treatment plan for another Sickness is restricted to a maximum benefit of $10,000 annually, including any complications from that Surgery. No benefits are available for weight reduction Surgery if it is the first course of treatment for Morbid Obesity.

Services in connection with surgical treatment of morbid obesity and/or panniculectomy will be covered, subject to the following conditions:

- (a) body weight must be at least two hundred percent (200%) of the optimal weight;
- (b) the patient must have been considered morbidly obese by a Physician for at least five (5) years prior to the date surgical treatment is sought;
- (c) non-surgical methods of weight reduction have been attempted under a Physician’s supervision for at least a three (3) year period immediately prior to the date surgical treatment is sought.

**Under the surgical treatment plan for Morbid Obesity expenses incurred for weight loss programs including office visits, x-ray, laboratory expenses, and prescription drugs is further limited to two (2) programs per person per lifetime. No benefits are payable for Expenses Incurred for Weight Watchers, TOPS, special diets; dietary supplements; and weight control meetings unless under the surgical treatment Physicians supervision.**

8.23 **Nursing Service:**

Care provided by a Physician Assistant ("P.A.")/Nurse Practitioner ("N.P."), Registered Nurse ("R.N.") or Licensed Practical Nurse ("L.P.N.") which requires the technical skills and professional training of
a P.A., N.P., R.N. or L.P.N. The service must be provided under the
direction or order of a physician and must be medically necessary. The
inherent complexity of the service prescribed for a patient must be such
that the service can safely and effectively be performed by the
professional licensed personnel.

8.24 Pap Test/Smear
(Papanicolaou Test):
Cervical Dysplasia Preventive Screening performed by a PPO Provider
is paid at 100% (see Wellness Program for details). Non-preventive
(diagnostic) screenings are subject to Deductible and Co-insurance.
Subject to Reasonable and Customary Allowance.

8.25 Pathologist:
Payment up to Reasonable and Customary Allowance. Inpatient and
Outpatient - Subject to Deductible and Co-Insurance.

8.26 Physical Exam
Annual Wellness Office Visit performed by a PPO Provider is paid at
100% (see Wellness Program for details). Subject to Reasonable and
Customary Allowance.

8.27 Physical/Occupational
Therapy
Limited to a combined total of sixty (60) therapy sessions per injury or
sickness unless Utilization Review approves additional sessions.

Inpatient:
Covered under the guidelines for PPO and NON-PPO In-Patient
Services. (See Sections 6 & 7).

Outpatient:
Payment up to Reasonable and Customary Allowance if Utilization
Review approved. Subject to Deductible and Co-Insurance. Provider
discounts at PPO hospitals.

8.28 Physician Charges:
Payment up to Reasonable and Customary Allowance. Subject to
Deductible and Co-Insurance.

8.29 Pregnancy Prevention:
Contraception and contraceptive counseling received from a PPO
Provider or received under the Prescription Drug Program is paid at
100% (see Wellness Program for details). All contraceptive methods,
sterilization procedures, and patient counseling approved by the United
States Food and Drug Administration for use to prevent pregnancy are
covered. Abortifacient drugs or services are not covered except as
specified elsewhere in this plan

8.30 Prescription Drugs
Eligible under major medical, but not eligible under the drug card
program. Subject to deductible and co-insurance.

8.31 Prostate-Specific Antigen
Test (PSA):
Preventive screenings performed by a PPO provider are paid at 100%
(see your Wellness Program for details). Non-preventive (diagnostic)
services are subject to Deductible and Co-insurance. Subject to
Reasonable and Customary Allowance.

8.32 Radiologist:
Payment up to Reasonable and Customary Allowance. Inpatient and
Outpatient - Subject to Deductible and Co-Insurance.

8.33 Speech Therapy:
Inpatient:
Covered under the guidelines for PPO and NON-PPO In-Patient
Services. (See Sections 6 & 7).

Outpatient:
Payment up to Reasonable and Customary Allowance if Utilization
Review approved. Subject to Deductible and Co-Insurance. (Co-
insurance is less if the PPO is utilized. See Sections 6 & 7).

8.34 Sterilization Procedures

Sterilizations performed by a PPO provider are paid at 100% (see your Wellness Program for details).

8.35 Transplants (organ/tissue)

Paid same as any other illness. Subject to Deductible and Co-insurance. Reasonable and Customary Expenses Incurred for the following named human organ transplants: cornea, kidney, bone marrow, stem cell and reinfusion, cord blood transfusion, tissue, heart, heart valve, heart/lung, lung (single or double), kidney/pancreas, pancreas and liver transplants, subject to the following:

a) An eligible transplant procedure must be (1) approved for Medicare coverage on the date the transplant is performed; and, (2) are not otherwise excluded under the Plan, e.g., the procedure is not experimental or investigational treatment.

A transplant procedure must be performed at a Transplant Facility in order to be considered an eligible expense. A “Transplant Facility” is a hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a transplant and:

• for organ transplants, it is an approved member of the United Network for Organ Sharing for such transplant or is approved by Medicare as a transplant facility for such procedure;

• for unrelated allogeneic bone marrow or stem cell transplants, it is a participant in the National Marrow Donor Program;

• for autologous stem cell transplants, it is approved to perform such transplant by (a) the state where the transplant is to be performed; or (b) Medicare; or, (c) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient facilities must be similarly approved.

• Skin and cornea transplants are also eligible but are not subject to the above limitations.

b) If both the donor and recipient are covered by the Plan, each shall have benefits computed in accordance with the provisions of his/her own coverage.

c) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient’s eligibility for benefits under the Plan.

1) Maximum Organ Procurement Benefit Non-living Donor: $10,000.00 during any Transplant Period.

2) Maximum Organ Procurement Benefit Living Donor: $25,000.00 during any Benefit Year.

d) If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

e) The Plan will pay for travel, lodging and meals as follows:
1) Transportation for the patient and one companion to accompany the patient to and from a transplant facility. If the patient is a minor child, the transportation expenses of two companions will be covered.

2) Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one (1) companion (two (2) companions for a minor child) who accompanied the patient.

3) Travel and lodging expenses are covered only if the transplant recipient resides more than fifty (50) miles from the transplant facility. Transportation, lodging and meal costs are limited to $200 per day and $10,000 per transplant.

f) Re-transplantation expenses for one (1) re-transplant, for a total of two (2) transplants per person, per lifetime while covered under this Plan.

g) The Plan will pay for Private Duty Nursing Benefit: $10,000.00 per Transplant Period.

h) The Plan will pay for Therapeutic care including speech, occupational and physical therapies.

1. **Vision Care:**

   Basic contacts and non-designer eyeglasses: Up to Age 21 benefits are 100% annually. Age 21+ benefits are first dollar benefit, limited to $100 per participant every year. Vision Examination 100% Benefit. When performed by an ophthalmologist, optometrist or optician, or any other qualified person licensed by the State of Illinois to conduct vision examinations.

   Healthcare Plan pays for first pair of non-designer eyeglasses following cataract surgery; subject to deductible, co-insurance and network requirements.

   Vision examinations, lenses, and frames, or contact lenses received before the participant's effective date of vision benefits, or after termination from the Plan, are not covered. **Payment for frames, lenses, or contact lenses will not be made until these items are received by the participant.**

2. **Well-Baby Care and Physical Exams:**

   Exams performed by a PPO provider are paid at 100% (see your Wellness Program for details). Non-preventive (diagnostic) services are subject to Deductible and Co-insurance. Subject to Reasonable and Customary Allowance. Services per American Association of Pediatrics www.aap.org

3. **Wellness Program:**

   Preventive Care Services performed by a PPO provider are paid at 100% (see your Wellness Program or go to [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html) for a complete list of covered services). Non-preventive (diagnostic) services are subject to Deductible and Co-insurance. Out-of-Network (Non-PPO) services are subject to Deductible and 50% Co-insurance. Subject to Reasonable and Customary Allowance.
9.00 The following services and charges incurred for the same are limited or excluded from benefits of the Plan. The HR Generalist-Health & Risk and County Administrator will have the full authority to determine whether or not the service and charges for the same fall within the exclusion section of the Plan.

9.01 Cosmetic surgery (as defined in Section 29) and related services and supplies, EXCEPT for the correction of congenital deformities evidenced and diagnosed within ten years of birth, or for conditions resulting from traumatic injuries received, illness or diseases suffered while covered under this Plan. Refer to Section 8.05 for coverage under the Breast Reconstruction Act following mastectomy.

9.02 Experimental and investigational services and procedures. (except as specified elsewhere in this Plan. See Sections 8.09 and 29).

9.03 Those services and supplies not necessary for treatment or not recommended by the attending physician.

9.04 Charges which exceed the Reasonable and Customary Allowance.

9.05 Charges made only because there is coverage, but which are not medically necessary.

9.06 Charges that a Covered Participant or Participant’s dependent is not legally obligated to pay.

9.07 Custodial care (i.e.: companions, non-medical care).

9.08 To the extent allowed by the law of the jurisdiction where the description of the Plan is delivered, those for services and supplies:
   a) furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any participant in the armed forces of a government; or
   b) furnished, paid for, or for which benefits are provided or required under any law of government.
      (This does not include a plan established by a government for its own employees or their dependent).

9.09 The law of the jurisdiction where a participant lives when a benefit request occurs may prohibit certain benefits. If so, they will not be paid.

9.10 Hearing aids or similar aid devices.

9.11 Hearing tests (except when ordered by a physician for the diagnosis and/or treatment of an illness; except for newborn hearing test as required under PPACA Preventive Covered Services).

9.12 Orthopedic or orthotic braces or appliances prescribed by a physician that are fabricated or designed to support the feet.

9.13 Birth control methods used to terminate an existing pregnancy including elective abortions. All contraceptive methods, sterilization procedures, and patient counseling approved by the United States Food and Drug Administration for use to prevent pregnancy are covered (see Section 8.29).

9.14 Treatment of infertility or restoration or enhancement of fertility, including but not limited to fertility drugs, techniques of in-vitro fertilization including G.I.F.T. procedures and techniques or artificial insemination, reverse sterilization procedures.

9.15 Vitamins, prescribed and over-the-counter (except as specified elsewhere in this Plan).

9.16 Sickness or injury arising out of or in the course of any occupation or employment for wage or profit or for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law, occupational disease law or similar law.

9.17 Hair transplants and non-human organ transplants.

9.18 Genetic testing (except as determined medically necessary by Utilization Review for treatment of a medical condition or symptoms; or as required under PPACA Preventive Covered Services).

9.19 Service agreements, maintenance agreements, or any other service expenses for the repair or maintenance of rented or purchased durable medical equipment.

9.20 Acupuncture.

9.21 Alternative, non-medical procedures.
9.22 Charge for service, supplies or treatments not recognized by the American Medical Association ("AMA") as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the AMA as having no medical value, or drugs not approved by the United States Food and Drug Administration.

9.23 Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with custodial care, education or training, or expenses actually incurred by other persons who are not Plan Participants.

9.24 Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the Armed Forces of any country, or with a civilian non-combatant unit serving with such forces.

9.25 Injury or Sickness sustained: (i) during the voluntary participation in a riot or the commission of an illegal act or crime, whether or not indicted or convicted, or (ii) while operating a motor vehicle under the influence of alcohol or other drug or controlled substance which is not taken as prescribed by a Physician. For purposes of this section, a person shall be presumed to be under the influence of alcohol if his blood-alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the Injury occurred. In addition, a person may be considered to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the Employer or Contract Administrator.

The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained.

9.26 Diagnostic testing unless prescribed by a personal or attending/consulting physician.

9.27 In a Veterans' Administration Hospital, unless required by law or regulation.

9.28 For treatment of Temporomandibular Joint Dysfunction/Pain Syndrome ("TMJ"). (See Section 10.022 k), except as specified elsewhere in this Plan).

9.29 Biomicroscopy, field charting or anisejkonic investigation.

9.30 Orthoptic or visual training.

9.31 I Q testing or other testing or training done for educational purposes.

9.32 Surgical and non-surgical treatment rendered to eliminate the need for corrective lenses.

9.33 Co-insurance under the prescription drug card is not covered under the medical portion of the Plan (it is applied to the Maximum Out-of-Pockets required under the ACA and IRS).

9.34 If admitted to a hospital on any Friday, Saturday or Sunday except if medically necessary and recommended by a doctor, due to an emergency, or if a surgical procedure is performed the day you are admitted.

9.35 Charges by a healthcare provider who is a relative of you or your spouse/civil union partner as defined in Section 29.

9.36 Charges for which confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual sickness or injury (except as specified elsewhere in the plan).

9.37 Services or supplies not mentioned in the Plan.

9.38 Diagnosis or treatment of impotence or erectile dysfunction, including but not limited to, therapeutic injections, oral medication therapy, hormonal therapy and other drugs, surgery, implantation devices, and supplies, unless otherwise stated in the plan.

9.39 Expenses incurred for special education or training for learning disabilities, testing or training for education or vocation, or speech therapy including evaluation and treatment for other than acute traumatic injury or physical defect or swallowing (except as specified elsewhere).

9.40 Services and supplies (including but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports related activity or solely for maintaining a muscle, bone, or joint function.

9.41 Charges incurred outside of the USA if the covered person/dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.
9.42 Prescribing and fitting of an artificial eye after the initial prescription and fitting.
9.43 Except as specified elsewhere in the Plan, weight loss programs, dietary supplements, food supplements or food.
9.44 Weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses, or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes or other devices for support of the feet.
9.45 Purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, or mattresses or waterbeds.
9.46 Purchase or rental of motorized transportation equipment, escalators, or elevators, saunas, steambaths and swimming pools.
9.47 Sex transformation and hormones related to such treatment.
9.48 Radial keratotomy or keratoplasty.
9.49 Chelation Therapy
9.50 Expenses covered by auto, property and casualty or liability insurance or for which another party is liable.
9.51 Complications of pregnancy and pre-natal and post-natal care of mother and child where the mother has failed to obtain pre-natal medical care by the end of the second trimester and it is determined as a reasonable degree of medical certainty that timely pre-natal care would have avoided or reduced the severity of the pregnancy complications and pre-natal and post-natal conditions requiring additional medical care.
10.01 Under the County’s Plan, each covered participant is given two (2) free preventative dental services per year. Failure to obtain at least one (1) exam per year will result in 50% reduction of Primary and Major dental benefits during the next calendar year.

10.01 a) Preventative Dental Service: 100% Payment up to Reasonable and Customary Allowance. Deductible and co-insurance is waived.

10.01 b) Primary Dental Services: 80% Payment up to Reasonable and Customary Allowance. Age 21+ Subject to Deductible. (20% Co-insurance and the deductible amount do not apply to out-of-pocket expenses limit).

10.01 c) Major Dental Services: Up to Age 21 – 80% no deductible. Age 21+ 50% after the deductible. Payment up to Reasonable and Customary Allowance. (Co-insurance and the deductible amount do not apply to out-of-pocket expenses limit).

10.01 d) Orthodontics: Up to Age 21 – 80% no deductible. Payment up to Reasonable and Customary Allowance. (20% Co-insurance does not apply to out-of-pocket expenses limit). Orthodontic benefits are only covered for individuals Up to Age 21.

10.01 e) PPACA In-Network Maximum Out-of-Pocket Up to Age 21 Dental and Orthodontics Co-insurance Out-of-Pockets will accumulate toward the PPACA In-Network Maximum Out-of-Pocket under Sec. 4.041.

**Pre-treatment estimate for services in excess of $500 is recommended**.

10.02 Definitions

10.021 Preventative dental services are defined as:

a) routine oral examinations, up to two (2) visits in a calendar year. (Failure to obtain at least one (1) exam will result in 50% reduction of Primary and Major dental benefits during the next benefit year);

b) routine cleaning & polishing, prophylaxis up to a maximum of two (2) treatments per calendar year;

c) topical fluoride application (to age nineteen (19)), up to a maximum of two (2) treatments per calendar year;

d) bitewing x-rays and full-mouth x-rays once a calendar year; and

e) sealants applied to permanent molar teeth of participants under age fifteen (15), but not more than one (1) application in any thirty-six (36) month period.

10.022 Primary dental services (routine) are defined as:

a) fillings; consisting of amalgam, silicate and plastic restorations;

b) extractions;

c) oral surgery;

d) endodontics;

e) space maintainers;

f) apicoectomies;

g) emergency treatment for relief of pain, including antibiotic injections;

h) periodontics, including gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontic examination, mucogingivoplasty surgery and management of acute periodontal infection and oral lesions, including perio prophylaxis;
i) repair and relining of removable dentures;

j) re-cementing of crowns, inlays and bridges;

k) charges for the treatment of Temporomandibular Joint Dysfunction/Pain Syndrome ("TMJ") if CPT coded and Utilization Review approved, and with an annual limit of $600;

l) general anesthesia, if administered in conjunction with performance of another covered dental procedure;

m) oral exams and x-rays which are other than routine in nature;

n) pulp vitality tests one (1) per year; and

o) hemisection.

10.023 Major dental services are defined as:

a) inlays, onlays, and crowns or crown buildups (except for temporary crowns);

b) bridges and bridge repair;

c) full and partial dentures;

d) gold foil restorations;

e) orthodontics; and

f) denture adjustments and relining during first six (6) months after obtaining dentures or having them repaired.

10.03 Major Dental Expenses

It is strongly recommended that your service provider submit a pre-treatment Plan for services estimated to be in excess of $500.00.

Also see Penalty 13.01 (f).
11.0 Covered Dental Charges do not include charges for services and supplies:

11.01 Not ordered by a doctor.

11.02 Which do not meet the standards set by the American Dental Association.

11.03 In a Veterans’ Administration Hospital, unless you would legally have to pay such charges.

11.04 Due to theft or loss of an appliance.

11.05 Which you would not legally have to pay if there was no coverage.

11.06 Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the Armed Forces of any country, or with a civilian non-combatant unit serving with such forces.

11.07 Which are payable by a local or other agency of a government, except Illinois medical aid (Medicaid).

11.08 For cosmetic reasons, except as a result of accidental injury, including altering or extracting and replacing sound teeth to change appearance.

11.09 For dental work on dentures or bridges except as shown under “Covered Dental Charges”.

11.10 Tooth implants.

11.11 Athletic mouth guards.

11.12 Oral hygiene, dietary, plaque control and other educational expenses.

11.13 Duplicate prosthetic appliances.

11.14 Sickness or injury arising out of or in the course of any occupation or employment for wage or profit or for which the Covered Person or Covered Dependent is entitled to benefits under any workers’ compensation law, employers’ liability law, occupational disease law or similar law.

11.15 The placement of crowns, inlays, dentures, or bridges or the relining of dentures more than once per consecutive five (5) year period for the same teeth, unless they can not be repaired and made serviceable.

11.16 For any service, supplies or treatments that may have been eligible under the medical portion of the Plan.

11.17 Services provided by your or your spouse/civil union partner’s immediate family or family of origin.

11.18 Oral surgery services related to a congenital deformity except when evidenced and diagnosed within ten years of birth, or for conditions resulting from traumatic injuries received, illness or diseases suffered while covered under this Plan.
## PENALTIES

<table>
<thead>
<tr>
<th>13.01</th>
<th>PENALTY REASON</th>
<th>AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>13.01 a)</td>
<td>Covered In-patient Admission to a NON-PPO Hospital.</td>
<td>$1,000</td>
</tr>
<tr>
<td>13.01 b)</td>
<td>*Inappropriate Use of the Emergency Room (see Section 15).</td>
<td>$150</td>
</tr>
<tr>
<td>13.01 c)</td>
<td>Failure to PRE-CERTIFY a covered In-Patient Admission, a covered Out-Patient Surgical Procedure of $500 or more, or a non-emergency CAT Scan, MRI or PET Scan.</td>
<td>$250</td>
</tr>
<tr>
<td>13.01 d)</td>
<td><strong>Use of a NON-PPO Facility for a covered Out-Patient Procedure over $500.</strong></td>
<td>$250</td>
</tr>
<tr>
<td>13.01 e)</td>
<td>Failure to CERTIFY a covered Emergency Admission within seventy-two (72) hours, or a covered Psych or Substance Abuse admission within twenty-four (24) hours.</td>
<td>$250</td>
</tr>
<tr>
<td>13.01 f)</td>
<td>Failure to obtain at least one (1) dental exam will result in 50% reduction of Primary and Major dental benefits during the next benefit year.</td>
<td>50% Reduction in Benefits</td>
</tr>
<tr>
<td>13.01 g)</td>
<td>Pre-certification of pregnancy and receipt of Pre-Natal Care by the end of the second trimester is mandated for the welfare of the mother and unborn child.</td>
<td>Possible reduction in benefits</td>
</tr>
<tr>
<td>13.01 h)</td>
<td>Maternity admission must be certified within twenty-four (24) hours or a delay in payment of claims may result.</td>
<td>Possible delay in payment</td>
</tr>
</tbody>
</table>

*The HR Generalist-Health & Risk will assess the situation if, after Utilization Review, there is a question of appropriateness.

**This penalty does not apply to a covered out-patient surgical procedure that can safely be performed in the physician’s office.

13.02 a) In order to avoid a penalty assessment, please follow the provisions set forth in this Plan. The Plan Administrator hopes that no one will be assessed a penalty.

13.02 b) Penalties will be deducted from the amount of claims eligible for payment at the time the eligible claims are processed.

13.02 c) Exclusions to the Penalty assessment are listed under Section 13.03.

13.02 d) Penalties will not apply towards a Deductible or Co-Insurance amounts.

13.02 e) Appeals of penalties must be made in writing to the Plan Administrator for consideration. The HR Generalist-Health & Risk can assist you in determining your rights.

13.02 f) In order to prove the pre-certification was completed on your part, please note the date of your telephone call and the name of the person with whom you spoke.

***IF IN DOUBT, CALL THE HR GENERALIST-HEALTH & RISK @ (309) 672-6071 FOR ASSISTANCE***
PENALTIES DO NOT APPLY IN THE FOLLOWING SITUATIONS:

13.03 a) If the County’s Plan is Secondary and the network guidelines of the Primary Plan are being followed.

13.03 b) If an Emergency Admission is certified within seventy-two (72) hours after admission.

13.03 c) If the services are not available at a PPO Facility and are referred to a NON-PPO by the PPO provider.

13.03 d) A court order requires treatment at a NON-PPO facility.

13.03 e) The Patient is referred to a Center of Excellence through Utilization Review.

13.03 f) The primary Participant is a Non-Custodial Parent of a dependent and is unable to influence the place of treatment.

13.03 g) The Participant suffers an emergency as defined in Section 15 and goes to the nearest hospital or other medical facility inside or outside the fifty (50) mile radius.

13.03 h) Participating retirees permanently residing outside the fifty (50) mile radius, Students attending school outside the fifty (50) mile radius and in the case of an emergency as defined in Section 15, or when prompt treatment is medically necessary as defined in Section 5, any Participant temporarily residing or traveling outside the fifty (50) mile radius other than traveling and/or residing for the primary purpose of receiving medical or other care covered by this Plan.
15.01 Below is a generally accepted list of emergency conditions or symptoms for which emergency room services may be required. If you or your dependent experiences any of the following conditions or symptoms and the emergency room report documents such, no penalty will be imposed for usage of the emergency room as indicated in Section 13.

15.01 a) Life or limb could be lost if symptoms are left untreated;
15.01 b) You have uncontrolled seizures, chest pain, difficulty breathing, or the possibility exists of heart attack or stroke;
15.01 c) There could be harm to an unborn child;
15.01 d) You are involved in an industrial accident involving severe burns or chemical exposure;
15.01 e) The condition is life-threatening;
15.01 f) You have uncontrolled bleeding;
15.01 g) Admission to the hospital;
15.01 h) You are experiencing the sudden onset of severe abdominal pain, nausea and vomiting;
15.01 i) You suffer the sudden onset of an unexplained headache.

15.02 Visit a Unity Point Clinic or Proctor First Care Methodist MedPointe if you are unable to visit your primary physician and experience any of the following:

- Cold
- Sore Throat
- Fever
- Upper Respiratory Difficulties
- Flu Symptoms
- Rash
- Sprained Ankle
- Minor Laceration
- Routine Non-Emergency Ailment
17.01 If a participant needs Hospital Care:

Pre-Certify with the Utilization Review Administrator, unless it is an emergency. Present Plan Identification Card when the participant enters the hospital. The participant may or may not need to fill out claim forms or report any hospital charges to the Claims Administrator. Most hospitals will bill the Claims Administrator directly and all covered services will be paid for the participant.

17.02 If a Participant Needs Physician Care:

The participant should show the Physician his/her identification card and request the physician to bill the Claims Administrator for all physician services to the participant which may be payable under this Plan—whether at his/her office, the participant’s home or in the hospital—indicating diagnosis, date(s) of service and fee(s).

17.03 Prescription Drugs:

When a physician prescribes medicine, use the preferred prescription program. (See "Exhibit A").

17.04 When to File a Claim:

The participant should file a claim as soon as she/he receives charges for services covered under the Plan. All claims relating to payment for a benefit covered by the Plan must be filed within ninety (90) days from the provider’s initial billing date, or within ninety (90) days of the primary carrier’s EOB should this Plan be secondary. A claim shall not be considered filed unless and until all required information relating to the service or benefit for which the claim has been filed has been provided to the Claims Administrator.

17.05 How to File a Claim:

All claims should be filed as promptly as possible after the date the expense was incurred. Most providers will bill the Claims Administrator for you, but sometimes the provider of healthcare services does not bill the Claims Administrator directly and bills the participant for such services as:

a) Physician Care;

b) Blood and blood Plasma;

c) Diagnostic X-ray and Laboratory Examinations;

d) Rental of Medical Appliances or Durable Medical Equipment; or

e) Ambulance Services.

CLAIMS FILED AFTER NINETY (90) DAYS FROM THE INITIAL BILLING DATE WILL BE DENIED. BENEFITS REQUESTS MAY NOT BE COVERED AFTER THIS PERIOD OF TIME.

17.06 Assignment of Benefits:

Benefits are automatically assigned and will be paid directly to the hospital, physician or other provider of healthcare services, unless the bill indicates that it has already been paid. IF THE PARTICIPANT HAS ALREADY PAID THE BILL, INDICATE THIS FACT CLEARLY WHEN THE CLAIM IS FILED.

17.07 Annual Enrollment:

The Primary Participant must submit an enrollment/waiver form each calendar year during the Open Enrollment period.
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RESERVED
19.01 Coordination of Benefits ("COB") applies when you have healthcare coverage through more than one healthcare plan. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled, but no more than the Plan would have paid without this provision. The total payment from all health Plans will not exceed more than this Plan would have paid without this special provision. It is your obligation to notify the Plan Administrator about coverage under other benefit plans. **Failure to do so which results in double or overpayment may constitute Criminal Fraud for which you will be prosecuted.**

19.02 When you are covered by more than one group healthcare plan, the following Coordination of Benefits provision applies, these following rules will be used to determine which plan will be the first to pay its benefits:

19.02 a) The plan that covers the person as an employee, primary participant or as the certificate holder is the plan that pays first. This plan is called the "primary plan." The plan that covers the person as a dependent spouse/civil union partner or other dependent is the plan that pays second. This plan is called the "secondary plan."

In the case of a participant retiree who was employed elsewhere and is covered under another plan as a retiree, the plan which covered the retiree for the longest period of time shall be the primary plan. If a participant retiree is employed and is covered under the new employer plan, our plan is secondary.

19.02 b) If a dependent child is covered by both participating parents’ plans, the plan covering the parent whose birthday falls earlier in the year pays first.

19.02 c) When the parents are divorced: If there is a court decree which established financial responsibility for the medical, dental or other healthcare expenses with respect to the dependent child, the benefits are determined in agreement with the court decree. In the absence of a court order, the "Birthday Rule" will be applied to the natural parents to determine which plan will be primary.

19.03 When another plan covers the participant, exact duplicates of all bills being submitted to each carrier or administrator involved should be sent to assist the plans in coordinating benefits without a lengthy delay. If the Plan is paying as the secondary plan, the Claims Administrator must be notified of the amount(s) paid by the primary plan before this Plan’s payment can be made.

19.04 If none of the above COB rules apply, a plan is Primary if it has covered the individual upon whose behalf the claim is made, for the longer period of time.

19.05 In the absence of COB provisions in other plans, this Plan’s provisions will be followed.
20.01 If you are in Active Service as an employee of the County of Peoria, and covered under the Plan for medical, dental, vision, and prescription drug benefits, this Plan will determine its benefits without taking into account Medicare benefits for which you or your covered spouse/civil union partner are eligible unless required by law (i.e. kidney dialysis). However, upon retirement, Medicare will become the primary payor and this plan’s benefits will be secondary, regardless of enrollment.

Pursuant to COBRA ’93 (Effective August 10, 1993):

20.01 a) MEDICARE

1) This Plan will be considered the primary plan for Primary Participants who are in Active Services, and their participating Dependents, who are nevertheless eligible for Medicare benefits if: (i) such Primary Participant or participating Dependents are age sixty-five (65) or older; or (ii) such Primary Participant or participating Dependents are disabled.

2) This Plan shall be considered the primary plan during the first thirty (30) months of coverage for End Stage Renal Disease unless the Primary Participant or participating Dependent rejects coverage under this Plan. After thirty (30) months, Medicare shall be considered the primary plan.

20.01 b) MEDICAID

Payments for expenses with respect to a Primary Participant or participating Dependent under this Plan will be made in accordance with any assignments of rights made by or on behalf of such Covered Participants or Covered Dependents as required under applicable provisions of Medicaid.
The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

f) Make available protected health information in accordance with 45 C.F.R. 164.524;

g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. and other applicable state or federal laws. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.
CLAIMS PROCEDURE AND APPEAL PROCESS

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any Rescission or request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

**Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

<table>
<thead>
<tr>
<th>Notification to claimant of benefit determination</th>
<th>72 hours</th>
</tr>
</thead>
</table>

**Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:**

<table>
<thead>
<tr>
<th>Notification to claimant, orally or in writing</th>
<th>24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response by claimant, orally or in writing</td>
<td>48 hours</td>
</tr>
<tr>
<td>Benefit determination, orally or in writing</td>
<td>48 hours</td>
</tr>
</tbody>
</table>

**Ongoing courses of treatment, notification of:**

<table>
<thead>
<tr>
<th>Reduction or termination before the end of treatment</th>
<th>72 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination as to extending course of treatment</td>
<td>24 hours</td>
</tr>
</tbody>
</table>

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.
Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification.

In the case of a Pre-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 15 days
- Extension due to matters beyond the control of the Plan: 15 days

Insufficient information on the Claim:

- Notification of: 15 days
- Response by claimant: 45 days
- Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim: 5 days

Ongoing courses of treatment:

- Reduction or termination before the end of the treatment: 15 days
- Request to extend course of treatment: 15 days

Review of adverse benefit determination: 15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Extension due to insufficient information on the Claim: 15 days
- Response by claimant following notice of insufficient information: 45 days
- Review of adverse benefit determination: 30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of adverse benefit determinations to the claimant.
any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The Claim involved including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings; the Plan's applicable standards; and, if an appeal, a discussion of the Plan's decision.

2. The specific reason or reasons for the adverse determination.

3. Reference to the specific Plan provisions on which the determination was based.

4. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

5. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.

6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan will provide the claimant, as soon as practicable, upon request, the diagnosis code and treatment code and their corresponding meanings. A request for these codes will not, in themselves, be considered an appeal.

7. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

8. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator for consideration by the Plan Administrator. A claimant may submit written comments, documents, records, and other information relating to the Claim and if desired may present evidence and testimony regarding the Claim to the Plan Administrator. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim as soon as possible and sufficiently in advance of the date the appeal must be decided. Before the Plan can issue a final adverse benefit determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date the appeal must be decided.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the benefit determination;
(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination, nor the subordinates of any such professional. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be appropriately identified to the claimant.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, personnel decisions, or other similar decisions, will not be based upon the likelihood that an individual will support the denial of benefits.

The Plan will further ensure that:

(1) Any notice of adverse benefit determination or decision on appeal include information sufficient to identify the Claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, and the treatment code and their corresponding meanings. A request for this information will not, in itself, be considered an appeal.

(2) In the case of a decision on appeal, the notice shall include a discussion of the decision.

(3) The Plan will provide a description of available internal appeals and external review processes, including how to initiate an appeal and the availability of and contact information for any assistance or ombudsman to assist individuals with internal claims and appeals and external review processes.

External Appeals

When a claimant receives an adverse benefit determination on appeal for a claim involving a medical judgment or for a Rescission, the claimant has 4 months after the date of receipt of a notice of denial of the appeal in which to file a request for an external review of the adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the 5th month following the receipt of the notice.

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(1) The claimant is or was covered under the Plan at the time the Claim was incurred;
The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process applicable law; and

The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan must allow the claimant to perfect the request for external review within the 4-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure independence. The Plan will contract with at least three IROs for assignments under the Plan and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO must provide the following:

1. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

2. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

3. Within 5 business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

4. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

5. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(a) The claimant's medical records;
(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;

(d) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(7) The assigned IRO's decision notice will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the Claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(f) A statement that judicial review may be available to the claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(8) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
23
SUBROGATION
And
THIRD PARTY RECOVERY

23.01 Subrogation:
If you or one of your covered dependents is injured by the act or omission of another person and benefits are provided for covered services described in this Plan, and if you or one of your covered dependents has a claim against that other person for payment of the medical or dental charges, the Plan will be subrogated to all rights the covered person may have against that other person.

You or your covered dependents must immediately reimburse the Plan 100% for any payments received, whether by action at law, settlement, or otherwise, to the extent that the Plan has provided benefits to you or your covered dependents; and the Plan will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the injury, the person’s agent or a court having jurisdiction in the matter.

It is your responsibility to execute and deliver in writing all required information to reimburse and provide the Plan a first lien and assist or provide any other documents that the Plan may request in order to secure the right of subrogation.

Only the amount recovered for medical or dental charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of medical or dental benefits paid for the injury under the Plan.

This right of subrogation and refund also applies when a covered person recovers under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan or any liability plan.

23.02 Third Party Recovery:
If any services or treatment are related to an injury or illness due to another person’s negligence for which you may seek recovery from a third party, your Plan will pay its normal benefits provided you agree, in writing, to reimburse the Plan 100% of the benefits so provided when you receive payment from the third party. This provision also applies to any payments made under an automobile insurance policy because of “no fault” automobile legislation.

23.03 Excess Insurance Provision
If at the time of injury or sickness there is available, or is potentially available, based on information known or provided to the Plan Administrator, the Contract Administrator, Plan Participant, any other insurance, or other form of indemnification, including but not limited to a judgment at law or settlement, the benefits under this Plan shall apply only as excess insurance over such other sources or indemnification; by way of illustrating but not in limitation, this provision shall be applicable to those Expenses incurred as the result of Sickness or Injury when:

a) the Plan Participant is injured by or in the course of operating a motor vehicle;

b) the Plan Participant is injured on the premises insured by the owner or occupier for indemnification;

c) the Plan Participant is injured by a third-party tortfeasor; or

d) the Plan Participant is injured while maintaining the status of a full-time student.

If, in the discretion of the Plan Administrator, payment of medical expenses is made when the provisions of this Section apply, or at a time when such provisions may later become applicable, said payment may be made on the condition that the Plan Participant or Participating Dependent agrees in writing to:

a) reimburse the Plan one hundred percent (100%) of the benefits actually provided without reduction for, or application of, the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, immediately upon collection of damages by him, whether obtained by action at law, settlement, or otherwise; and

b) provide the Plan with a first lien to the extent of benefits provided by the Plan. Said lien may be filed with any person or organization liable, or potentially liable, to the Plan Participant for indemnification, the Plan Participant’s attorney, or the court.
24.01 Termination of Coverage:
Coverage for a Covered Employee shall automatically terminate except as provided in Section 25, upon the earliest of the 15th or the last day of the month in which any of the following events occur:
  a) Employee fails to meet the eligibility requirements.
  b) Employee fails to make any required contribution for coverage.
  c) Employee terminates employment with the County of Peoria.
  d) Employee requests in writing the termination of coverage. (Employee must wait until annual enrollment period to rejoin the Plan).
  e) Employee fails to renew coverage for the following year; coverage will terminate as of January 1.
  f) Death.

24.02 A dependent’s coverage shall automatically terminate except as provided in Section 25, upon the earliest of the 15th or the last day of the month in which any of the following events occur:
  a) The dependent is no longer eligible as defined in this Plan.
  b) Employee’s coverage terminates.
  c) Employee fails to make any required contribution for coverage.
  d) Employee requests, in writing, termination of dependent coverage. Such request must be co-signed by his or her spouse/civil union partner, or former spouse/civil union partner having custody of dependent children.
  e) Death
  f) Dependent becomes eligible to be covered as an employee.

In the event that the entire Plan terminates or the Plan terminates all dependent coverage, coverage will terminate on the date of the termination made by the Plan.

24.03 The Plan may retroactively rescind coverage on participants due to fraud or material misrepresentation of facts. Participants have the right to appeal in writing within 30 days of notification.
25.0 **Termination of Employment Primary Participant/Continuation Rights of Participating Dependents**

25.01 If you are an inpatient at the time your coverage under this Plan is terminated, benefits will be provided for, and limited to, the covered services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, or Psychiatric Day Treatment Facility. Benefits will be provided until you are discharged or until twelve (12) months have passed since the date coverage would otherwise terminate, whichever occurs first. In any event, required premium payments must continue.

25.02 **Continuation of Benefits under COBRA:**

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specific conditions.

For the purpose of this Section, “Qualified Beneficiary” means any beneficiary defined as such pursuant to Section 300bb-8(3) of Public Health Service Act (PHSA), 42 U.S.C.A. § 300bb-8(3), and which generally includes any participant whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this section.

25.021 **Eligibility to Make Election:**

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

25.021 a) The Primary Participant’s death;

25.021 b) Termination of the Primary Participant’s employment or reduction of the Primary Participant’s hours (whether voluntary or involuntarily);

25.021 c) Divorce of the Primary Participant and his/her spouse/civil union partner;

25.021 d) A Primary Participant’s child ceasing to be an Eligible Dependent; or

25.021 e) A proceeding in bankruptcy under Title II, United States Code, commencing on or after July 1, 1986, with respect to the Employer.

25.022 Not withstanding the above, a Qualified Beneficiary is not entitled to elect continuation of coverage if the participant’s termination of employment is for gross conduct as determined by the Employer in its sole discretion, pursuant to a uniform, nondiscriminatory policy. In the case of bankruptcy proceedings as described in (e) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceeding.

You should carefully review the COBRA NOTICE attached hereto as "Exhibit C".

25.03 **Health Insurance Marketplace Options for You and Your Family**

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace visit www.healthcare.gov.

25.04 **Continuation of Coverage upon a Primary Participant’s death (Survivors):**
25.04 a) In the event of your death while you are covered as a Primary Participant of the Plan Sponsor, your surviving dependents* enrolled in the plan may continue coverage until the end of the month in which the death occurs, plus the following three (3) calendar months at no contribution (at no cost), or until the dependent is eligible to be enrolled in another group plan, whichever occurs first.

25.04 b) Coverage may also be continued under legislation commonly referred to as COBRA. See attached COBRA documents "Exhibit C". Continued participation is contingent upon payment of the required monthly premium and will be subject to the eligibility requirements set forth in this plan.

25.04 c) In circumstances not specifically covered in this Plan, coverage may also be continued for yourself and your dependents consistent with the personnel policy or State of Illinois Laws applicable to you.

*Includes current pregnancy at the time of the Primary Participant’s death.

25.05 Continuation of Coverage while Primary Participant on Military Leave

In accordance with the Uniformed Service Employment and Reemployment Rights Act of 1994 ("USERRA"), continuation coverage under the Plan is available to Primary Participants and their Participating Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section described above.

25.05 a) Election and Duration of Coverage

A Primary Participant may elect to continue coverage under the Plan for himself and his Participating Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his service in the uniformed services. The maximum period of coverage available to all Primary Participants and Participating Dependents under the provisions of this Section shall be the lesser of:

(1) the eighteen (18) month period beginning on the date on which the Primary Participant’s military leave began; or

(2) the day after the date on which the Primary Participant fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

25.05 b) Benefits

Benefits under the Plan for Primary Participants and Participating Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Primary Participants and Participating Dependents. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Primary Participants and Participating Dependents.

25.05 c) Payment for Benefits

A Primary Participant is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or scheduled of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Primary Participant’s failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Primary Participant shall be precluded from extending, renewing or reelecting such continuation coverage.

25.05 d) Employee Returning from Military Leave
In the case of a Primary Participant whose coverage under the Plan was terminated by reason of service in the uniformed services, the Primary Participant and his Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to Full-time Employment. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

25.06 Retirees:

All employees (and applicable dependents) have a right to continuation coverage under the Peoria County Health Care Plan as retirees if they participate in the Peoria County IMRF retirement and disability plan.

A few employees qualify for different retirement health care coverage under their respective collective bargaining agreements. Each individual employee must consult their applicable collective bargaining agreement to determine if any of these specific plans apply to them.

A Participating Retiree will automatically be enrolled in the IMRF Medicare Eligible Plan at the time they (and their applicable dependents) become eligible for Medicare. You should contact a Social Security office as soon as you or your dependent become eligible for Medicare.

The continuation coverage mandated for those under the IMRF makes available continuation coverage at full premium during the “retirement or disability”. Specifically as set forth in the applicable statute as follows:

(4) The “retirement or disability period” of an employee means the period:

(A) which begins on the day the employee is removed from the municipality payroll because of the occurrence of either of the following events: (i) the employee retires from active service as an employee with an attained age and accumulated creditable service which together qualify the employee for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code, or (ii) the employee’s disability is established under Article 7 of the Illinois Pension Code; and

(B) which ends on the first to occur of any of the following events: (i) the employee’s reinstatement or reentry into active service as provided for under Article 7 of the Illinois Pension Code, (ii) the employee’s exercise of any refund option or acceptance of any separation benefit available under Article 7 of the Illinois Pension Code, (iii) the employee’s loss pursuant to Section 7-219 of the Illinois Pension code of any benefits provided for in Article 7 of that Code, or (iv) the employee’s death or, if at the time of the employee’s death the employee is survived by a spouse/civil union partner who, in that capacity, is entitled to receive a surviving spouse/civil union partner’s monthly pension pursuant to Article 7 of the Illinois Pension Code, the death or remarriage of that spouse/civil union partner.

25.07 Certain Health Department Employees/Retirement Coverage:

Prior to joining the Peoria County Self Insured Health Plan, the City/County Health Department provided Employer paid Health Care coverage during retirement. When the Health Department joined the County Plan, it was agreed that twenty-two (22) long standing employees would be “grandfathered” and have the right to maintain retirement Health coverage with the County paying $486.46 of each Premium (80% of the Premium in effect on December 31, 2004), and the employee paying any remaining portion of each Premium. The requirements are:

a) enrolled in the Peoria County Health Benefit Plan; and

b) have at least twenty (20) years of service with the department may continue single coverage under the County’s Plan, except for the dental coverage, upon retirement under the rules of the Illinois Municipal Retirement Fund.
25.08 S.L.E.P. LAW ENFORCEMENT RETIREES:

The County will provide continued coverage of the Peoria Health Benefit for employees who meet the retirement eligibility criteria – of (a) having at least twenty (20) years of service with the Sheriff’s Department as a commissioned officer and (b) meets the S.L.E.P. required minimum retirement age of fifty (50) years old and retires at the same rate as paid by active employees. Employees who retire after December 31, 1993 will pay all of the premium cost (100%) as a member and all of the premium cost (100%) for dependent coverage.

25.1 Upon Leaves of Absence, Disability, Maternity, Medical, Military Reserve, and Workman’s Compensation

25.11 Participating employees who take either a single or a combination of leaves by reason of disability, maternity, medical extended illness, military reserve training, and workman’s compensation have a right to continued coverage at the employee’s rate up to one year. Maternity leave, however, is limited to the period of time which is medically necessary as determined by a physician. During any such period of leave of absence, the Primary Participant and Participating Dependents maintain all rights of enrollment and re-enrollment as if the Primary Participant were actively employed. Such period of leave, in most instances, will count towards the calculation of maximum extended coverage under COBRA. (See Section 25.02). Any questions concerning the actual duration of continuation coverage while on leave of absence should be directed to the HR Generalist-Health & Risk. **Please note that the failure to timely pay the employee rate premium while on any leave of absence will result in a termination of coverage pursuant to Section 3 and Section 24 of this Plan.**
26.01 In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Primary Participants and their Covered Dependents under certain specified conditions.

A Primary Participant who takes a leave of absence under applicable provision of FMLA is entitled to continued coverage under the Plan for him/herself and his/her Covered Dependents. Benefits under the Plan are available to the same extent as if the Primary Participant has been in Active Service during the entire leave period, subject to the following terms and conditions.

26.01 a) Coverage shall cease for a Primary Participant (and his/her Covered Dependents) for the duration of the leave if at any time the Primary Participant is more than thirty (30) days late in paying any required contribution. **COBRA does not apply.**

26.01 b) A Primary Participant who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same term as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

26.01 c) If a Primary Participant who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his absence, the Primary Participant’s entitlement to the Plan benefits continues unless and until the Primary Participant advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied. **COBRA may apply.**

26.01 d) Any portion of the cost of coverage which had been paid by the Primary Participant prior to the leave must continue to be paid by the Primary Participant during the leave. If the cost is raised or lowered during the leave, the Primary Participant shall pay the new rates. If the leave is unpaid, the Primary Participant and the Employer shall negotiate a reasonable means for paying the Primary Participant’s portion of the cost.

26.01 e) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Primary Participant is on leave, the Primary Participant is entitled to the new or changed plan and benefits to the same extent as if the Primary Participant were not on leave.

26.01 f) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Primary Participant fails to return to work after the Primary Participant’s leave entitlement has been exhausted or expires, unless the reason the Primary Participant does not return to work is due to (1) the continuation, recurrence, or onset of a serious health condition which would entitle the Primary Participant to additional leave under FMLA; or (2) other circumstances beyond the Primary Participant’s control. If a Primary Participant fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Primary Participant’s behalf during a period of unpaid leave, the Employer may require medical certification of the Primary Participant’s or the Covered Dependent’s serious health condition. The Primary Participant is required to provide medical certification within thirty (30) days from the date of the Employer’s request. If the Employer requests medical certification and the Primary Participant does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.
27.01 The plan shall comply with the terms of a Qualified Medical Child Support Order ("QMEDs") directing the Plan to provide benefits to one or more alternate recipients. The Order must be served on the Plan Administrator. The Administrator has twenty (20) days after receipt to make a preliminary determination as to whether or not the Order satisfies the requirements of a valid QMED.

In order to qualify as a QMEDs, a court order must contain, at minimum, the following information:

27.01 a) a clause which creates or recognizes the existence of a dependant’s right to receive benefits under the Plan;
27.01 b) the name and last-known mailing address of the covered person with respect to whom the order is issued and each dependent covered by the order;
27.01 c) the social security number of each dependent covered by the order;
27.01 d) a reasonable description of the type of coverage to be provided by the Plan to each dependent;
27.01 e) a clause which specifies that the order applies to the Plan, as well as the time period to which the order applies; and
27.01 f) a clause which states that the order does not require the Plan to provide any type or form of benefit not otherwise provided under the plan.

27.02 An order which, in the judgment of the Plan Administrator, does not meet the requirements of the QMED shall be returned to legal counsel who prepared the order, or to the employee, retiree, survivor or COBRA participant, for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.
28.01 **FUNDING THE PLAN AND PAYMENTS OF BENEFITS:**

Funding of the Plan is derived from the funds of the County of Peoria, outside groups and contributions made by the covered Primary Participants.

The amount of any participant contributions will be set by the Peoria County Board. These participant contributions will be used in funding the cost of the Plan as soon as practical after they have been received from the participant or withheld from the participant’s pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

28.02 **INVALID PROVISION:**

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Benefits are paid directly from the Plan through the Claims Administrator.

28.03 **GOVERNING LAW:**

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois, where it has been executed, except where preempted by federal law.

28.04 **EXCLUSIVE BENEFIT/LEGAL ENFORCEABILITY:**

The Plan has been established, and is being maintained, for the exclusive benefit of the participants of the County of Peoria’s Healthcare Plan. The Plan terms, as provided herein, are legally enforceable by the participants.

28.05 **NON-ALIENATION OF BENEFITS:**

Benefits payable under this Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse/civil union partner or former spouse/civil union partner or for any other relative of a Primary Participant or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

28.06 **TERMINATION OR AMENDMENT TO THE PLAN:**

The Peoria County Board intends to maintain this Plan indefinitely. This includes amending the benefits under the Plan.

The Plan may be amended, cancelled or discontinued at any time by the Peoria County Board, with or without the consent of any covered individual provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a participant shall have become entitled prior to such amendment or termination of the Plan. In the event of termination of the Plan, written notice of such termination and the rights of all plan participants shall be provided to all Participants in a timely manner. In the event of an amendment which affects any rights described in the Summary Plan Descriptions issued under the Plan, new booklets or notices showing the change will be distributed.

If the Plan is terminated, the rights of the participants are limited to expenses incurred before termination.
28.07 **OUTSTANDING CLAIMS AFTER TERMINATION OF THE PLAN:**

No benefits are available for services or supplies incurred after date of termination of the Plan except as otherwise specifically stated. Any outstanding or un-reimbursed claims incurred prior to the termination date of the Plan will be the responsibility of the Plan.

28.08 **LEGAL ACTION:**

No legal action can be brought to recover under any claim for payment of benefits after one (1) year from the time proof of loss is required by this Plan.

Benefit payment will not be reduced or denied on the grounds that a condition existed before a person’s coverage went into effect, if the loss occurs more than one (1) year from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss. In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.

28.09 **CLAIMS MISTAKENLY PAID:**

The Claims Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid in the basis of claims filed which were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with the Claims Review Procedures herein. A payment by the Claims Administrator in accordance with the Plan is not an admission by the Employer or Claims Administrator that the Expenses incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

28.10 **LIABILITY DISCHARGE**

Any payment by the Claims Administrator in accordance with these provisions if not timely appealed will discharge the Employer and the Claims Administrator from all further liability to the extent of the payment made.

28.11 **RIGHT TO RECEIVE AND RELEASE INFORMATION**

The Claims Administrator, pursuant to the reasonable exercise of its discretion, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Claims Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if they apply. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

28.12 **WITHHOLDING OF BENEFIT PAYMENTS**

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Claims Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer’s sole judgment is satisfactory to it, or until the Employer and Claims Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

28.13 **INDEPENDENT MEDICAL EXAMINATIONS**

The Plan Administrator will have the right and opportunity to request an independent medical examination of any Covered Participant who is requesting benefits consideration. This examination will be paid for by the Plan.
29.0  **Certain words and phrases have a special meaning in this booklet. The explanations that follow will help you understand your coverage.**

**ACCIDENT:** An unforeseen, undersigned, sudden, and unexpected event resulting in an injury, excluding events of intentional or reckless criminal acts by the Participant.

**ACTIVE EMPLOYMENT:** An individual will be considered in Active Employment on a day which is a scheduled work day if he/she is performing in the customary manner all of the regular duties of his/her employment either at his/her place of employment or at some location at which that employment requires him/her to travel, or if he/she is absent from work solely by reason of vacation or authorized absence (other than due to disability). An individual will be considered in Active Employment on a day which is not a scheduled work day only if he/she was performing in the customary manner all of the regular duties of his/her employment on the last preceding scheduled work day.

A dependent will be considered in Active Employment on any day if he/she is then engaging in all the normal activities of a person in good health of the same age and sex, and he/she is not confined in a medical facility. (This paragraph does not apply to a newborn child).

**AMBULANCE SERVICE:** Use of a vehicle for transportation of the sick and injured, equipped and staffed to provide medical care during transit.

**ANCILLARY CHARGES:** Reasonable and medically necessary inpatient facility charges not otherwise stipulated or excluded in the Plan.

**ANESTHESIA:** Partial or complete loss of sensation with or without loss of consciousness as a result of disease, injury or administration of an anesthetic agent, usually by injection or inhalation.

**BIRTHDAY RULE:** The plan of the parent whose birthday (month and day) occurs earlier in a calendar year will be the primary plan.

**BIRTH CONTROL:** Prevention of implantation of the ovum, or of birth, by temporary or permanent measures.

**CHEMOTHERAPY:** The treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs.

**CHIROPRACTOR:** A person certified and licensed to practice chiropractic care.

**CLAIM:** Notification that a service has been rendered or furnished to you. This notification must include full details of the service received and any other information which may be requested in connection with services rendered to you.

**CLAIM CHARGE:** The amount which appears on a claim as the provider’s charge for service(s) rendered to you.

**CLAIM PAYMENT:** The resulting benefit payment calculated after submission of a claim, in accordance with the benefits described in this Plan.

**CLINICAL TRIALS:** A clinical trial is a prospective biomedical or behavioral research study of human volunteers that is designed to answer specific questions about biomedical or behavioral interventions (drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. A clinical trial is one type of clinical research that follows a pre-defined plan or protocol.

**C.N.A.:** Certified Nursing Assistant

**COBRA:** Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer must offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate under the terms of this Plan.

**CO-INSURANCE:** The portion of eligible charges paid in a calendar year by the Plan Participant as stated in the Plan, but not including the deductible.
COLO-RECTAL CANCER SCREEN: Initial non-surgical test used for the early detection of cancer in the colon and rectal areas.

COMPLICATIONS OF PREGNANCY: Conditions (when the pregnancy is not terminated) where diagnoses are distinct from the pregnancy but which are adversely affected by pregnancy such as: acute nephritis, nephritis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include, but are not limited to, elective caesarian section, an ectopic pregnancy which is terminated or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible; and pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy).

Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions which, although associated with the management of a difficult pregnancy, are not medically classified as distinct complications of pregnancy.

CONGENITAL DEFORMITY: An abnormality present at birth.

COSMETIC SURGERY: A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an illness or injury.

COVERED PERSON: A participant or eligible dependent whose coverage is in effect under the Plan.

COVERED SERVICE: A service or supply specified in this Plan for which benefits will be provided.

CT (CAT) SCAN: Computerized Tomography

CUSTODIAL CARE SERVICE: Those services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of custodial care services are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial care service also means providing inpatient service and supplies to you if you are not receiving skilled nursing services on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can be safely and effectively administered to you as an inpatient in the health care facility involved.

DEDUCTIBLE: The first amount of eligible charges to be paid by the Participant up to stated Plan specific limits in a calendar year.

DENTAL SERVICES: Means care and treatment of the teeth and gums, or any services rendered by a Dentist or dental surgeon.

DENTIST: Means a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

DEPENDENT: As defined in Section 1.02 of this Plan.

DIAGNOSTIC SERVICE: Tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyogram.

DIALYSIS FACILITY: A facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DIALYSIS TREATMENT (RENAL): One unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

DISABILITY OR DISABLED: Wholly and continuously disabled by illness or injury which prevents an eligible participant from working for remuneration or profit, as determined by a physician. With respect to dependents, wholly and continuously prevented by accidental bodily injury or illness, from engaging in substantially all normal activities of a person of like age and sex in good health, as determined by a physician.
**DURABLE MEDICAL EQUIPMENT**: Equipment which is able to withstand repeated use and is primarily and customarily used to serve a medical purpose and not generally useful to a person in the absence of illness or injury.

**EFFECTIVE DATE**: The date, as determined under enrollment, on which a participant’s coverage under this Plan commences.

**ELECTED OFFICIAL**: Auditor, Circuit Clerk, Coroner, County Clerk, Recorder of Deeds, Sheriff, State’s Attorney, and Treasurer.

**ELIGIBLE CHARGE**: Medically necessary expenditures for services, supplies and treatments for injury and illness for which the provisions of the Plan specifically provide benefits, as set forth herein. In no event shall any expenditure that is incurred for an injury or illness for which the provisions of the Plan do not specifically provide benefits be considered an eligible charge.

**ELIGIBLE PERSON**: A Participant who meets the eligibility requirements for this health coverage, as described in the eligibility section of the Plan.

**EMERGENCY**: The sudden and unexpected onset of a medical condition or injury as defined in Section 15.

**ESSENTIAL HEALTH BENEFITS (EHB)**: means, to the extent they are covered under the Plan, ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs, rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and embedded pediatric oral and vision care services. Such benefit shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto. Spinal manipulations, wigs/hairpieces, services related to organ donation, and charges related to the diagnosis and treatment of: infertility (including prescription drugs), and autism spectrum disorders are not Essential Health Benefits.

**EXPERIMENTAL AND INVESTIGATIONAL**: The medical use of a service or supply that is still under study and which is not yet recognized throughout the medical profession in the United States as safe and effective for diagnosis or treatment. This includes, but is not limited to, all phases of clinical trials, all treatment protocol based upon or similar to those used in clinical trials, drugs approved by the United States Food and Drug Administration under its Treatment Investigational New Drug Regulation, and United States Food and Drug Administration approved drugs used for unrecognized treatment indications.

The Plan Administrator must make an independent evaluation of the experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The treatment will be considered experimental:

a) If the drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

c) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study 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

d) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 the standard means of treatment or diagnosis.

**FAMILY COVERAGE**: Coverage for a Primary Participant and one or more eligible dependents under this Plan.
FORMULARY: Means a list of prescription medications compiled by the Pharmacy Benefit Manager of safe, effective therapeutic drugs specifically covered by this Plan.

FULL-TIME REGULAR EMPLOYEE: A person who is directly employed and compensated for services by The County of Peoria and who is scheduled to work at least thirty(30) hours per week in The County of Peoria’s business. For the purpose of this definition “County of Peoria” shall be construed as including outside groups presently utilizing the Plan.

GRANDCHILD (IRS Definition): As defined under the current Internal Revenue Services’ guidelines for determining dependent eligibility for taxation purpose, subject to change.

HEALTH/FITNESS DISCOUNT: A professional health and fitness center offering facilities for physical exercise similar to those offered by facilities such as the YMCA, Landmark Health Club, River City Athletic Club, etc. This fitness center must be able to verify attendance by County employees to the satisfaction of the County.

HOME HEALTH CARE: A plan that provides for continued care and treatment after discharge from a Hospital or in lieu of hospitalization. The care and treatment must be for the same or related condition that required the hospital stay, prescribed in writing by the attending Physician, and a viable alternative to staying in the Hospital. Care must be provided by an agency that mainly provides skilled nursing & other therapeutic services and is associated with a professional group that makes policy, consisting of at least one Physician & one (1) R.N., and keeps complete medical records of each person, has a full-time administrator, and meets licensing standards.

HOSPICE: Means an entity licensed, approved or authorized to provide inpatient or at home medical relief of pain and supportive care to terminally ill persons, and which is staffed and equipped to provide care for and treat terminally ill persons who do not require Hospital Care; and has a paid staff of medical professionals to supervise such care and treatment.

HOSPITAL: A medical facility that: mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons; is supervised by a staff of physicians; is not mainly a place for rest, for the aged, or a nursing home; and charges a fee. The term “hospital” is further expanded to include a substance abuse treatment facility, operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, which meets all of the requirements of an accredited hospital; and a facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

ILLNESS: Shall include disease, bodily sickness, mental illness/substance abuse, disorders, pregnancy or complications of pregnancy.

IMMUNIZATIONS: Vaccinations to prevent diseases and/or conditions.

IMMEDIATE FAMILY: A family member of either you or your spouse/civil union partner, whether related by blood or marriage by law, including only spouse/civil union partner, brother, sister, parent, child, grandparent, grandchild, step parents, and step child.

INJURY: Shall mean any bodily injury caused by any act or omission except illegal acts or omissions of the injured plan participant. All injuries sustained by a covered individual in connection with any one accident shall be considered one injury.

INPATIENT: When the covered person is a registered bed patient and treated as such in a facility.

LEAVE OF ABSENCE ("LOA"): Any applicants authorized by the employer under the Employer’s Standard personnel practices provided that collective bargaining agreements provided that all persons under similar circumstances must be treated alike in granting them such leaves of absence and provided further that the employee return within the period of authorized absence.

LIFETIME: Means the period of time in a Participant’s life while covered under this Plan. It does not mean the entire lifetime of the Covered Person.

L.P.N.: A licensed practical nurse.

MAINTENANCE PROGRAM: Therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur (refers to occupational therapy, physical therapy, speech therapy and chiropractic care).
MAMMOGRAM (MAMMOGRAPHY): Radiography of the breast.

MANIPULATIVE THERAPY: Treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment. It includes all tests, x-rays, examinations, office visits, medications, or similar services provided in conjunction with this type of treatment.

MATERNITY: Means the services rendered for an inter-uterine pregnancy which results in a vaginal or medically necessary cesarean section delivery.

MAXIMUM OUT-OF POCKET: The total dollar amount participant(s) with single or family coverage must pay of eligible charges before the Plan pays at the 100% level for the calendar year. This does not include: any penalties; non-covered expenses; or amounts over the Reasonable & Customary allowance, or otherwise excluded elsewhere in the Plan.

MEDICALLY NECESSARY: Means health care services, supplies or treatment which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered.

MEDICARE: Title XVIII of the Social Security Act, as amended.

MENTAL ILLNESS: Means those illnesses defined as a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders classified as mental disorders in Section ii of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

MINOR EMERGENCY CARE: Services for treatment of symptoms or conditions that are not considered life threatening, do not require emergency room treatment or inpatient hospitalization, and can be treated by a general practice physician or medical provider.

MORBID OBESITY: Means a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person or Covered Dependent.

MRI: Magnetic Resonance Imaging

NON-PREFERRED PROVIDER (“NON-PPO”): Any vendor that does not have a Preferred Provider agreement in effect with the County of Peoria.

NORMAL PREGNANCY: The services rendered for an inter-uterine pregnancy, which results in a vaginal or medically necessary cesarean section delivery.

N.P.: A licensed Nurse Practitioner.

NURSING SERVICE: Care provided by a Physician Assistant ("P.A.")/Nurse Practitioner ("N.P."), Registered Nurse ("R.N.") or Licensed Practical Nurse ("L.P.N.") which requires the technical skills and professional training of an P.A., N.P., R.N. or L.P.N. The service must be provided under the direction or order of a physician and must be medically necessary. The inherent complexity of the service prescribed for a patient must be such that the service can safely and effectively be performed by the professional licensed personnel.

OCCUPATIONAL THERAPY: Means constructive therapeutic activity designed and adapted to promote the restoration of a useful physical function. Occupational therapy does not include educational training or services designed and adapted to develop a physical function.

OPEN ENROLLMENT: Means the period, established by the Employer, when the employee and/or dependent(s) meeting eligibility requirements may be added to the Plan for coverage if they were not added within thirty-one (31) days of an eligibility event. Employee and/ or Dependent coverage obtained during the open enrollment period become effective January 1st following the open enrollment period.

ORAL SURGERY: means:
   a) surgical removal of bony or tissue impacted teeth;
   b) excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
c) surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and

d) excision of exostoses of the jaws and hard palate (provided that his procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

**ORGAN/TISSUE TRANSPLANT:** Means the surgical transfer of organ or bone marrow as specified in the Plan.

**OUTPATIENT:** A covered participant receiving treatment while not confined as an inpatient. Outpatient care may be received at, but not limited to, Physician’s office, laboratory or x-ray facility, ambulatory surgical treatment center, Hospital, or urgent care facility.

**OUTSIDE GROUPS:** Other agencies purchasing health care coverage from the County of Peoria.

**P.A.:** A licensed physician’s assistant.

**PAP TEST/SMEAR (PAPANICOLAOU TEST):** Collecting, examining, and testing material from areas of the body that shed cells or in which shed cells collect, especially the cervix and vagina.

**PARTICIPANT:** Eligible person enrolled in this Health Care Plan.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (“PPACA”):** or the Affordable Care Act (ACA) is a United States federal statute signed into law on March 23, 2010. It provides a number of mechanisms including mandates to employers and individuals to increase the coverage rate.

**PET SCAN:** Positron Emission Tomography

**PHARMACY:** Means any licensed establishment in which the profession of pharmacy is practiced.

**PHYSICAL THERAPY:** Means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Physical therapy does not include educational training or services designed and adapted to develop a physical function.

**PHYSICIAN:** Person licensed to practice within the scope and limitation of that license under the Illinois Medical Practice Act, Clinical Psychologist Licensing Acts or similar laws of Illinois or other states.

**PLAN:** The County of Peoria Employee’s Healthcare Dental, Vision and Prescription Plan which describes the benefits, terms, and provisions for payment of benefits. The Plan may be modified or amended from time to time and such modifications which affect covered participants will be communicated to Plan participants.

**PREFERRED PROVIDER ORGANIZATION (“PPO”):** Those health care providers who have contracted with the County of Peoria to provide certain services for which benefits are provided under the terms of this Plan.

**PRE-NATAL CLASSES:** Courses taken from approved pre-natal organizations prior to birth of baby.

**PRIMARY PARTICIPANT:** Employee or former employee enrolled in the Plan, or covered under any of the Extension of Benefits provision.

**PRIVATE DUTY NURSING:** Skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse who is not providing this service as an employee or agent of a hospital or other health care facility. Private duty nursing service does not include custodial care service.

**PROCUREMENT SERVICES:** Services and supplies related to the removal, preservation and transportation of the donated organ.

**PROVIDER:** Any health care facility (for example, a Hospital or skilled nursing facility) or person (for example, a Physician or dentist) or entity duly licensed to render covered services to you.

**PROSTATE-SPECIFIC ANTIGEN TEST (“PSA”):** Blood draw test which measures an antigen in the blood that may be indicative of cancer in the prostate.

**PSYCHIATRIC, MENTAL/NERVOUS ILLNESS CARE:** Diagnostic or therapeutic medical service provided by a Physician, psychiatrist, registered clinical psychologist, licensed marriage, family or child counselor or licensed social worker for the treatment of conditions classified as mental illness. Psychiatric care includes:
Psychological testing – one or more psychological tests;
Group therapy – group psychotherapeutic sessions;
Psychotherapy – individual psychotherapeutic sessions;

and, those illnesses classified as disorders by the American Psychiatric Association as of the date services are rendered.

**REASONABLE AND CUSTOMARY ALLOWANCE:** The usual charge made by a Physician or supplier of services, medicines, or supplies which shall not exceed the customary level of charges for such services or supplies rendered in the same geographical locality as determined by the Health Benefits Committee. Reasonable & customary hospital allowance will be based upon the Plan’s in-network fee schedule.

**REGISTERED CLINICAL PSYCHOLOGIST:** A clinical psychologist who is registered with the Illinois Department of Registration and Education pursuant to the Illinois “Psychologist Registration Act” or is such stated where statutory licensure exists. The clinical psychologist must hold a valid credential for such practice, and if practicing in a state where statutory licensure does not exist, such a person must meet the qualifications specified in the definition of a clinical psychologist.

**RELATIVE:** The term “Relative for interpretation of this Plan includes all persons who are related to the primary participant or the primary participant’s current or any former spouse/civil union partner as grandparent, parent, aunt, uncle, niece, nephew, child or grandchild, including the spouse/civil union partner of any of these relatives and any person in a step relationship with any of these relatives.

**R.N.:** A licensed registered nurse.

**ROOM AND BOARD:** Those charges made by a facility for room and board and other necessary services and supplies – room, board, general duty nursing, intensive care and any other services regularly furnished by the facility as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

**SECOND SURGICAL OPINION:** A physical examination of the Covered Participant, including: X-ray and laboratory examinations and a written report by the Physician who is rendering the opinion. The second surgical opinion must be performed by a Physician who is certified by the American Board of Surgery or other specialty board and be performed by a Physician not financially associated with the original diagnosing Physician. The examination must take place before the date the Participant is scheduled for the proposed surgery.

**SEMI-PRIVATE RATE:** This is the charge for room and board which a facility applies to its semi-private rooms with 2 or more beds. If there are no such rooms, it will be the rate most commonly charged by that facility.

**SINGLE COVERAGE:** Coverage under this Plan for the Participant but not his or her spouse/civil union partner and/or dependent(s).

**SINGLE SOURCE BRAND (PRESCRIPTION DRUGS):** A brand-name drug for which no generic equivalent has been developed, released or approved by the United States Food and Drug Administration ("USFDA").

**SKILLED NURSING FACILITY:** A facility that fully meets all of these tests:

a) it is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse ("R.N.") or by a licensed practical nurse ("L.P.N.") under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

b) Its services are provided for compensation and under the full-time supervision of a Physician.

c) It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

d) It maintains a complete medical record on each patient.

e) It has an effective utilization management plan.

f) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
g) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as a Skilled Nursing Facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

**SKILLED NURSING SERVICE:** Those services provided by an R.N. or L.P.N. which require the technical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled Nursing Service does not include custodial care service.

**SPEECH THERAPY:** Services performed by a licensed and certified speech/language therapist to restore speech loss or impairment due to one of the following:

1) illness or injury (other than a functional nervous disorder) which happens while the participant is covered under this Plan;
2) cerebral vascular accident (stroke); or
3) congenital malformation for which surgery is scheduled or has been performed.

**SUBSTANCE ABUSE:** The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a Physician. The criteria established by the American Society of Addiction Medicine including the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co–Occurring Conditions will be used for substance use disorders; and to determine medically necessary acute treatment services and stabilization services.

**SUBSTANCE ABUSE TREATMENT FACILITY:** Means a facility (other than a Hospital) whose primary function is the treatment of substance abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

**SURGERY:** The performance of operative or cutting procedures including specialized instrumentation and the correction of fractures or of complete dislocations and any other procedures as reasonably approved by the Plan.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION ("TMJ") AND RELATED DISORDERS:** Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

**THIRD PARTY ADMINISTRATOR:** An organization which, at the discretion of the plan sponsor, is engaged to administer the Plan.

**TREATMENT PROGRAM (SUBSTANCE ABUSE):** An organized, intensive, structured, rehabilitative treatment program of either a Hospital, or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a physician or psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

**TRANSPLANT CARE:** Those services associated with the transplant of major organs and bone marrow as outlined in the Plan.

**TRIMESTER OF PREGNANCY:** Increments during pregnancy marked at three (3) month or ninety (90) day intervals.

**VARIABLE EMPLOYEE:** Part-time, temporary or seasonal employees.
Final authority for interpretation of the terms and provisions of the Plan is vested in the Peoria County Board. Any interpretation so required shall be made in good faith, subject to reasonable care and prudence. All such interpretations are final, subject only to the ultimate authority and responsibility of the County Board. Appeals of decisions involving individual claims are addressed under separate provisions in the Plan.

The County of Peoria

By: ____________________________

Title: County Administrator
EXHIBIT A
PRESCRIPTION DRUG CARD BENEFITS
FORMULARY PROGRAM
(Refer to front of Plan for Qualified High Deductible Benefit Highlights)

1. The prescription drug benefit is an independent component of the healthcare program, separate from regular medical benefits, and administered by MEDTRAK.

Expenses for prescription medications:
• Are not subject to an annual deductible.
• Count toward meeting your PPACA In-Network Maximum Out-of-Pocket under Sec. 4.041.

You will be issued a Prescription Drug Card that you and your dependents will need to present at the time of service in order to obtain prescription drug services.

Every prescription drug has two names: the trademark or brand name, and the chemical or generic name. By law, both brand-name and generic drugs must meet the same standards for safety, purity, strength and quality. Many drugs are available in generic form. Generic drugs can save a great deal of money for both you and the Plan. You should ask your doctor to prescribe your medication on a generic basis whenever possible.

The Plan requires that you use a participating network pharmacy. It will be your responsibility to inquire if the pharmacy you are utilizing is in the network.

2. RETAIL PROVIDER:
You can purchase up to thirty (30) days worth of drugs.

- Generic Participant pays $10.00 for up to a 30 day supply.
- Preferred Brand Participant pays $40.00 for up to a 30 day supply.
- Non-Preferred Brand Participant pays $60.00 for up to a 30 day supply.
- Specialty Participant pays $75.00.
- Non-Preferred Specialty Participant pays 20% up to $250.

The Prescription Drug Benefit under the Qualified High Deductible Plan is Subject to Deductible and Coinsurance.

3. MEDTRAK MAIL ORDER PROVIDER AND/OR 90 DAY RETAIL PROVIDER:
You may receive up to a ninety (90) day supply through a participating retail pharmacy or the MEDTRAK mail order provider. Mail order forms are available in County Administration or from the HR Generalist-Health & Risk.

- Generic Participant pays $20.00 for up to a 90 day supply.
- Preferred Brand Participant pays $100.00 for up to a 90 day supply.
- Non-Preferred Brand Participant pays $150.00 for up to a 90 day supply.

The Prescription Drug Benefit under the Qualified High Deductible Plan is Subject to Deductible and Coinsurance.

Any prescribed medication not covered under the Prescription Drug Preferred Provider Agreement may be eligible under the medical benefits portion of this Plan, subject to Utilization Review approval, deductible and Co-Insurance.

Prescriptions are valid for one (1) year from the date of issuance as required by law. A new physician’s order must be issued to obtain any prescriptions over one (1) year.
### EXHIBIT A
### PRESCRIPTION DRUG CARD BENEFITS
### COVERED DRUG CHECKLIST
### Summary of Coverage

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.D.H.D./Narcolepsy agents (e.g. Dexedrine, Ritalin, Cylert)</strong></td>
<td></td>
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<tr>
<td>Aids Related Drugs (Medication used for treatment or suppression of HIV, e.g. Retrovir, Crizivan)</td>
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<tr>
<td>Anabolic Steroids (Medication used to promote building of muscle (e.g. Anadrol-50, Durabolin, Nandrolone, Oxandrin, Winstrol)</td>
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<tr>
<td>Anti-obesity (Medications used for the purpose of weight loss, e.g. Phentermine, Meredia, Xenical)</td>
<td></td>
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<tr>
<td>Biologics (Certain injectables, e.g., allergens, serums, vaccines)</td>
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<tr>
<td>Compounds with legend ingredients (Medications mixed together using at least one ingredient that requires a prescription)</td>
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<tr>
<td>Contraceptives – all methods approved by US-FDA are covered</td>
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<tr>
<td>Cosmetic Drugs:</td>
<td></td>
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<tr>
<td>— Accutane (oral drug to treat acne)</td>
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<tr>
<td>— Acne (topical–Metro Gel, 75%)</td>
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</tr>
<tr>
<td>— Tretinoin (Retin-A) (Anti-acne cream)</td>
<td></td>
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<tr>
<td>Diabetic Supplies: (Blood Glucose Testing Machine covered under medical portion of Health Plan)</td>
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<tr>
<td>— Blood Sugar Diagnostics (e.g. Blood Test Stripe)</td>
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<tr>
<td>— Insulin</td>
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<tr>
<td>— Insulin Syringes/Needles</td>
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<tr>
<td>Fluoride Preps (Oral fluoride, e.g. Fluoritab, Karidium, Luride, Lozi-tabs, Phos-Flur)</td>
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<tr>
<td>Folic Acid for women planning on becoming pregnant is covered 100%</td>
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<tr>
<td>Immunizations as mandated by PPACA are covered 100%—see your Wellness Program or go to <a href="http://www.healthcare.gov/center/regulations/prevention.html">www.healthcare.gov/center/regulations/prevention.html</a></td>
<td></td>
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<tr>
<td>Immunosuppressives (Medication used for the suppression of the body’s immune system. Typically used for patient post-transplant or with autoimmune diseases—e.g. Imuran, Neoral, Sandimunne)</td>
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<tr>
<td>Lamisil (Anti-Fungal)</td>
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<tr>
<td>Lotronex (Females Only)</td>
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<tr>
<td>Migraine Drugs (e.g. Imitrex, Zomig, Amerge, Maxalt)</td>
<td></td>
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<tr>
<td>Misc. Medical Supplies–Legend</td>
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<tr>
<td>Multiple Sclerosis (e.g. Avonex, Betaseron, Copaxone), Injectable forms if medication included.</td>
<td></td>
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<tr>
<td>Non-Insulin Injectables (Legend injectables other than insulin).</td>
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<tr>
<td>Nutritional/Dietary Supplements–Legend.</td>
<td></td>
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<tr>
<td>Prenatal Prescription Vitamins (e.g. Natafort)</td>
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<tr>
<td>Relenza (Limit 2 inhalers every 180 days—at retail only, mail excluded)</td>
<td>Two treatments per year.</td>
</tr>
<tr>
<td>Smoking Cessation products–Over-the-Counter (gum &amp; patches) and Prescription (Zyban, Chantix, Bupropion, inhaler &amp; nasal spray) treatments are covered 100%.</td>
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<tr>
<td>Item</td>
<td>Coverage</td>
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<tr>
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<tr>
<td>Inhaler &amp; Nasal Spray</td>
<td>Yes</td>
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<tr>
<td>Syringes (non-insulin)</td>
<td></td>
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<tr>
<td>Tamiflu (Limit 20 per 180 days at retail only, excluded at mail)</td>
<td>Yes</td>
</tr>
<tr>
<td>Vitamins Legend–Non Prenatal (e.g. Prescription Niacin, Prescription Vitamin K)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The preceding list is subject to change.

For questions regarding coverage, contact HR Generalist-Health & Risk at (309) 672-6071.
For Pharmacy locations, contact MEDTRAK at 1-800-771-4648.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the County of Peoria Employee’s Healthcare, Dental, Vision and Prescription Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

The Plan Administrator is the County of Peoria, 324 Main St., Room 502, Peoria, Illinois 61602, (309) 672-6071. COBRA continuation coverage for the Plan is administered by Consociate, Inc., 2828 N. Monroe, P.O. Box 1068, Decatur, Illinois 61525-1068, 217-423-7788 or 800-798-2422. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.
The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

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

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you,
you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

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

**IMPORTANT:**

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

**NOTICE PROCEDURES:**

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

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

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

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a)  (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

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

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

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

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

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

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
EMPLOYEE INDEMNITY
IMRF MEDICARE ELIGIBLE RETIREE PLAN

Effective July 1, 2015 January 1, 2020
COUNTY OF PEORIA IMRF MEDICARE ELIGIBLE RETIREE PLAN

–Network restrictions do not apply. Individual lifetime maximum of $50,000 applies.
Other major medical coverage is required to participate in this Plan.

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<tr>
<th>HOSPITAL SERVICES – per benefit period</th>
<th>BENEFITS</th>
</tr>
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<tr>
<td>*A benefit period begins on the 1st day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.</td>
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<tr>
<td><strong>Hospitalization</strong>*</td>
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<tr>
<td>Semi-private room and board, general nursing, and miscellaneous services/supplies</td>
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</tr>
<tr>
<td>First 60 days</td>
<td>$1,400</td>
</tr>
<tr>
<td>61st through 90th day</td>
<td>$400 a day</td>
</tr>
<tr>
<td>91st day and after:</td>
<td></td>
</tr>
<tr>
<td>While using 60 Lifetime Reserve days</td>
<td>$700 a day</td>
</tr>
<tr>
<td>Once Lifetime Reserve days are used:</td>
<td>100%</td>
</tr>
<tr>
<td>Additional 365 days</td>
<td></td>
</tr>
<tr>
<td>Beyond the additional 365 days</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong>*</td>
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<tr>
<td>You must meet requirements, including having been in a hospital for at least three days and entered an approved facility within 30 days after leaving the hospital</td>
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<tr>
<td>First 20 days</td>
<td>$0</td>
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<tr>
<td>21st through 100th day</td>
<td>Up to $200 a day</td>
</tr>
<tr>
<td>101st day and after</td>
<td>$0</td>
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<tr>
<td><strong>Blood</strong></td>
<td></td>
</tr>
<tr>
<td>First three pints</td>
<td>100%</td>
</tr>
<tr>
<td>Additional amounts</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
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<tr>
<td>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</td>
<td>$0</td>
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<tr>
<td>ALL OTHER BENEFITS</td>
<td>BENEFITS</td>
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</tr>
<tr>
<td>Diagnostic tests</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td></td>
</tr>
<tr>
<td>First three pints paid @ 100%</td>
<td></td>
</tr>
<tr>
<td>Additional amounts</td>
<td>The first $180 annually then 20%</td>
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<tr>
<td><strong>Laboratory Services</strong></td>
<td>$0</td>
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<tr>
<td><strong>Home Health Skilled Care Services</strong></td>
<td>$0</td>
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<tr>
<td>Medically necessary skilled care services and medical supplies</td>
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<tr>
<td><strong>Foreign Travel</strong></td>
<td>80% to a lifetime maximum benefit of $50,000</td>
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<tr>
<td><strong>Dental</strong></td>
<td></td>
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<tr>
<td>$100 annual deductible per person / $200 max per family</td>
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<tr>
<td>$1,000 annual maximum</td>
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<tr>
<td>Preventative Services - two routine cleanings &amp; exams per year, one set of x-rays (no deductible)</td>
<td>100%</td>
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<td>Primary Services</td>
<td>80%</td>
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<tr>
<td>Major Services</td>
<td>50%</td>
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<tr>
<td>Orthodontics</td>
<td>50%</td>
</tr>
<tr>
<td>- lifetime maximum of $2,000, limited to age 19 and under</td>
<td></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
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<tr>
<td>Adults, 18 and older</td>
<td>$100 every two years</td>
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<tr>
<td>Children, 17 and younger</td>
<td>$100 annually</td>
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<tr>
<td><strong>PRESCRIPTION CARD BENEFIT</strong></td>
<td><strong>YOUR CO-PAY</strong></td>
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<td><strong>Pharmacy Formulary</strong></td>
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<td>Individual Calendar Year Maximum of $3,000 Applies</td>
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<tr>
<td>Generic</td>
<td>30 day supply</td>
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<tr>
<td>Preferred Brand name</td>
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<tr>
<td>Non-Preferred Brand name</td>
<td>$40</td>
</tr>
<tr>
<td>Preferred Specialty</td>
<td>$60</td>
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<tr>
<td>Non-Preferred Specialty</td>
<td>$75</td>
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<tr>
<td>20% up to $250</td>
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INTRODUCTION

The County of Peoria Employee’s Healthcare, Dental, Vision and Prescription Plan is a self-funded health benefit plan established to provide medical, dental and prescription benefits for employees of the County of Peoria (“The County”). This Plan represents the efforts of The County to provide its employees and their dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a description of all benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus, we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you may come across terms and phrases that are unfamiliar to you. Please refer to the Definitions Section 29 or you may contact the Claims Administrator, Consociate, at (800) 798-2422 between 8:00 A.M. and 5:00 P.M., Monday through Friday for clarification of these terms and phrases.

If you have difficulty in understanding the booklet or your rights under the Plan, you may contact the County’s HR Generalist-Health & Risk/Healthcare Administrator at (309) 672-6071 between 8:00 A.M. and 5:00 P.M., Monday through Friday.

Any information that you obtain concerning your rights and benefits may not be relied upon as a guarantee of your rights or that benefits will be paid in that manner. The availability of benefits is determined solely from the terms of the Plan as contained in the Plan document. A determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Third Party Administrator and they fully adjudicate your claim. Final determination of any claim rests with the Plan Administrator.

PLEASE BE ADVISED…If you have any changes in your status, such as a birth, death, marriage, divorce, address changes or any other information that may affect your benefits, it is mandatory that you contact the HR Generalist-Health & Risk at (309) 672-6071 with this information, within thirty-one (31) days of the eligibility event.

FAILURE TO NOTIFY PERSONNEL OF ANY CHANGE IN STATUS MAY RESULT IN A DELAY OR DENIAL OF HEALTHCARE BENEFITS.

Unity Point Health Plus (Methodist, Proctor and Pekin) is the Preferred Physician Hospital Network. The Preferred Hospital is METHODIST MEDICAL CENTER which provides free parking.
Quick Reference List
Listed below are a few numbers of importance. These numbers are listed here for your quick reference and convenience.

County Administration .......................................................... (309) 672-6056
.......................................................... (309) 672-6054 – Fax

HR Generalist-Health & Risk ...................................................... (309) 672-6071

Risk Management Coordinator .............................................. (309) 672-6941

Pharmacy Benefit Manager
MEDTRAK ........................................................................... (800) 771-4648
7101 College Blvd., Suite 1000
Overland Park KS 66210

Third Party Administrator (Claim Administration and Customer Service of Benefits)
Consociate ........................................................................... (800) 798-2422
151 E. Decatur Street ............................................................... (217) 233-7252 – Fax
PO Box 1068
Decatur, IL 62525-1068
Payer ID# 37135

Pre-Certification/Utilization Review
Hines & Associates, Inc. ............................................................ (800) 944-9401
ADMINISTRATIVE INFORMATION

Name of Plan:
County of Peoria Employee’s Healthcare, Dental, Vision, and Prescription Plan.

Plan Sponsor/Administrator:
Director of Human Resources in coordination with the Third Party Administrator.

County of Peoria
324 Main Street, Room 502
Peoria, IL 61602
(309) 672-6056

Plan Sponsor Employer Identification Number ("EIN"): 37-6001763

Type of Plan:
Healthcare benefit plan providing medical, dental, vision and prescription benefits.

Funding and Sources of Contribution to the Plan:
The Plan is self-insured and the cost of providing benefits under the Plan is shared by the Employer, Outside Groups and Employees. A schedule of premiums will be distributed periodically setting forth the current cost of benefits and the amount of those costs that are paid by the Employer, Outside Groups and Employees.

Claims Administrator:
Consociate
151 E. Decatur Street
PO Box 1068
Decatur, IL 62525-1068
(800) 798-2422
FAX (217) 233-7252

Medical Utilization Review:
Hines & Associates, Inc.
(800) 944-9401

Agent for Service of Legal Process:
Note: Service of legal process may be made upon the Employer/Plan Administrator.

Fiscal Year of the Plan:
January 1 through December 31.

Effective Date of the Plan:
September 1, 1983

Effective Date of Restated Plan:
January 1, 2020

HR Generalist-Health & Risk:
Peoria County Courthouse, Room 502
324 Main Street
Peoria, IL 61602
(309) 672-6071
ELIGIBILITY & PARTICIPATION REQUIREMENTS

To be considered a Primary Participant or Eligible Dependent, you must have other major medical coverage and one or more of the following criteria must be met and maintained:

1.01 Primary Participant includes:
   a) All IMRF Eligible Retirees who are also Medicare eligible (also known as Employee) and their Dependents (see Section 25) currently enrolled in the Standard or QHDHP Health Benefit Plan of the Employer.
   b) Full-time Regular Active Employees of the County of Peoria;
   c) Qualified Retirees (see Section 25);
   d) Survivors (see Section 25);
   e) Active Elected Officials;

1.02 Eligible Dependent includes:
   a) the Primary Participant’s lawful spouse/civil union partner;
   b) any natural or legally adopted child under age twenty-six (26).
   c) Also, unmarried child from birth to the end of the month in which the child reaches age thirty (30) if such child is an Illinois resident, served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and has received a release or discharge other than a dishonorable discharge. The eligible dependent must submit to the Third Party Administrator a form approved by the Illinois Department of Veterans’ Affairs stating the date on which the dependent was released from service;
   d) a stepchild or other child for whom you or your covered spouse/civil union partner have assumed a legal responsibility, such as legal guardianship or a foster child, or responsibility has been determined by court order, and is a dependent, as defined by the United States Internal Revenue Code Section 152 (26 U.S.C. § 152);
   f) any unmarried child twenty-six (26) years or over who is incapable of self-sustaining employment by reason of a mental condition or physical handicap and who is dependent upon the Primary Participant for support and maintenance, provided the dependent is suffering from a documented disability on the date he or she otherwise ceases to be eligible for benefits under the Plan. Such disability must be verified during each annual open enrollment period or at such times as the Employer may reasonably require.

1.03 But, excludes the following:
   a) any person who is not a resident within the United States of America or Canada;
   b) any person who is already covered under this Plan as a primary Participant;
   c) any person who is on active duty in any military, naval, or air force of any country;
   d) any spouse/civil union partner of a Primary Participant who is legally divorced from the Primary Participant.

The term "child" means any child of the Primary Participant, including a stepchild, adopted child, or child in the custody of a Primary Participant while adoption proceedings with respect to that child by the Primary Participant are pending, a grandchild who resides with the Primary Participant, and a child for whom the Primary Participant has obtained legal guardianship.

In the case of a grandchild, a child for whom the Employee has legal guardianship and a child who qualifies as an eligible dependent under Section 1.02(c) above, the child must be fully dependent upon the primary participant for support and maintenance and qualify as a dependent as defined by the Internal Revenue Service Code Section 152 (26 U.S.C. § 152).
Coverage for grandchildren, persons with disabilities, and legal guardianship children is secondary to any other source of coverage, except as provided by State or Federal laws and regulations.

1.04 **Rehiring a Terminated Employee:**
A terminated employee who is rehired must satisfy the Eligibility Requirements of a new hire and be subject to the pre-existing condition waiting period of the Plan. However, an employee returning to work directly from coverage under the Plan’s COBRA continuation option need not satisfy the new employment waiting period and will not begin a new pre-existing waiting period.

1.05 **Reinstatement of Coverage:**
An employee whose coverage has terminated must satisfy the Eligibility Requirements of a new hire and be subject to the pre-existing condition waiting period of the Plan upon reinstatement. However, an employee returning to coverage directly from coverage under the Plan’s COBRA continuation option need not satisfy the new employment waiting period and will not begin a new pre-existing waiting period.
2.01 Eligibility to be enrolled as a participant in the Plan

An IMRF Medicare Eligible Retiree is eligible for coverage from the first day that he or she is in a class eligible (See Section 1.01) for coverage. The covered Dependents of such a Medicare Eligible Retiree or disabled Employee must already be covered under the Plan on the day before such Employee is moved from the Standard or QHDHP Health Benefit Plan.

2.02 A Participating Retiree will automatically be enrolled in the IMRF Medicare Eligible Retiree Plan at the time they (and their applicable dependents) become eligible for Medicare. The Plan will coordinate its benefits in the manner described under Section 20.01 for all Medicare benefits which you (or your dependent) are entitled even if you have not enrolled. Therefore, you should contact a Social Security office as soon as you or your dependent become eligible for Medicare. (Subject to Federal and State Laws as they become applicable.)

2.02 New Employee and Dependents

New employees and dependents are eligible to apply for enrollment during the first thirty days of continuous regular full-time employment. An employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage becoming effective.

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Waiting period: New employee and dependents become enrolled as plan participants on the first day of the next month following completion of one calendar month of continuous regular full-time employment.

Restrictions: Employee and dependents are subject to pre-existing conditions clause, Section 2.06.

2.03 Full-time Employee, 31+ Days of Employment

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Eligibility: Only during the annual open enrollment period.

Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of January following enrollment during open enrollment period;

b) The date of approval by the employer and claims administrator of the evidence of good health.

Restrictions: Subject to Evidence of Insurability, Section 2.07 and Pre-existing Clause, Section 2.06.

2.031 Full-time Employee, 31+ Days of Employment/Loss of Other Coverage

Requirement: Regular full-time employment (thirty (30) hours or more per week)
Eligibility: Within thirty (30) days of the loss of other coverage; or sixty (60) days of losing eligibility status through Medicaid or CHIP. Dependents (Same).

Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of the month following the month in which application for enrollment is made;

b) The date that other coverage is terminated;

c) The date of approval by the employer and claims administrator of the evidence of good health.

Restrictions: Subject to Evidence of Insurability, Section 2.07, and Preexisting Clause, Section 2.06.

2.032 Full-time Employee, 31+ Days of Employment/Eligible for Employment assistance under Medicaid or CHIP

Requirement: Regular full-time employment (thirty (30) hours or more per week)

Eligibility: Within sixty (60) days of becoming eligible for Employment assistance under Medicaid or CHIP. Dependents (Same).

Waiting period: Employee and dependents become enrolled as plan participants on the latest of:

a) The first day of the month following the month in which application for enrollment is made;

b) The date of approval by the employer and claims administrator of the evidence of good health.

Restrictions: Subject to Evidence of Insurability, Section 2.07, and Preexisting Clause, Section 2.06.

2.04 Newly Acquired Dependent of Participating Employee (Primary participant without dependent coverage).

Eligibility: Eligible to obtain dependent coverage and enroll new dependent when acquired by:

2.041 Newborn or adoption

Requirements: Enroll within thirty-one (31) days of birth or placement for adoption.

Waiting period: None

Restrictions: None

2.042 New Spouse/Civil Union Partner/Other Eligible Dependents:

Requirements: Enroll within thirty-one (31) days of date when new dependent acquired.

Waiting Period: None
Restrictions: Subject to pre-existing condition clause, Section 2.06.

2.043 Newly Acquired Dependent of Primary Participant with Dependent Coverage

Requirements: Enroll within thirty-one (31) days of date when new dependent acquired*.

Waiting Period: None

Restrictions: Except for newborn and child placed for adoption, pre-existing condition clause, Section 2.06 applies.

*The Primary Participant’s failure to timely enroll new dependent under this section will result in two consequences:

a) Dependent will have no prescription plan coverage and will not be able to recover prescription expenses that occur prior to enrollment date.

b) Payment of claims for benefits incurred prior to enrollment will be delayed.

2.0503 Annual Enrollment

The Primary Participant must submit an enrollment form each calendar year during the Open Enrollment Period.

2.06 Pre-existing Condition Clause:

A pre-existing condition of an employee or dependent means an illness, injury or prescription for which such employee or dependent received medical care within a ninety (90) day period ending immediately prior to the date the employee or dependent became covered under this Plan. Pregnancy alone at the time of enrollment of a timely entrant shall not be subject to the pre-existing condition provisions. However, complications caused by an illness or injury not caused by the pregnancy shall be subject to this pre-existing condition clause using the “but for” analysis.

This limit does not apply to eligible dependent children under the age of 19.

This limit does not apply to a newborn or child placed for adoption, or to an employee/elected official whose employment terminates or whose term ends and at the time of such termination, was subject to the proof of good health or the pre-existing condition provisions throughout this Plan, and who is rehired/re-elected within six months of such termination and remains subject to such provisions.

Benefit payments are limited to a maximum of $1,500 for medical or dental benefits in the first twelve (12) months of coverage and such charges are due to a pre-existing condition. This limit does not apply or include prescription card or mail order prescription benefits.

2.07 Evidence of Insurability/Medical Underwriting:

Process by which the applicant must submit, at his own expense, evidence of his good health which is satisfactory to the claims administrator’s medical review. An applicant for whom coverage is so approved will be subject to the limitation on pre-existing conditions as prescribed herein and the eligibility date will be the later of: (i) the date determined in accordance with the above eligibility date section, or (ii) the date of approval by the employer and claims administrator of the evidence of good health. Failure to prove good health which is satisfactory to the claims administrator is grounds for denial.

This limit does not apply to eligible dependent children under the age of 19.
All primary participants in the County of Peoria Health Plan are required to make premium payments, either by active payroll deduction, pension deductions, or self-pay. At such time that the primary participant is required to self-pay their premiums, due to retirement, disability, unpaid leave of absence or any other interruption of active employment, that primary participant is required to do so by the first day of the month. Courtesy invoices will be issued twelve to fifteen (12-15) days prior to the due date. Failure to pay within thirty (30) days of the due date will result in immediate termination from the Plan. **IF YOU ARE TERMINATED FROM THE PLAN FOR NON-PAYMENT OF PREMIUMS, YOU MAY APPEAL THAT TERMINATION TO THE HR GENERALIST-HEALTH & RISK/HEALTHCARE ADMINISTRATOR’S OFFICE.**
5.01 This is a special program designed to assist you in determining the course of treatment that will maximize your benefits under this Plan. There are several components of Utilization Review that are described below (e.g. pre-certification, continued stay review, discharge planning, second surgical opinion, case management, etc.)

5.02 **Pre-Certification:** Whenever a non-emergency inpatient admission or out-patient service is required by your Physician, it is your responsibility to call Utilization Review for pre-certification prior to the admission or service. In the event of an emergency admission, you, or someone calling on your behalf, must notify Utilization Review within seventy-two (72) hours from the date of admission. **However, it is your ultimate responsibility to make sure the call is made.**

5.03 ******NOTE: FAILURE TO NOTIFY UTILIZATION REVIEW PRIOR TO AN INPATIENT ADMISSION, OUT-PATIENT SERVICE OVER $500, OR WITHIN SEVENTY-TWO (72) HOURS OF AN EMERGENCY ADMISSION WILL RESULT IN A $250 PENALTY PER ADMISSION OR SERVICE. THIS AMOUNT WILL NOT BE APPLIED TO ANY OUT-OF-POCKET EXPENSE LIMITATION OF THIS PLAN. THIS PENALTY WILL NOT APPLY IF THIS PLAN IS THE SECONDARY PAYOR.******

When you call Utilization Review, be sure to identify yourself as a County of Peoria employee or healthcare participant.

When you contact Utilization Review, you should be prepared to provide the following:

a) Primary Participant name, address, phone number, social security number;

b) Name of employer;

c) Patient name and date of birth;

d) Date of admission;

e) Hospital name and address;

f) Name and address of admitting Physician; and

g) Admitting diagnosis, procedure and expected length of stay if known.

Once the pre-certification call has been received, make a note of the date, time and person you spoke to. This is your verification that you met your portion of the pre-certification requirement. The Utilization Review Administrator will contact the attending Physician for medical information, comparing that with pre-established medical criteria, an anticipated length of stay will be determined. After the admission, confirmation will be sent to the Participant and the attending Physician.

5.04 IF THE ADMISSION OR OUT-PATIENT SERVICE HAS NOT BEEN PRE-CERTIFIED AND APPROVED, AND YOU CHOOSE TO BE ADMITTED TO THE HOSPITAL OR TO PROCEED WITH THE SERVICE, YOUR BENEFIT LEVEL MAY BE REDUCED OR DENIED FOR THE CHARGES INCURRED.

During the pre-certification process, the Utilization Review Administrator may also review for:

a) Surgery that may be performed on an outpatient basis. The Utilization Review Administrator will review procedures for recommendation of outpatient surgical setting; and/or

b) Second Surgical Opinion. The Utilization Review Administrator may recommend a second opinion for certain surgical procedures.

c) Pre-admission testing. The Utilization Review Administrator may recommend that pre-surgical testing be done prior to admission.
5.05 **Continued Stay Review:** Continued Stay Review occurs when the patient remains hospitalized beyond the original length of stay. The attending Physician may contact the Utilization Review Administrator during the hospital stay to request additional days or the Utilization Review Administrator will contact the Physician prior to or on the expected discharge date. Additional days will be assigned based upon the patient’s continued need for hospitalization. Letters of recertification for the continued stay will be sent to the Participant, the Physician and the Hospital.

If the additional Hospital days are not approved and you choose to remain hospitalized after adequate notification, there will be no benefits paid by the Plan.

5.06 **Discharge Planning:** Discharge planning is designed to identify individuals who will require care after discharge from the Hospital. The Utilization Review Administrator may identify a certain diagnosis or procedure that usually has potential for discharge planning. Contact will then be made with the Hospital’s social service/discharge planning department to determine the need for post discharge care. The Utilization Review Administrator will also work with the Physician and family as indicated to ensure that all discharge plans and home health treatment plans are appropriate to the patient’s condition and home setting.

5.07 **Second Surgical Opinion**

A second surgical opinion may be required by Utilization Review. If your Physician has recommended surgery, either you or the Utilization Review Administrator may request a second surgical opinion. The Utilization Review Administrator will give you instructions on obtaining that second opinion. If a second surgical opinion is arranged by the Utilization Review Administrator, expenses for the second surgical opinion will be paid at 100% with no deductible.

If the second surgical opinion does not confirm the first opinion, a third opinion may be approved. If the third opinion is approved or arranged by the Utilization Review Administrator, it too, will be paid at 100% with no deductible.

5.08 **Large Case Management:** A large case management approach may be indicated at no charge to the patient. This may involve the exploration of alternative means of care. The Utilization Review Administrator may arrange for review and/or case management services from a professional who is qualified to perform such services. Upon the advice of such professional, and agreement of the patient, the Utilization Review Administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect that a cost-effective result can be achieved without a sacrifice to quality of patient care.

5.09 **Retrospective Review:** In the event you fail to call Utilization Review prior to your admission, outpatient service, or within seventy-two hours following an emergency admission, the penalty will apply. In addition, the entire medical record relating to this admission may be reviewed by the Utilization Review Administrator on a retrospective basis.

Payments for days of care that were not medically necessary will be denied. You will be held responsible for these charges. Written notification of the denial will be sent by the Utilization Review firm to you, the attending Physician and the Hospital.

5.10 **Right of Appeal:** Should you choose to appeal a Utilization Review denial decision, you may do so by written request within sixty (60) days from the date of notification.

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Effective July 1, 2015

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Correspondence should be directed to the HR Generalist-Health & Risk.

NOTE: See Claims Appeal Process, Section 22.

5.11 Mothers/Newborn Benefits:

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable).
Please refer to Definitions and Explanations, Section 29, for clarification of terms.

8.01 **Allergy Testing and Serum:** Payment up to Reasonable and Customary Allowance.

8.02 **Ambulance Services:** Payment up to Reasonable and Customary Allowance. Transport requires medical necessity.

8.03 **Autism:** Coverage for the diagnosis and treatment of autism spectrum disorders for dependents under the age of 21; includes coverage for the following treatment:
   a) Psychiatric care;
   b) Psychological care;
   c) Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
   d) Therapeutic care, including behavioral speech, occupational, and physical therapies addressing the following areas:
      • Self-care and feeding
      • Pragmatic, receptive, and expressive language
      • Cognitive functioning
      • Applied behavioral analysis, intervention, and modification
      • Motor planning
      • Sensory processing

8.04 **Anesthesiology:** Payment up to Reasonable and Customary Allowance.

8.05 **Blood and other Fluids:** The extent charges are not reduced by blood donations; Payment up to Reasonable and Customary Allowance.

8.06 **Breast Reconstruction:** Payment up to Reasonable and Customary Allowance. The following are benefits for elective breast reconstruction in connection with a mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications in all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and patient.

8.07 **Chemotherapy:** Payment up to Reasonable and Customary Allowance.

8.08 **Chiropractic Care:** Payment up to Reasonable and Customary Allowance up to $1,500 per calendar year. Subject to Deductible and Co-insurance.

8.09 **Colo-Rectal Cancer Screen:** 100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance. For participants age forty (40) and over OR medically necessary diagnostic testing at any age.
8.10 **Other Dental Benefits**

Impacted or due to accidental injury to the jaw, teeth, mouth or face. Payment up to Reasonable and Customary Allowance.

8.11 **Diagnostic, X-ray, Lab:**

In physician’s office – payment up to Reasonable and Customary Allowance.

8.12 **Dialysis Treatment:**

Payment up to Reasonable and Customary Allowance.

8.13 **Durable Medical Equipment:**

Payment up to Reasonable and Customary Allowance. If not Utilization Review approved, there are no benefits paid by the Plan. Includes charges for prosthetic appliances to replace a limb or organ, if the appliance is the first one or a replacement due to pathological changes or normal growth; casts, splints, trusses, braces, crutches, rental of wheel chairs, hospital-type beds and equipment to give oxygen; rental of an iron lung or other mechanical equipment required to treat respiratory paralysis, certain prescription medications not covered by the prescription card program, or other durable medical equipment. **UTILIZATION REVIEW APPROVAL REQUIRED FOR ALL OUTPATIENT DME PURCHASES, in excess of $500.00.**

8.14 **Health/Fitness Activities:**

This benefit is offered to an employee who is a member of the Health Care Plan and it is also available for such employees’ spouse/civil union partners who are also County employees. Benefit is half of the single membership cost when the employee or a spouse/civil union partner employed by the County attends the health club eight (8) times a month. Benefit is 100% of the single membership cost when the employee or a spouse/civil union partner employed by the County attends the health club twelve (12) times a month. When the employee or a spouse/civil union partner employed by the County is on vacation the prorated number for attendance will be used. **This benefit is separate from benefits processed and paid by the Third Party Administrator. Check with HR Generalist-Health & Risk.**

8.15 **Home Health Care:**

Payment up to Reasonable and Customary Allowance **if prescribed by a physician and Utilization Review approved.** The home health care must commence within seven days of hospital confinement and is limited to sixty (60) visits (note that four (4) hours counts as one (1) visit). Additional visits may be covered with Utilization Review approval when it is determined to be the most cost effective method to provide medically necessary health care with or without prior hospitalization. If not Utilization Review approved, then there are no benefits paid by this Plan. Coverage is for private duty nursing and hospice or home health care services by an R.N., L.P.N. or other service provider, but only when prescribed by a physician and pre-approved by the Claim Administrator. Home health care provided by a relative as defined in Section 29 or by a person residing in the Participant’s household, is not covered by this Plan.

8.16 **Hospice Care:**

Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six (6) months, limited as follows:

(a) Room and Board;
(b) Necessary services and supplies at a facility or in home;
(c) Part-time nursing care;
(d) Consultation and case management services by a Physician;
(e) Physical therapy; and
8.17 **Immunizations (childhood and adult):**

100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance. Check with your local Health Department for discounted immunizations.

**PLEASE NOTE:** Once the child(ren) has been born, the participant **must** notify the Personnel Department within thirty-one (31) days of the birth and add the child(ren) to the Plan. Calling the Third Party Administrator **does not** automatically add the dependent to the Plan. Failure to add the child(ren) within the thirty-one (31) day limit may result in a delay or denial of benefits. If you fail to add a new dependent as described above and your coverage level would have increased (single to family) as a result of adding the dependent, a late entrant can only be added during the open enrollment period.

8.18 **Mammogram**

100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance. Baseline mammogram for women 35 to 39 years of age. Annual mammogram even if no symptoms are present, for women 40 years and older, OR medically necessary diagnostic testing at any age for either gender.

8.19 **Mental/Nervous Illness; Substance Abuse Treatment**

Inpatient, outpatient, partial hospitalization, individual or group psychotherapeutic treatment by licensed providers under the supervision of a physician or referred through the County Employee Assistance Program Provider. Payment up to Reasonable and Customary Allowance. Maximum inpatient $10,000; outpatient $1,000 per Participant per calendar year, which is included in the $30,000 maximum per Participant per annual limitation.

8.20 **Morbid Obesity/Weight Reduction**

Expenses Incurred for weight loss programs including office visits, x-ray and laboratory expenses, and prescription drugs, for Morbid Obesity, limited to two (2) programs per person per lifetime. No benefits are payable for Expenses Incurred for Weight Watchers, TOPS, special diets; dietary supplements; and weight control meetings unless under the supervision of a Physician.

Diagnostic services, surgical procedures and prescription drugs for the treatment of Morbid Obesity. A surgical treatment plan must be provided to the Plan Administrator by the patient’s attending Physician prior to Surgery. Surgical treatment, including but not limited to gastric restrictive procedures and gastric bypass, whether or not it is, in any case, a part of the treatment plan for another Sickness is restricted to a maximum benefit of $10,000 annually, including any complications from that Surgery. No benefits are available for weight reduction Surgery if it is the first course of treatment for Morbid Obesity.

Services in connection with surgical treatment of morbid obesity and/or panniculectomy will be covered, subject to the following conditions:

**a)** body weight must be at least two hundred percent (200%) of the optimal weight;

**b)** the patient must have been considered morbidly obese by a Physician for at least five (5) years prior to the date
c) non-surgical methods of weight reduction have been attempted under a Physician’s supervision for at least a three (3) year period immediately prior to the date surgical treatment is sought.

Under the surgical treatment plan for Morbid Obesity expenses incurred for weight loss programs including office visits, x-ray, laboratory expenses, and prescription drugs is further limited to two (2) programs per person per lifetime. No benefits are payable for Expenses Incurred for Weight Watchers, TOPS, special diets; dietary supplements; and weight control meetings unless under the surgical treatment Physicians supervision.

<table>
<thead>
<tr>
<th>8.21 Nursing Service:</th>
<th>Care provided by a Physician Assistant (&quot;P.A.&quot;)/Nurse Practitioner (&quot;N.P.&quot;), Registered Nurse (&quot;R.N.&quot;) or Licensed Practical Nurse (&quot;L.P.N.&quot;) which requires the technical skills and professional training of a P.A., N.P., R.N. or L.P.N. The service must be provided under the direction or order of a physician and must be medically necessary. The inherent complexity of the service prescribed for a patient must be such that the service can safely and effectively be performed by the professional licensed personnel.</th>
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<tbody>
<tr>
<td>8.22 Pap Test/Smear (Papanicolaou Test):</td>
<td>100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance. for female participants.</td>
</tr>
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<td>8.23 Pathologist:</td>
<td>Payment up to Reasonable and Customary Allowance. Inpatient and Outpatient -.</td>
</tr>
<tr>
<td>8.24 Physical Exam</td>
<td>100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance, for routine physical exams.</td>
</tr>
<tr>
<td>8.25 Physical Therapy</td>
<td>Limited to a combined total of sixty (60) therapy sessions per injury or sickness unless Utilization Review approves additional sessions. Payment up to Reasonable and Customary Allowance.</td>
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<td>8.26 Physician Charges:</td>
<td>Payment up to Reasonable and Customary Allowance.</td>
</tr>
<tr>
<td>8.27 Pregnancy Prevention:</td>
<td>Outpatient contraceptive drugs approved by the United States Food and Drug Administration for use to prevent pregnancy are covered as other drugs under the Prescription Drug Program. Payment is limited to reasonable and customary costs. &quot;Outpatient contraceptive services&quot; means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy, but does not include methods to terminate an existing pregnancy.</td>
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<tr>
<td>8.28 Prescription Drugs</td>
<td>Eligible under major medical, but not eligible under the drug card program.</td>
</tr>
<tr>
<td>8.29 Prostate-Specific Antigen Test (PSA):</td>
<td>100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance, for</td>
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men age (forty) 40 and over OR medically necessary diagnostic testing at any age.

8.30 Radiologist: Payment up to Reasonable and Customary Allowance. Inpatient and Outpatient.

8.31 Speech Therapy: Payment up to Reasonable and Customary Allowance if Utilization Review approved.

8.32 Sterilization Procedures Payments up to Reasonable and Customary Allowance. Medical necessity not required.

8.33 Transplants (organ/tissue) Reasonable and Customary Expenses Incurred for the following named human organ transplants: cornea, kidney, bone marrow, heart, heart valve, heart/lung, lung (single or double), kidney/pancreas, pancreas and liver transplants, stem cell and reinfusion, cord blood transfusion, and tissue, subject to the following:

  a) If both the donor and recipient are covered by the Plan, each shall have benefits computed in accordance with the provisions of his/her own coverage.

  b) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient’s eligibility for benefits under the Plan.

  c) If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

  d) The Plan will pay for travel, lodging and meals as follows:

     (1) Transportation for the patient and one companion to accompany the patient to and from a transplant facility. If the patient is a minor child, the transportation expenses of two companions will be covered.

     (2) Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one (1) companion (two (2) companions for a minor child) who accompanied the patient.

     (3) Travel and lodging expenses are covered only if the transplant recipient resides more than fifty (50) miles from the transplant facility. Transportation, lodging and meal costs are limited to $200 per day and $10,000 per transplant.

  e) Re-transplantation expenses for one (1) re-transplant, for a total of two (2) transplants per person, per lifetime while covered under this Plan.

8.34 Vision Care: Benefits are first dollar benefit limited to $100 per participant every calendar year if participant is under eighteen (18) years of age, and every two (2) years if participant is eighteen (18) years and older.

• Vision Examination

When performed by an ophthalmologist, optometrist or optician, or any other qualified person licensed by the State of Illinois to conduct vision
examinations.

- Vision lenses and frames
- Contact lenses

Vision examinations, lenses, and frames, or contact lenses received before the participant’s effective date of vision benefits, or after termination from the Plan, are not covered. **Payment for frames, lenses, or contact lenses will not be made until these items are received by the participant.**

8.35 Well-Baby Care and Physical Exams:

100% payment up to maximum Wellness Benefit allowance (see 8.36) after which, Payment up to Reasonable and Customary Allowance, Routine infant healthcare charges, usually occurring at three (3) month intervals for the first eighteen (18) months of life; then from 18 months of age until age five (5) annual pediatric well-care covered.

8.36 Wellness Benefit:

100% Payment up to Reasonable and Customary Allowance for the first $500 of in-network Wellness charges incurred annually by each participant. Covered wellness services received in excess of the annual maximum will be subject to benefits as described in the Summary of Benefits. Examples of covered wellness services include: PAP (for women), PSA (for men), Mammogram, Flu & Pneumonia vaccines, childhood immunizations, well-baby visits, routine physical exams, cholesterol and other routine screenings.
HEALTHCARE BENEFITS  
Limitations and Exclusions

9.00 The following services and charges incurred for the same are limited or excluded from benefits of the Plan. The HR Generalist-Health & Risk and County Administrator will have the full authority to determine whether or not the service and charges for the same fall within the exclusion section of the Plan.

9.01 Cosmetic surgery (as defined in Section 29) and related services and supplies, EXCEPT for the correction of congenital deformities evidenced and diagnosed within ten years of birth, or for conditions resulting from traumatic injuries received, illness or diseases suffered while covered under this Plan. Refer to Section 8.05 for coverage under the Breast Reconstruction Act following mastectomy.

9.02 Experimental and investigational services and procedures. (See Section 29).

9.03 Those services and supplies not necessary for treatment or not recommended by the attending physician.

9.04 Charges which exceed the Reasonable and Customary Allowance.

9.05 Charges made only because there is coverage, but which are not medically necessary.

9.06 Charges that a Covered Participant or Participant’s dependent is not legally obligated to pay.

9.07 Custodial care (i.e.: companions, non-medical care).

9.08 To the extent allowed by the law of the jurisdiction where the description of the Plan is delivered, those for services and supplies:
   a) furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any participant in the armed forces of a government; or
   b) furnished, paid for, or for which benefits are provided or required under any law of government.
      (This does not include a plan established by a government for its own employees or their dependent).

9.09 The law of the jurisdiction where a participant lives when a benefit request occurs may prohibit certain benefits. If so, they will not be paid.

9.10 Hearing aids or similar aid devices.

9.11 Hearing tests (except when ordered by a physician for the diagnosis and/or treatment of an illness).

9.12 Orthopedic or orthotic braces or appliances prescribed by a physician that are fabricated or designed to support the feet.

9.13 Birth control methods used to terminate an existing pregnancy including elective abortions. Birth control methods used to prevent unintended pregnancies are covered under the conditions listed in Section 8.27.

9.14 Treatment of infertility or restoration or enhancement of fertility, including but not limited to fertility drugs, techniques of in-vitro fertilization including G.I.F.T. procedures and techniques or artificial insemination, reverse sterilization procedures.

9.15 Vitamins, prescribed and over-the-counter (except as specified elsewhere in this Plan).

9.16 Sickness or injury arising out of or in the course of any occupation or employment for wage or profit or for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law, occupational disease law or similar law.

9.17 Routine physical exams (except as specified elsewhere in this Plan) and county sponsored health screenings.

9.18 Immunization (except as specified elsewhere in this Plan).

9.19 Genetic testing (except as determined medically necessary by Utilization Review for treatment of a medical condition or symptoms).

9.20 Service agreements, maintenance agreements, or any other service expenses for the repair or maintenance of rented or purchased durable medical equipment.

9.21 Acupuncture.
9.22 Alternative, non-medical procedures.

9.23 Charge for service, supplies or treatments not recognized by the American Medical Association ("AMA") as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the AMA as having no medical value, or drugs not approved by the United States Food and Drug Administration.

9.24 Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with custodial care, education or training, or expenses actually incurred by other persons who are not Plan Participants.

9.25 Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the Armed Forces of any country, or with a civilian non-combatant unit serving with such forces.

9.26 Injury or Sickness sustained: (i) during the voluntary participation in a riot or the commission of an illegal act or crime, whether or not indicted or convicted, or (ii) while operating a motor vehicle under the influence of alcohol or other drug or controlled substance which is not taken as prescribed by a Physician. For purposes of this section, a person shall be presumed to be under the influence of alcohol if his blood-alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the Injury occurred. In addition, a person may be considered to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the Employer or Contract Administrator.

The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained.

9.27 Diagnostic testing unless prescribed by a personal or attending/consulting physician.

9.28 In a Veterans’ Administration Hospital, unless required by law or regulation.

9.29 For treatment of Temporomandibular Joint Dysfunction/Pain Syndrome ("TMJ"). (See Section 10.022 k), except as specified elsewhere in this Plan).

9.30 Biomicroscopy, field charting or anisekonic investigation.

9.31 Orthoptic or visual training.

9.32 IQ testing or other testing or training done for educational purposes.

9.33 Surgical and non-surgical treatment rendered to eliminate the need for corrective lenses.

9.34 Co-insurance under the prescription drug card is not covered under the medical portion of the Plan.

9.35 If admitted to a hospital on any Friday, Saturday or Sunday except if medically necessary and recommended by a doctor, due to an emergency, or if a surgical procedure is performed the day you are admitted.

9.36 Charges by a healthcare provider who is a relative of you or your spouse/civil union partner as defined in Section 29.

9.37 Charges for which confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual sickness or injury (except as specified elsewhere in the plan).

9.38 Services or supplies not mentioned in the Plan.

9.39 Diagnosis or treatment of impotence or erectile dysfunction, including but not limited to, therapeutic injections, oral medication therapy, hormonal therapy and other drugs, surgery, implantation devices, and supplies.

9.40 Expenses incurred for special education or training for learning disabilities, testing or training for education or vocation, or speech therapy including evaluation and treatment for other than acute traumatic injury or physical defect or swallowing (except as specified elsewhere).

9.41 Services and supplies (including but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports related activity or solely for maintaining a muscle, bone, or joint function.
9.42 Pre-existing medical conditions (except as otherwise provided herein).
9.43 Charges incurred outside of the USA if the covered person/dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.
9.44 Prescribing and fitting of an artificial eye after the initial prescription and fitting.
9.45 Except as specified elsewhere in the Plan, weight loss programs, dietary supplements, food supplements or food.
9.46 Weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses, or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes or other devices for support of the feet.
9.47 Purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, or mattresses or waterbeds.
9.48 Purchase or rental of motorized transportation equipment, escalators, or elevators, saunas, steam baths and swimming pools.
9.49 Sex transformation and hormones related to such treatment.
9.50 Radial keratotomy or keratoplasty.
9.51 Chelation Therapy
9.52 Expenses covered by auto, property and casualty or liability insurance or for which another party is liable.
9.53 Complications of pregnancy and pre-natal and post-natal care of mother and child where the mother has failed to obtain pre-natal medical care by the end of the second trimester and it is determined as a reasonable degree of medical certainty that timely pre-natal care would have avoided or reduced the severity of the pregnancy complications and pre-natal and post-natal conditions requiring additional medical care.
10.01 Under the County’s Plan, each covered participant is given two (2) free preventative dental services per year. Failure to obtain at least one (1) exam per year will result in 50% reduction of Primary and Major dental benefits during the next calendar year. Annual Dental limit of $1,000 per participant.

10.01 a) Preventative Dental Service:
100% Payment up to Reasonable and Customary Allowance. Deductible and co-insurance is waived.

10.01 b) Primary Dental Services:
80% Payment up to Reasonable and Customary Allowance. Subject to Deductible. (20% Co-insurance and the deductible amount do not apply to out-of-pocket expenses limit)

10.01 c) Major Dental Services:
50% Payment up to Reasonable and Customary Allowance. Subject to Deductible. (50% Co-insurance and the deductible amount do not apply to out-of-pocket expenses limit).

10.01 d) Orthodontics:
50% payment up to Reasonable and Customary Allowance. Subject to deductible. $2,000.00 Annual maximum per participant for all charges and fees for orthodontics due on or after January 1, 1998, less any amount previously paid by the Plan for the same continuous orthodontic treatment. Orthodontic benefits are separate from the $1,000 annual dental limit. Except orthodontic treatments commenced prior to May 1, 2001, orthodontic benefits are only available to Participants who have been covered under the Plan for twelve (12) or more continuous months immediately preceding the treatment. Orthodontic benefits are only covered for individuals age nineteen (19) and younger, unless the individual is a full-time student, in which case orthodontic benefits extend to age twenty-five (25).

**Pre-treatment estimate for services in excess of $500 is recommended**.

10.02 Definitions

10.021 Preventative dental services are defined as:

a) routine oral examinations, up to two (2) visits in a calendar year. (Failure to obtain at least one (1) exam will result in 50% reduction of Primary and Major dental benefits during the next benefit year);

b) routine cleaning & polishing, prophylaxis up to a maximum of two (2) treatments per calendar year;

c) topical fluoride application (to age nineteen (19)), up to a maximum of two (2) treatments per calendar year;

d) bitewing x-rays and full-mouth x-rays once a calendar year; and

e) sealants applied to permanent molar teeth of participants under age fifteen (15), but not more than one (1) application in any thirty-six (36) month period.

10.022 Primary dental services (routine) are defined as:

a) fillings; consisting of amalgam, silicate and plastic restorations;

b) extractions;

c) oral surgery;

d) endodontics;

e) space maintainers;

f) apicoectomies;

g) emergency treatment for relief of pain, including antibiotic injections;
h) periodontics, including gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontic examination, mucogingivoplasty surgery and management of acute periodontal infection and oral lesions, including perio prophylaxis;

i) repair and relining of removable dentures;

j) re-cementing of crowns, inlays and bridges;

k) charges for the treatment of Temporomandibular Joint Dysfunction/Pain Syndrome ("TMJ") if CPT coded and Utilization Review approved, and with an annual limit of $600;

l) general anesthesia, if administered in conjunction with performance of another covered dental procedure;

m) oral exams and x-rays which are other than routine in nature;

n) pulp vitality tests one (1) per year; and

o) hemisection.

10.023 Major dental services are defined as:
   a) inlays, onlays, and crowns or crown buildups (except for temporary crowns);
   b) bridges and bridge repair;
   c) full and partial dentures;
   d) gold foil restorations;
   e) orthodontics; and
   f) denture adjustments and relining during first six (6) months after obtaining dentures or having them repaired.

10.03 Orthodontics:
Orthodontics $2,000.00 Annual per participant to Age 19 and under for all charges and fees for orthodontics due on or after January 1, 1998 less any amount previously paid by the Plan for the same continuous orthodontic treatment. Orthodontic benefits are separate from the $1,000 annual dental limit. Except orthodontic treatments commenced prior to May 1, 2001, orthodontic benefits are only available to participants who have been covered under the Plan for twelve (12) or more continuous months immediately preceding the treatment.

10.04 Major Dental Expenses
Due to the 50% co-insurance provision for major dental services, it is strongly recommended that your service provider submit a pre-treatment Plan for services estimated to be in excess of $500.00.
11.0 Covered Dental Charges do not include charges for services and supplies:

11.01 Not ordered by a doctor.

11.02 Which do not meet the standards set by the American Dental Association.

11.03 In a Veterans’ Administration Hospital, unless you would legally have to pay such charges.

11.04 Due to theft or loss of an appliance.

11.05 Which you would not legally have to pay if there was no coverage.

11.06 Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the Armed Forces of any country, or with a civilian non-combatant unit serving with such forces.

11.07 Which are payable by a local or other agency of a government, except Illinois medical aid (Medicaid).

11.08 For cosmetic reasons, except as a result of accidental injury, including altering or extracting and replacing sound teeth to change appearance.

11.09 For dental work on dentures or bridges except as shown under “Covered Dental Charges”.

11.10 Tooth implants.

11.11 Athletic mouth guards.

11.12 Oral hygiene, dietary, plaque control and other educational expenses.

11.13 Duplicate prosthetic appliances.

11.14 Sickness or injury arising out of or in the course of any occupation or employment for wage or profit or for which the Covered Person or Covered Dependent is entitled to benefits under any workers’ compensation law, employers’ liability law, occupational disease law or similar law.

11.15 The placement of crowns, inlays, dentures, or bridges or the relining of dentures more than once per consecutive five (5) year period for the same teeth, unless they can not be repaired and made serviceable.

11.16 For any service, supplies or treatments that may have been eligible under the medical portion of the Plan.

11.17 Services provided by your or your spouse/civil union partner's immediate family or family of origin.

11.18 Oral surgery services related to a congenital deformity except when evidenced and diagnosed within ten years of birth, or for conditions resulting from traumatic injuries received, illness or diseases suffered while covered under this Plan.
13.01 PENALTY REASON AMOUNT

| 13.01 a) | Covered In-patient Admission to a NON-PPO Hospital. | $1,000 |
| 13.01 b) | *Inappropriate Use of the Emergency Room (see Section 15). | $150 |
| 13.01 c) | Failure to PRE-CERTIFY a covered In-Patient Admission, a covered Out-Patient Surgical Procedure of $500 or more, or a non-emergency CAT Scan, MRI or PET Scan. | $250 |
| 13.01 d) | **Use of a NON-PPO Facility for a covered Out-Patient Procedure over $500. | $250 |
| 13.01 e) | Failure to CERTIFY a covered Emergency Admission within seventy-two (72) hours, or a covered Psych or Substance Abuse admission within twenty-four (24) hours. | $250 |
| 13.01 f) | Failure to obtain at least one (1) dental exam will result in 50% reduction of Primary and Major dental benefits during the next benefit year. | 50% Reduction in Benefits |
| 13.01 g) | Pre-certification of pregnancy and receipt of Pre-Natal Care by the end of the second trimester is mandated for the welfare of the mother and unborn child. Possible reduction in benefits |
| 13.01 h) | Maternity admission must be certified within twenty-four (24) hours or a delay in payment of claims may result. Possible delay in payment |

*The HR Generalist-Health & Risk will assess the situation if, after Utilization Review, there is a question of appropriateness.

**This penalty does not apply to a covered out-patient surgical procedure that can safely be performed in the physician’s office.

13.02 a) In order to avoid a penalty assessment, please follow the provisions set forth in this Plan. The Plan Administrator hopes that no one will be assessed a penalty.

13.02 b) Penalties will be deducted from the amount of claims eligible for payment at the time the eligible claims are processed.

13.02 c) Exclusions to the Penalty assessment are listed under Section 13.03.

13.02 d) Penalties will not apply towards a Deductible or Co-Insurance amounts.

13.02 e) Appeals of penalties must be made in writing to the Plan Administrator for consideration. The HR Generalist-Health & Risk can assist you in determining your rights.

13.02 f) In order to prove the pre-certification was completed on your part, please note the date of your telephone call and the name of the person with whom you spoke.

***IF IN DOUBT, CALL THE HR GENERALIST-HEALTH & RISK @ (309) 672-6071 FOR ASSISTANCE***
PENALTIES DO NOT APPLY IN THE FOLLOWING SITUATIONS:

13.03 a) If the County’s Plan is Secondary and the network guidelines of the Primary Plan are being followed.
13.03 b) If an Emergency Admission is certified within seventy-two (72) hours after admission.
13.03 c) If the services are not available at a PPO Facility and are referred to a NON-PPO by the PPO provider.
13.03 d) A court order requires treatment at a NON-PPO facility.
13.03 e) The Patient is referred to a Center of Excellence through Utilization Review.
13.03 f) The primary Participant is a Non-Custodial Parent of a dependent and is unable to influence the place of treatment.
13.03 g) The Participant suffers an emergency as defined in Section 15 and goes to the nearest hospital or other medical facility inside or outside the fifty (50) mile radius.
13.03 h) Participating retirees permanently residing outside the fifty (50) mile radius, Students attending school outside the fifty (50) mile radius and in the case of an emergency as defined in Section 15, or when prompt treatment is medically necessary as defined in Section 5, any Participant temporarily residing or traveling outside the fifty (50) mile radius other than traveling and/or residing for the primary purpose of receiving medical or other care covered by this Plan.
15.01 Below is a generally accepted list of emergency conditions or symptoms for which emergency room services may be required. If you or your dependent experiences any of the following conditions or symptoms and the emergency room report documents such, no penalty will be imposed for usage of the emergency room as indicated in Section 13.

15.01 a) Life or limb could be lost if symptoms are left untreated;
15.01 b) You have uncontrolled seizures, chest pain, difficulty breathing, or the possibility exists of heart attack or stroke;
15.01 c) There could be harm to an unborn child;
15.01 d) You are involved in an industrial accident involving severe burns or chemical exposure;
15.01 e) The condition is life-threatening;
15.01 f) You have uncontrolled bleeding;
15.01 g) Admission to the hospital;
15.01 h) You are experiencing the sudden onset of severe abdominal pain, nausea and vomiting;
15.01 i) You suffer the sudden onset of an unexplained headache.

15.02 Visit a Unity Point Clinic or Proctor First Care Methodist MedPointe if you are unable to visit your primary physician and experience any of the following:

- Cold
- Sore Throat
- Fever
- Upper Respiratory Difficulties
- Flu Symptoms
- Rash
- Sprained Ankle
- Minor Laceration
- Routine Non-Emergency Ailment
17.01 If a participant needs Hospital Care:
Pre-Certify with the Utilization Review Administrator, unless it is an emergency. Present Plan Identification Card when the participant enters the hospital. The participant may or may not need to fill out claim forms or report any hospital charges to the Claims Administrator. Most hospitals will bill the Claims Administrator directly and all covered services will be paid for the participant.

17.02 If a Participant Needs Physician Care:
The participant should show the Physician his/her identification card and request the physician to bill the Claims Administrator for all physician services to the participant which may be payable under this Plan—whether at his/her office, the participant’s home or in the hospital—indicating diagnosis, date(s) of service and fee(s).

17.03 Prescription Drugs:
When a physician prescribes medicine, use the preferred prescription program. (See "Exhibit A").

17.04 When to File a Claim:
The participant should file a claim as soon as she/he receives charges for services covered under the Plan. All claims relating to payment for a benefit covered by the Plan must be filed within ninety (90) days from the provider’s initial billing date, or within ninety (90) days of the primary carrier’s EOB should this Plan be secondary. A claim shall not be considered filed unless and until all required information relating to the service or benefit for which the claim has been filed has been provided to the Claims Administrator.

17.05 How to File a Claim:
All claims should be filed as promptly as possible after the date the expense was incurred. Most providers will bill the Claims Administrator for you, but sometimes the provider of healthcare services does not bill the Claims Administrator directly and bills the participant for such services as:

a) Physician Care;
b) Blood and blood Plasma;
c) Diagnostic X-ray and Laboratory Examinations;
d) Rental of Medical Appliances or Durable Medical Equipment; or
e) Ambulance Services.

CLAIMS FILED AFTER NINETY (90) DAYS FROM THE INITIAL BILLING DATE WILL BE DENIED. BENEFITS REQUESTS MAY NOT BE COVERED AFTER THIS PERIOD OF TIME.

17.06 Assignment of Benefits:
Benefits are automatically assigned and will be paid directly to the hospital, physician or other provider of healthcare services, unless the bill indicates that it has already been paid. IF THE PARTICIPANT HAS ALREADY PAID THE BILL, INDICATE THIS FACT CLEARLY WHEN THE CLAIM IS FILED.

17.07 Annual Enrollment:
The Primary Participant must submit an enrollment form each calendar year during the Open Enrollment period.
19
COORDINATION OF BENEFITS

19.01 Coordination of Benefits ("COB") applies when you have healthcare coverage through more than one healthcare plan. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled, but no more than the Plan would have paid without this provision. The total payment from all health Plans will not exceed more than this Plan would have paid without this special provision. It is your obligation to notify the Plan Administrator about coverage under other benefit plans. **Failure to do so which results in double or overpayment may constitute Criminal Fraud for which you will be prosecuted.**

19.02 When you are covered by more than one group healthcare plan, the following Coordination of Benefits provision applies, these following rules will be used to determine which plan will be the first to pay its benefits:

19.02 a) The plan that covers the person as an employee, primary participant or as the certificate holder is the plan that pays first. This plan is called the “primary plan.” The plan that covers the person as a dependent spouse/civil union partner or other dependent is the plan that pays second. This plan is called the “secondary plan.”

In the case of a participant retiree who was employed elsewhere and is covered under another plan as a retiree, the plan which covered the retiree for the longest period of time shall be the primary plan. If a participant retiree is employed and is covered under the new employer plan, our plan is secondary.

19.02 b) If a dependent child is covered by both participating parents’ plans, the plan covering the parent whose birthday falls earlier in the year pays first.

19.02 c) When the parents are divorced: If there is a court decree which established financial responsibility for the medical, dental or other healthcare expenses with respect to the dependent child, the benefits are determined in agreement with the court decree. In the absence of a court order, the "Birthday Rule" will be applied to the natural parents to determine which plan will be primary.

19.03 When another plan covers the participant, exact duplicates of all bills being submitted to each carrier or administrator involved should be sent to assist the plans in coordinating benefits without a lengthy delay. If the Plan is paying as the secondary plan, the Claims Administrator must be notified of the amount(s) paid by the primary plan before this Plan’s payment can be made.

19.04 If none of the above COB rules apply, a plan is Primary if it has covered the individual upon whose behalf the claim is made, for the longer period of time.

19.05 In the absence of COB provisions in other plans, this Plan’s provisions will be followed.
20.01 If you are in Active Service as an employee of the County of Peoria, and covered under the Plan for medical, dental, vision, and prescription drug benefits, this Plan will determine its benefits without taking into account Medicare benefits for which you or your covered spouse/civil union partner are eligible unless required by law (i.e. kidney dialysis). However, upon retirement, Medicare will become the primary payor and this plan’s benefits will be secondary, regardless of enrollment.

Pursuant to COBRA '93 (Effective August 10, 1993):

20.01 a) MEDICARE

1) Upon retirement, Medicare will become the primary payor and this plan’s benefits will be secondary, regardless of enrollment. This Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B & D, regardless of whether or not the person was enrolled under any of these parts.

2) This Plan will be considered the primary plan for Primary Participants who are in Active Services, and their participating Dependents, who are nevertheless eligible for Medicare benefits if: (i) such Primary Participant or participating Dependents are age sixty-five (65) or older; or (ii) such Primary Participant or participating Dependents are disabled.

23) This Plan shall be considered the primary plan during the first thirty (30) months of coverage for End Stage Renal Disease unless the Primary Participant or participating Dependent rejects coverage under this Plan. After thirty (30) months, Medicare shall be considered the primary plan.

4) Coordination of Prescription Drug Benefits With Other Plans. If another plan, including a Medicare Part D prescription drug plan, is primary for a member of your family (it should pay its benefits first), you should give the pharmacy both ID cards and any secondary benefits for which this Plan is responsible may be processed at the point of sale. If, for some reason, this does not occur, you may submit copies of the prescription and the primary plan's Explanation of Benefits (or a copy of the receipt for the co-payment if the other plan has a drug card or mail-order program) to MedTrak for reimbursement using the patient profile found on the mail-order envelope.

20.01 b) MEDICAID

Payments for expenses with respect to a Primary Participant or participating Dependent under this Plan will be made in accordance with any assignments of rights made by or on behalf of such Covered Participants or Covered Dependents as required under applicable provisions of Medicaid.
The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

f) Make available protected health information in accordance with 45 C.F.R. 164.524;

g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. and other applicable state or federal laws. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.
22.01 In cases where a claim is denied in whole or in part, the claimant may appeal the denial. Should you choose to appeal a claim Payment/Denial decision, you may do so by written request within ninety (90) days after the claim payment date or the date of the notification of the denial of benefits. Correspondence should be directed to the Third Party Administrator, which shall date and record the date the appeal is received:

Consociate  
151 E. Decatur Street  
PO Box 1068  
Decatur, IL 62525-1068  
Fax (217) 233-7252

This appeal provision will allow the claimant or anyone authorized to act upon his/her behalf to:

- Request a review of the eligibility status for any claim denied in whole or in part.
- Request a review of any claim payment. Such request must include the name of the employee, his/her social security number and the name of the patient.
- Stating, in writing, in clear and concise terms the reason(s) for this disagreement with the handling of the claim, as well as any pertinent data, questions or appropriate comments.

The Third Party Administrator shall grant or deny the appealed claim within thirty (30) days of receipt. If after review by the Third Party Administrator the claim is still denied, a review will be made by the County Administrator designated HR Generalist-Health & Risk. The HR Generalist-Health & Risk will provide the claimant with a written response within sixty (60) days of the date the HR Generalist-Health & Risk received the claimant’s written request for review. If, because of extenuating circumstances, the HR Generalist-Health & Risk is unable to complete the review process within sixty (60) days, the HR Generalist-Health & Risk shall notify the claimant of the delay within the sixty (60) day period and shall provide a final written response to the request for review within one hundred and twenty (120) days of the date the claimant’s written request for review was received.

The HR Generalist-Health & Risk’s written response to the claimant shall, if the denial is upheld, cite the specific Plan provision(s) upon which the denial is based.

Should a participant choose to appeal a healthcare decision, he/she may do so by written request to the County Administrator at:

County Administrator  
County of Peoria  
324 Main Street, Room 502  
Peoria, Illinois 61602

Please note that all appeals are by an assigned number. All identifiers of the Participants will be deleted by the HR Generalist-Health & Risk. All employees fully understand the privacy rights inherent in medical care, and that improper dissemination of any information can result in severe liability/penalties for the person or persons violating privacy rights.

If you have any questions about your right of appeal, you may contact the HR Generalist-Health & Risk at (309) 672-6071.
23
SUBROGATION
And
THIRD PARTY RECOVERY

23.01 Subrogation:
If you or one of your covered dependents is injured by the act or omission of another person and benefits are provided for covered services described in this Plan, and if you or one of your covered dependents has a claim against that other person for payment of the medical or dental charges, the Plan will be subrogated to all rights the covered person may have against that other person.

You or your covered dependents must immediately reimburse the Plan 100% for any payments received, whether by action at law, settlement, or otherwise, to the extent that the Plan has provided benefits to you or your covered dependents; and the Plan will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the injury, the person’s agent or a court having jurisdiction in the matter.

It is your responsibility to execute and deliver in writing all required information to reimburse and provide the Plan a first lien and assist or provide any other documents that the Plan may request in order to secure the right of subrogation.

Only the amount recovered for medical or dental charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of medical or dental benefits paid for the injury under the Plan.

This right of subrogation and refund also applies when a covered person recovers under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan or any liability plan.

23.02 Third Party Recovery:
If any services or treatment are related to an injury or illness due to another person’s negligence for which you may seek recovery from a third party, your Plan will pay its normal benefits provided you agree, in writing, to reimburse the Plan 100% of the benefits so provided when you receive payment from the third party. This provision also applies to any payments made under an automobile insurance policy because of “no fault” automobile legislation.

23.03 Excess Insurance Provision
If at the time of injury or sickness there is available, or is potentially available, based on information known or provided to the Plan Administrator, the Contract Administrator, Plan Participant, any other insurance, or other form of indemnification, including but not limited to a judgment at law or settlement, the benefits under this Plan shall apply only as excess insurance over such other sources or indemnification; by way of illustrating but not in limitation, this provision shall be applicable to those Expenses incurred as the result of Sickness or Injury when:

a) the Plan Participant is injured by or in the course of operating a motor vehicle;
b) the Plan Participant is injured on the premises insured by the owner or occupier for indemnification;
c) the Plan Participant is injured by a third-party tort feasor; or
d) the Plan Participant is injured while maintaining the status of a full-time student.

If, in the discretion of the Plan Administrator, payment of medical expenses is made when the provisions of this Section apply, or at a time when such provisions may later become applicable, said payment may be made on the condition that the Plan Participant or Participating Dependent agrees in writing to:

a) reimburse the Plan one hundred percent (100%) of the benefits actually provided without reduction for, or application of, the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, immediately upon collection of damages by him, whether obtained by action at law, settlement, or otherwise; and

b) provide the Plan with a first lien to the extent of benefits provided by the Plan. Said lien may be filed with any person or organization liable, or potentially liable, to the Plan Participant for indemnification, the Plan Participant’s attorney, or the court.
24.01 Termination of Coverage:
Coverage for a Covered Employee shall automatically terminate except as provided in Section 25, upon the earliest of the 15th or the last day of the month in which any of the following events occur:

a) Employee fails to meet the eligibility requirements.

b) Employee fails to make any required contribution for coverage.

c) Employee terminates employment with the County of Peoria.

d) Employee requests in writing the termination of coverage. (Employee must wait until annual enrollment period to rejoin the Plan).

e) Employee fails to renew coverage for the following year; coverage will terminate as of January 1.

f) Death.

24.02 A dependent’s coverage shall automatically terminate except as provided in Section 25, upon the earliest of the 15th or the last day of the month in which any of the following events occur:

a) The dependent is no longer eligible as defined in this Plan.

b) Employee’s coverage terminates.

c) Employee fails to make any required contribution for coverage.

d) Employee requests, in writing, termination of dependent coverage. Such request must be co-signed by his or her spouse/civil union partner, or former spouse/civil union partner having custody of dependent children.

e) Death

f) Dependent becomes eligible to be covered as an employee.

In the event that the entire Plan terminates or the Plan terminates all dependent coverage, coverage will terminate on the date of the termination made by the Plan.

24.03 The Plan may retroactively rescind coverage on participants due to fraud or misrepresentation of facts. Participants have the right to appeal in writing within 30 days of notification.
25.0 **Termination of Employment Primary Participant/Continuation Rights of Participating Dependents**

25.01 If you are an inpatient at the time your coverage under this Plan is terminated, benefits will be provided for, and limited to, the covered services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, or Psychiatric Day Treatment Facility. Benefits will be provided until you are discharged or until twelve (12) months have passed since the date coverage would otherwise terminate, whichever occurs first. In any event, required premium payments must continue.

25.02 **Continuation of Benefits under COBRA:**

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specific conditions.

For the purpose of this Section, “Qualified Beneficiary” means any beneficiary defined as such pursuant to Section 300bb-8(3) of Public Health Service Act (PHSA), 42 U.S.C.A. § 300bb-8(3), and which generally includes any participant whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this section.

25.021 **Eligibility to Make Election:**

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

25.021 a) The Primary Participant's death;

25.021 b) Termination of the Primary Participant's employment or reduction of the Primary Participant's hours (whether voluntary or involuntarily);

25.021 c) Divorce of the Primary Participant and his/her spouse/civil union partner;

25.021 d) A Primary Participant's child ceasing to be an Eligible Dependent; or

25.021 e) A proceeding in bankruptcy under Title II, United States Code, commencing on or after July 1, 1986, with respect to the Employer.

25.022 Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation of coverage if the participant's termination of employment is for gross conduct as determined by the Employer in its sole discretion, pursuant to a uniform, nondiscriminatory policy. In the case of bankruptcy proceedings as described in (e) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceeding.

You should carefully review the COBRA NOTICE attached hereto as "Exhibit C".

25.03 **Health Insurance Marketplace Options for You and Your Family**

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace visit [www.healthcare.gov](http://www.healthcare.gov).
25.04 Continuation of Coverage upon a Primary Participant's death (Survivors):

25.04 a) In the event of your death while you are covered as a Primary Participant of the Plan Sponsor, your surviving dependents* enrolled in the plan may continue coverage until the end of the month in which the death occurs, plus the following three (3) calendar months at no contribution (at no cost), or until the dependent is eligible to be enrolled in another group plan, whichever occurs first.

25.04 b) Coverage may also be continued under legislation commonly referred to as COBRA. See attached COBRA documents "Exhibit C". Continued participation is contingent upon payment of the required monthly premium and will be subject to the eligibility requirements set forth in this plan.

25.04 c) In circumstances not specifically covered in this Plan, coverage may also be continued for yourself and your dependents consistent with the personnel policy or State of Illinois Laws applicable to you.

*Includes current pregnancy at the time of the Primary Participant’s death.

25.05 Continuation of Coverage while Primary Participant on Military Leave

In accordance with the Uniformed Service Employment and Reemployment Rights Act of 1994 ("USERRA"), continuation coverage under the Plan is available to Primary Participants and their Participating Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section described above.

25.05 a) Election and Duration of Coverage

A Primary Participant may elect to continue coverage under the Plan for himself and his Participating Dependents if coverage would otherwise cease under the Plan due to that person’s absence from employment with the Employer by reason of his service in the uniformed services. The maximum period of coverage available to all Primary Participants and Participating Dependents under the provisions of this Section shall be the lesser of:

(1) the eighteen (18) month period beginning on the date on which the Primary Participant’s military leave began; or

(2) the day after the date on which the Primary Participant fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.

25.05 b) Benefits

Benefits under the Plan for Primary Participants and Participating Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Primary Participants and Participating Dependents. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Primary Participants and Participating Dependents.

25.05 c) Payment for Benefits

A Primary Participant is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or scheduled of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Primary Participant’s failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Primary Participant shall be precluded from extending, renewing or reelecting such continuation coverage.
25.05 d) Employee Returning from Military Leave

In the case of a Primary Participant whose coverage under the Plan was terminated by reason of service in the uniformed services, the Primary Participant and his Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to Full-time Employment. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

25.06 Retirees:

All employees (and applicable dependents) have a right to continuation coverage under the Peoria County IMRF Medicare Eligible Retiree Health Care Plan as retirees if they participate in the Peoria County IMRF retirement and disability plan and are eligible for Medicare. A few employees qualify for different retirement health care coverage under their respective collective bargaining agreements. Each individual employee must consult their applicable collective bargaining agreement to determine if any of these specific plans apply to them.

The continuation coverage mandated for those under the IMRF makes available continuation coverage at full premium during the “retirement or disability”. Specifically as set forth in the applicable statute as follows:

(4) The “retirement or disability period” of an employee means the period:

(A) which begins on the day the employee is removed from the municipality payroll because of the occurrence of either of the following events: (i) the employee retires from active service as an employee with an attained age and accumulated creditable service which together qualify the employee for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code, or (ii) the employee’s disability is established under Article 7 of the Illinois Pension Code; and

(B) which ends on the first to occur of any of the following events: (i) the employee’s reinstatement or reentry into active service as provided for under Article 7 of the Illinois Pension Code, (ii) the employee’s exercise of any refund option or acceptance of any separation benefit available under Article 7 of the Illinois Pension Code, (iii) the employee’s loss pursuant to Section 7-219 of the Illinois Pension code of any benefits provided for in Article 7 of that Code, or (iv) the employee’s death or, if at the time of the employee’s death the employee is survived by a spouse/civil union partner who, in that capacity, is entitled to receive a surviving spouse/civil union partner’s monthly pension pursuant to Article 7 of the Illinois Pension Code, the death or remarriage of that spouse/civil union partner.

25.07 Certain Health Department Employees/Retirement Coverage:

Prior to joining the Peoria County Self Insured Health Plan, the City/County Health Department provided Employer paid Health Care coverage during retirement. When the Health Department joined the County Plan, it was agreed that twenty-two (22) long standing employees would be “grandfathered” and have the right to maintain retirement Health coverage with the County paying $486.46 of each Premium (80% of the Premium in effect on December 31, 2004), and the employee paying any remaining portion of each Premium. The requirements are:

a) enrolled in the Peoria County Health Benefit Plan; and

b) have at least twenty (20) years of service with the department may continue single coverage under the County’s Plan, except for the dental coverage, upon retirement under the rules of the Illinois Municipal Retirement Fund.

25.08 S.L.E.P. LAW ENFORCEMENT RETIREES:

The County will provide continued coverage of the Peoria Health Benefit for employees who meet the retirement eligibility criteria – of (a) having at least twenty (20) years of service with the
Sheriff’s Department as a commissioned officer and (b) meets the S.L.E.P. required minimum retirement age of fifty (50) years old and retires at the same rate as paid by active employees. Employees who retire after December 31, 1993 will pay all of the premium cost (100%) as a member and all of the premium cost (100%) for dependent coverage.

25.1 Upon Leaves of Absence, Disability, Maternity, Medical, Military Reserve, and Workman’s Compensation

25.11 Participating employees who take either a single or a combination of leaves by reason of disability, maternity, medical extended illness, military reserve training, and workman’s compensation have a right to continued coverage at the employee’s rate up to one year. Maternity leave, however, is limited to the period of time which is medically necessary as determined by a physician. During any such period of leave of absence, the Primary Participant and Participating Dependents maintain all rights of enrollment and re-enrollment as if the Primary Participant were actively employed. Such period of leave, in most instances, will count towards the calculation of maximum extended coverage under COBRA. (See Section 25.02). Any questions concerning the actual duration of continuation coverage while on leave of absence should be directed to the HR Generalist-Health & Risk. Please note that the failure to timely pay the employee rate premium while on any leave of absence will result in a termination of coverage pursuant to Section 3 and Section 24 of this Plan.
In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Primary Participants and their Covered Dependents under certain specified conditions.

A Primary Participant who takes a leave of absence under applicable provision of FMLA is entitled to continued coverage under the Plan for him/herself and his/her Covered Dependents. Benefits under the Plan are available to the same extent as if the Primary Participant has been in Active Service during the entire leave period, subject to the following terms and conditions.

26.01 a) Coverage shall cease for a Primary Participant (and his/her Covered Dependents) for the duration of the leave if at any time the Primary Participant is more than thirty (30) days late in paying any required contribution. COBRA does not apply.

26.01 b) A Primary Participant who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same term as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

26.01 c) If a Primary Participant who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his absence, the Primary Participant’s entitlement to the Plan benefits continues unless and until the Primary Participant advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied. COBRA may apply.

26.01 d) Any portion of the cost of coverage which had been paid by the Primary Participant prior to the leave must continue to be paid by the Primary Participant during the leave. If the cost is raised or lowered during the leave, the Primary Participant shall pay the new rates. If the leave is unpaid, the Primary Participant and the Employer shall negotiate a reasonable means for paying the Primary Participant’s portion of the cost.

26.01 e) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Primary Participant is on leave, the Primary Participant is entitled to the new or changed plan and benefits to the same extent as if the Primary Participant were not on leave.

26.01 f) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Primary Participant fails to return to work after the Primary Participant’s leave entitlement has been exhausted or expires, unless the reason the Primary Participant does not return to work is due to (1) the continuation, recurrence, or onset of a serious health condition which would entitle the Primary Participant to additional leave under FMLA; or (2) other circumstances beyond the Primary Participant’s control. If a Primary Participant fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Primary Participant’s behalf during a period of unpaid leave, the Employer may require medical certification of the Primary Participant or the Covered Dependent’s serious health condition. The Primary Participant is required to provide medical certification within thirty (30) days from the date of the Employer’s request. If the Employer requests medical certification and the Primary Participant does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.
27.01 The plan shall comply with the terms of a Qualified Medical Child Support Order (“QMEds”) directing the Plan to provide benefits to one or more alternate recipients. The Order must be served on the Plan Administrator. The Administrator has twenty (20) days after receipt to make a preliminary determination as to whether or not the Order satisfies the requirements of a valid QMED.

In order to qualify as a QMEDs, a court order must contain, at minimum, the following information:

27.01 a) a clause which creates or recognizes the existence of a dependant’s right to receive benefits under the Plan;

27.01 b) the name and last-known mailing address of the covered person with respect to whom the order is issued and each dependent covered by the order;

27.01 c) the social security number of each dependent covered by the order;

27.01 d) a reasonable description of the type of coverage to be provided by the Plan to each dependent;

27.01 e) a clause which specifies that the order applies to the Plan, as well as the time period to which the order applies; and

27.01 f) a clause which states that the order does not require the Plan to provide any type or form of benefit not otherwise provided under the plan.

27.02 An order which, in the judgment of the Plan Administrator, does not meet the requirements of the QMED shall be returned to legal counsel who prepared the order, or to the employee, retiree, survivor or COBRA participant, for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.
28 GENERAL ADMINISTRATIVE INFORMATION

28.01 FUNDING THE PLAN AND PAYMENTS OF BENEFITS:

Funding of the Plan is derived from the funds of the County of Peoria, outside groups and contributions made by the covered Primary Participants.

The amount of any participant contributions will be set by the Peoria County Board. These participant contributions will be used in funding the cost of the Plan as soon as practical after they have been received from the participant or withheld from the participant's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

28.02 INVALID PROVISION:

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Benefits are paid directly from the Plan through the Claim Administrator.

28.03 GOVERNING LAW:

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois, where it has been executed, except where preempted by federal law.

28.04 EXCLUSIVE BENEFIT/LEGAL ENFORCEABILITY:

The Plan has been established, and is being maintained, for the exclusive benefit of the participants of the County of Peoria’s Healthcare Plan. The Plan terms, as provided herein, are legally enforceable by the participants.

28.05 NON-ALIENATION OF BENEFITS:

Benefits payable under this Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse/civil union partner or former spouse/civil union partner or for any other relative of a Primary Participant or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

28.06 TERMINATION OR AMENDMENT TO THE PLAN:

The Peoria County Board intends to maintain this Plan indefinitely. This includes amending the benefits under the Plan.

The Plan may be amended, cancelled or discontinued at any time by the Peoria County Board, with or without the consent of any covered individual provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a participant shall have become entitled prior to such amendment or termination of the Plan. In the event of termination of the Plan, written notice of such termination and the rights of all plan participants shall be provided to all Participants in a timely manner. In the event of an amendment which affects any rights described in the Summary Plan Descriptions issued under the Plan, new booklets or notices showing the change will be distributed.

If the Plan is terminated, the rights of the participants are limited to expenses incurred before termination.
OUTSTANDING CLAIMS AFTER TERMINATION OF THE PLAN:
No benefits are available for services or supplies incurred after date of termination of the Plan except as otherwise specifically stated. Any outstanding or un-reimbursed claims incurred prior to the termination date of the Plan will be the responsibility of the Plan.

LEGAL ACTION:
No legal action can be brought to recover under any claim for payment of benefits after one (1) year from the time proof of loss is required by this Plan.

Benefit payment will not be reduced or denied on the grounds that a condition existed before a person’s coverage went into effect, if the loss occurs more than one (1) year from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss. In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.

CLAIMS MISTAKENLY PAID:
The Claims Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid in the basis of claims filed which were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with the Claims Review Procedures herein. A payment by the Claims Administrator in accordance with the Plan is not an admission by the Employer or Claims Administrator that the Expenses incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

LIABILITY DISCHARGE
Any payment by the Claims Administrator in accordance with these provisions if not timely appealed will discharge the Employer and the Claims Administrator from all further liability to the extent of the payment made.

RIGHT TO RECEIVE AND RELEASE INFORMATION
The Claims Administrator, pursuant to the reasonable exercise of its discretion, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Claims Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if they apply. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

WITHHOLDING OF BENEFIT PAYMENTS
In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Claims Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer’s sole judgment is satisfactory to it, or until the Employer and Claims Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

INDEPENDENT MEDICAL EXAMINATIONS
The Plan Administrator will have the right and opportunity to request an independent medical examination of any Covered Participant who is requesting benefits consideration. This examination will be paid for by the Plan.

The Plan does not, however, pay for medical exams or records requested due to the Evidence of Insurability investigations initiated for late entrant employees and dependents. All expenses incurred for such investigations are the responsibility of the applicant.
29.0 Certain words and phrases have a special meaning in this booklet. The explanations that follow will help you understand your coverage.

**ACCIDENT:** An unforeseen, undersigned, sudden, and unexpected event resulting in an injury, excluding events of intentional or reckless criminal acts by the Participant.

**ACTIVE EMPLOYMENT:** An individual will be considered in Active Employment on a day which is a scheduled work day if he/she is performing in the customary manner all of the regular duties of his/her employment either at his/her place of employment or at some location at which that employment requires him/her to travel, or if he/she is absent from work solely by reason of vacation or authorized absence (other than due to disability). An individual will be considered in Active Employment on a day which is not a scheduled work day only if he/she was performing in the customary manner all of the regular duties of his/her employment on the last preceding scheduled work day.

A dependent will be considered in Active Employment on any day if he/she is then engaging in all the normal activities of a person in good health of the same age and sex, and he/she is not confined in a medical facility. (This paragraph does not apply to a newborn child).

**AMBULANCE SERVICE:** Use of a vehicle for transportation of the sick and injured, equipped and staffed to provide medical care during transit.

**ANCILLARY CHARGES:** Reasonable and medically necessary inpatient facility charges not otherwise stipulated or excluded in the Plan.

**ANESTHESIA:** Partial or complete loss of sensation with or without loss of consciousness as a result of disease, injury or administration of an anesthetic agent, usually by injection or inhalation.

**BIRTHDAY RULE:** The plan of the parent whose birthday (month and day) occurs earlier in a calendar year will be the primary plan.

**BIRTH CONTROL:** Prevention of implantation of the ovum, or of birth, by temporary or permanent measures.

**CHEMOTHERAPY:** The treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs.

**CHIROPRACTOR:** A person certified and licensed to practice chiropractic care.

**CLAIM:** Notification that a service has been rendered or furnished to you. This notification must include full details of the service received and any other information which may be requested in connection with services rendered to you.

**CLAIM CHARGE:** The amount which appears on a claim as the provider's charge for service(s) rendered to you.

**CLAIM PAYMENT:** The resulting benefit payment calculated after submission of a claim, in accordance with the benefits described in this Plan.

**C.N.A.:** Certified Nursing Assistant

**COBRA:** Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer must offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate under the terms of this Plan.

**CO-INSURANCE:** The portion of eligible charges paid in a calendar year by the Plan Participant as stated in the Plan, but not including the deductible.

**COLO-RECTAL CANCER SCREEN:** Initial non-surgical test used for the early detection of cancer in the colon and rectal areas.

**COMPLICATIONS OF PREGNANCY:** Conditions (when the pregnancy is not terminated) where diagnoses are distinct from the pregnancy but which are adversely affected by pregnancy such as: acute nephritis, nephritis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable
severity. Complications of pregnancy also include, but are not limited to, elective caesarian section, an ectopic pregnancy which is terminated or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible; and pernicious vomiting (hypermnesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy).

Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions which, although associated with the management of a difficult pregnancy, are not medically classified as distinct complications of pregnancy.

**CONGENITAL DEFORMITY:** An abnormality present at birth.

**COSMETIC SURGERY:** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an illness or injury.

**COVERED PERSON:** A participant or eligible dependent whose coverage is in effect under the Plan.

**COVERED SERVICE:** A service or supply specified in this Plan for which benefits will be provided.

**CT (CAT) SCAN:** Computerized Tomography

**CUSTODIAL CARE SERVICE:** Those services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of custodial care services are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial care service also means providing inpatient service and supplies to you if you are not receiving skilled nursing services on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can be safely and effectively administered to you as an inpatient in the health care facility involved.

**DEDUCTIBLE:** The first amount of eligible charges to be paid by the Participant up to stated Plan specific limits in a calendar year.

**DENTAL SERVICES:** Means care and treatment of the teeth and gums, or any services rendered by a Dentist or dental surgeon.

**DENTIST:** Means a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**DEPENDENT:** As defined in Section 1.02 of this Plan.

**DIAGNOSTIC SERVICE:** Tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyogram.

**DIALYSIS FACILITY:** A facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

**DIALYSIS TREATMENT (RENAL):** One unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

**DISABILITY OR DISABLED:** Wholly and continuously disabled by illness or injury which prevents an eligible participant from working for remuneration or profit, as determined by a physician. With respect to dependents, wholly and continuously prevented by accidental bodily injury or illness, from engaging in substantially all normal activities of a person of like age and sex in good health, as determined by a physician.

**DURABLE MEDICAL EQUIPMENT:** Equipment which is able to withstand repeated use and is primarily and customarily used to serve a medical purpose and not generally useful to a person in the absence of illness or injury.

**EFFECTIVE DATE:** The date, as determined under enrollment, on which a participant’s coverage under this Plan commences.
ELECTED OFFICIAL: Auditor, Circuit Clerk, Coroner, County Clerk, Recorder of Deeds, Sheriff, State's Attorney, and Treasurer.

ELIGIBLE CHARGE: Medically necessary expenditures for services, supplies and treatments for injury and illness for which the provisions of the Plan specifically provide benefits, as set forth herein. In no event shall any expenditure that is incurred for an injury or illness for which the provisions of the Plan do not specifically provide benefits be considered an eligible charge.

ELIGIBLE PERSON: A Participant who meets the eligibility requirements for this health coverage, as described in the eligibility section of the Plan.

EMERGENCY: The sudden and unexpected onset of a medical condition or injury as defined in Section 15.

EVIDENCE OF INSURABILITY/ MEDICAL UNDERWITING: Process by which the applicant must submit, at his own expense, evidence of his good health which is satisfactory to the claims administrator’s medical review. An applicant for whom coverage is so approved will be subject to the limitation on pre-existing conditions as prescribed herein and the eligibility date will be the late of (i) the date determined in accordance with the above eligibility date section, or (ii) the date of approval by the employer and claims administrator of the evidence of good health. Failure to prove good health which is satisfactory to the claims administrator is grounds for denial.

EXPERIMENTAL AND INVESTIGATIONAL: The medical use of a service or supply that is still under study and which is not yet recognized throughout the medical profession in the United States as safe and effective for diagnosis or treatment. This includes, but is not limited to, all phases of clinical trials, all treatment protocol based upon or similar to those used in clinical trials, drugs approved by the United States Food and Drug Administration under its Treatment Investigational New Drug Regulation, and United States Food and Drug Administration approved drugs used for unrecognized treatment indications.

The Plan Administrator must make an independent evaluation of the experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The treatment will be considered experimental:

a) If the drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

c) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study 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

d) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 the standard means of treatment or diagnosis.

FAMILY COVERAGE: Coverage for a Primary Participant and one or more eligible dependents under this Plan.

FORMULARY: Means a list of prescription medications compiled by the Pharmacy Benefit Manager of safe, effective therapeutic drugs specifically covered by this Plan.

FULL-TIME REGULAR EMPLOYEE: A person who is directly employed and compensated for services by The County of Peoria and who is scheduled to work at least thirty-five (35) hours per week in The County of Peoria’s business. For the purpose of this definition “County of Peoria” shall be construed as including outside groups presently utilizing the Plan.
**GRANDCHILD (IRS Definition):** As defined under the current Internal Revenue Services’ guidelines for determining dependent eligibility for taxation purpose, subject to change.

**HEALTH/FITNESS DISCOUNT:** A professional health and fitness center offering facilities for physical exercise similar to those offered by facilities such as the YMCA, Landmark Health Club, River City Athletic Club, etc. This fitness center must be able to verify attendance by County employees to the satisfaction of the County.

**HOME HEALTH CARE:** A plan that provides for continued care and treatment after discharge from a Hospital or in lieu of hospitalization. The care and treatment must be for the same or related condition that required the hospital stay, prescribed in writing by the attending Physician, and a viable alternative to staying in the Hospital. Care must be provided by an agency that mainly provides skilled nursing & other therapeutic services and is associated with a professional group that makes policy, consisting of at least one Physician & one (1) R.N., and keeps complete medical records of each person, has a full-time administrator, and meets licensing standards.

**HOSPICE:** Means an entity licensed, approved or authorized to provide inpatient or at home medical relief of pain and supportive care to terminally ill persons, and which is staffed and equipped to provide care for and treat terminally ill persons who do not require Hospital Care; and has paid staff of medical professionals to supervise such care and treatment.

**HOSPITAL:** A medical facility that: mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons; is supervised by a staff of physicians; is not mainly a place for rest, for the aged, or is a nursing home; and charges a fee. The term “hospital” also includes a substance abuse treatment facility, operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, which meets all of the requirements of an accredited hospital.

**ILLNESS:** Shall include disease, bodily sickness, mental illness, substance abuse or emotional disorders.

**IMMUNIZATIONS:** Vaccinations to prevent diseases and/or conditions.

**IMMEDIATE FAMILY:** A family member of either you or your spouse/civil union partner, whether related by blood or marriage by law, including only spouse/civil union partner, brother, sister, parent, child, grandparent, grandchild, step parents, and step child.

**INJURY:** Shall mean any bodily injury caused by any act or omission except illegal acts or omissions of the injured plan participant. All injuries sustained by a covered individual in connection with any one accident shall be considered one injury.

**INPATIENT:** When the covered person is a registered bed patient and treated as such in a facility.

**LEAVE OF ABSENCE (“LOA”):** Any applicants authorized by the employer under the Employer’s Standard personnel practices provided that collective bargaining agreements provided that all persons under similar circumstances must be treated alike in granting them such leaves of absence and provided further that the employee return within the period of authorized absence.

**LIFETIME:** Means the period of time in a Participant’s life while covered under this Plan. It does not mean the entire lifetime of the Covered Person.

**L.P.N.:** A licensed practical nurse.

**MAINTENANCE PROGRAM:** Therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur (refers to occupational therapy, physical therapy, speech therapy and chiropractic care).

**MAMMOGRAM (MAMMOGRAPHY):** Radiography of the breast.

**MANIPULATIVE THERAPY:** Treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment. It includes all tests, x-rays, examinations, office visits, medications, or similar services provided in conjunction with this type of treatment.

**MATERNITY:** Means the services rendered for an inter-uterine pregnancy which results in a vaginal or medically necessary cesarean section delivery.

**MAXIMUM OUT-OF POCKET:** The total dollar amount participant(s) with single or family coverage must pay of eligible charges before the Plan pays at the 100% level for the calendar year. This does not include:
outpatient mental/ nervous, substance abuse; dental benefits; deductibles; any penalties; non-covered expenses; or amounts over the Reasonable & Customary allowance, or otherwise excluded elsewhere in the Plan.

**MEDICALLY NECESSARY:** Means health care services, supplies or treatment which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered.

**MEDICARE:** Title XVIII of the Social Security Act, as amended.

**MENTAL ILLNESS:** Means those illnesses defined as a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, classified as mental disorders in Section ii of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

**MINOR EMERGENCY CARE:** Services for treatment of symptoms or conditions that are not considered life threatening, do not require emergency room treatment or inpatient hospitalization, and can be treated by a general practice physician or medical provider.

**MORBID OBESITY:** Means a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person or Covered Dependent.

**MRI:** Magnetic Resonance Imaging

**NON-PREFERRED PROVIDER:** Any vendor that does not have a Preferred Provider agreement in effect with the County of Peoria.

**NORMAL PREGNANCY:** The services rendered for an inter-uterine pregnancy, which results in a vaginal or medically necessary cesarean section delivery.

**N.P.:** A licensed Nurse Practitioner.

**NURSING SERVICE:** Care provided by a Physician Assistant ("P.A."), Nurse Practitioner ("N.P.") or Licensed Practical Nurse ("L.P.N."). The service must be provided under the direction or order of a physician and must be medically necessary. The inherent complexity of the service prescribed for a patient must be such that the service can safely and effectively be performed by the professional licensed personnel.

**OCCUPATIONAL THERAPY:** Means constructive therapeutic activity designed and adapted to promote the restoration of a useful physical function. Occupational therapy does not include educational training or services designed and adapted to develop a physical function.

**OPEN ENROLLMENT:** Means the period, established by the Employer, when the employee and/or dependent(s) meeting eligibility requirements may be added to the Plan for coverage if they were not added within thirty-one (31) days of an eligibility event. Employee and/or Dependent coverage obtained during the open enrollment period become effective January 1st following the open enrollment period. Subject to EOI.

**ORAL SURGERY:** means:

- surgical removal of bony or tissue impacted teeth;
- excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
- excision of exostoses of the jaws and hard palate (provided that his procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
ORGAN/TISSUE TRANSPLANT: Means the surgical transfer of organ or bone marrow as specified in the separate plan.

OUTPATIENT: A covered participant receiving treatment while not confined as an inpatient. Outpatient care may be received at, but not limited to, Physician’s office, laboratory or x-ray facility, ambulatory surgical treatment center, Hospital, or urgent care facility.

OUTSIDE GROUPS: Other agencies purchasing health care coverage from the County of Peoria.

P.A.: A licensed physician’s assistant.

PAP TEST/SMEAR (PAPANICOLAOU TEST): Collecting, examining, and testing material from areas of the body that shed cells or in which shed cells collect, especially the cervix and vagina.

PARTICIPANT: Eligible person enrolled in this Health Care Plan.

PET SCAN: Positron Emission Tomography

PHARMACY: Means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPY: Means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Physical therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN: Person licensed to practice within the scope and limitation of that license under the Illinois Medical Practice Act, Clinical Psychologist Licensing Acts or similar laws of Illinois or other states.

PLAN: The County of Peoria Employee’s Healthcare Dental, Vision and Prescription Plan which describes the benefits, terms, and provisions for payment of benefits. The Plan may be modified or amended from time to time and such modifications which affect covered participants will be communicated to Plan participants.

PRE-EXISTING CONDITION: Any disease, illness, injury, sickness, malady or condition which was diagnosed or treated by a provider three (3) months prior to your effective date, or which produced symptoms three (3) months prior to your effective date which would have caused an ordinarily prudent person to seek medical diagnosis or treatment. Treatment by a provider includes the ongoing use of prescription medication prescribed by a provider.

PREFERRED PROVIDER ORGANIZATION (“PPO”): Those health care providers who have contracted with the County of Peoria to provide certain services for which benefits are provided under the terms of this Plan.

PRE-NATAL CLASSES: Courses taken from approved pre-natal organizations prior to birth of baby.

PRIMARY PARTICIPANT: Employee or former employee enrolled in the Plan, or covered under any of the Extension of Benefits provision.

PRIVATE DUTY NURSING: Skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse who is not providing this service as an employee or agent of a hospital or other health care facility. Private duty nursing service does not include custodial care service.

PROVIDER: Any health care facility (for example, a Hospital or skilled nursing facility) or person (for example, a Physician or dentist) or entity duly licensed to render covered services to you.

PROSTATE-SPECIFIC ANTIGEN TEST (“PSA”): Blood draw test which measures an antigen in the blood that may be indicative of cancer in the prostate.

PSYCHIATRIC, MENTAL/NERVOUS ILLNESS CARE: Diagnostic or therapeutic medical service provided by a Physician, psychiatrist, registered clinical psychologist, licensed marriage, family or child counselor or licensed social worker for the treatment of conditions classified as mental illness. Psychiatric care includes:

- Psychological testing – one or more psychological tests;
- Group therapy – group psychotherapeutic sessions;
- Psychotherapy – individual psychotherapeutic sessions;

and, those illnesses classified as disorders by the American Psychiatric Association as of the date services are rendered.
**REASONABLE AND CUSTOMARY ALLOWANCE:** The usual charge made by a Physician or supplier of services, medicines, or supplies which shall not exceed the customary level of charges for such services or supplies rendered in the same geographical locality as determined by the Health Benefits Committee. Reasonable & customary hospital allowance will be based upon the Plan's in-network fee schedule.

**REGISTERED CLINICAL PSYCHOLOGIST:** A clinical psychologist who is registered with the Illinois Department of Registration and Education pursuant to the Illinois “Psychologist Registration Act” or is such stated where statutory licensure exists. The clinical psychologist must hold a valid credential for such practice, and if practicing in a state where statutory licensure does not exist, such a person must meet the qualifications specified in the definition of a clinical psychologist.

**RELATIVE:** The term “Relative for interpretation of this Plan includes all persons who are related to the primary participant or the primary participant’s current or any former spouse/civil union partner as grandparent, parent, aunt, uncle, niece, nephew, child or grandchild, including the spouse/civil union partner of any of these relatives and any person in a step relationship with any of these relatives.

**R.N.:** A licensed registered nurse.

**ROOM AND BOARD:** Those charges made by a facility for room and board and other necessary services and supplies – room, board, general duty nursing, intensive care and any other services regularly furnished by the facility as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

**SECOND SURGICAL OPINION:** A physical examination of the Covered Participant, including: X-ray and laboratory examinations and a written report by the Physician who is rendering the opinion. The second surgical opinion must be performed by a Physician who is certified by the American Board of Surgery or other specialty board and be performed by a Physician not financially associated with the original diagnosing Physician. The examination must take place before the date the Participant is scheduled for the proposed surgery.

**SEMI-PRIVATE RATE:** This is the charge for room and board which a facility applies to its semi-private rooms with 2 or more beds. If there are no such rooms, it will be the rate most commonly charged by that facility.

**SINGLE COVERAGE:** Coverage under this Plan for the Participant but not his or her spouse/civil union partner and/or dependent(s).

**SINGLE SOURCE BRAND (PRESCRIPTION DRUGS):** A brand-name drug for which no generic equivalent has been developed, released or approved by the United States Food and Drug Administration (“USFDA”).

**SKILLED NURSING FACILITY:** A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (“R.N.”) or by a licensed practical nurse (“L.P.N.”) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization management plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as a Skilled Nursing Facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

**SKILLED NURSING SERVICE:** Those services provided by an R.N. or L.P.N. which require the technical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who
Skilled Nursing Service does not include custodial care service.

**SPEECH THERAPY:** Services performed by a licensed and certified speech/language therapist to restore speech loss or impairment due to one of the following:

1) illness or injury (other than a functional nervous disorder) which happens while the participant is covered under this Plan;
2) cerebral vascular accident (stroke); or
3) congenital malformation for which surgery is scheduled or has been performed.

**SUBSTANCE ABUSE:** The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a Physician. The criteria established by the American Society of Addiction Medicine including the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co–Occurring Conditions will be used for substance use disorders; and to determine medically necessary acute treatment services and stabilization services.

**SUBSTANCE ABUSE TREATMENT FACILITY:** Means a facility (other than a Hospital) whose primary function is the treatment of substance abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

**SURGERY:** The performance of operative or cutting procedures including specialized instrumentation and the correction of fractures or of complete dislocations and any other procedures as reasonably approved by the Plan.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION ("TMJ") AND RELATED DISORDERS:** Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

**THIRD PARTY ADMINISTRATOR:** An organization which, at the discretion of the plan sponsor, is engaged to administer the Plan.

**TREATMENT PROGRAM (SUBSTANCE ABUSE):** An organized, intensive, structured, rehabilitative treatment program of either a Hospital, or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a physician or psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

**TRANSPLANT CARE:** Those services associated with the transplant of major organs and bone marrow as outlined in the Plan.

**TRIMESTER OF PREGNANCY:** Increments during pregnancy marked at three (3) month or ninety (90) day intervals.
Final authority for interpretation of the terms and provisions of the Plan is vested in the Peoria County Board. Any interpretation so required shall be made in good faith, subject to reasonable care and prudence. All such interpretations are final, subject only to the ultimate authority and responsibility of the County Board. Appeals of decisions involving individual claims are addressed under separate provisions in the Plan.

The County of Peoria

By: ____________________________

Title: County Administrator
1. The prescription drug benefit is an independent component of the healthcare program, separate from regular medical benefits, and administered by MEDTRAK.

Expenses for prescription medications:

- Are not subject to an annual deductible.
- Do not count toward meeting your **Individual Lifetime Maximum out-of-pocket maximum** under the medical plan.

Benefits for IMRF employees on and after his/her entitlement to Medicare will be limited to **$3,000 benefit payable per person per calendar year**. Once the $3,000 per person per calendar year benefit has been paid no further benefits will be paid. Prescription Drug Benefits paid will accumulate toward the **$50,000 Maximum Benefit Payable Per Lifetime Per Person**.

You will be issued a Prescription Drug Card that you and your dependents will need to present at the time of service in order to obtain prescription drug services.

Every prescription drug has two names: the trademark or **brand name**, and the chemical or **generic name**. By law, both brand-name and generic drugs must meet the same standards for safety, purity, strength and quality. Many drugs are available in generic form. Generic drugs can save a great deal of money for both you and the Plan. You should ask your doctor to prescribe your medication on a generic basis whenever possible.

The Plan requires that you use a participating network pharmacy. It will be your responsibility to inquire if the pharmacy you are utilizing is in the network.

2. **RETAIL PROVIDER:**

You can purchase up to thirty (30) days worth of drugs.

- **Generic** Participant pays $10.00 for up to a 30 day supply.
- **Preferred Brand** Participant pays $40.00 for up to a 30 day supply.
- **Non-Preferred Brand** Participant pays $60.00 for up to a 30 day supply.
- **Specialty** Participant pays $75.00
- **Non-Preferred Specialty** Participant pays 20% up to $250.

3. **MEDTRAK MAIL ORDER PROVIDER AND/OR 90 DAY RETAIL PROVIDER:**

You may receive up to a ninety (90) day supply through a participating retail pharmacy or the MEDTRAK mail order provider. Mail order forms are available in County Administration or from the HR Generalist-Health & Risk.

- **Generic** Participant pays $20.00 for up to a 90 day supply.
- **Preferred Brand** Participant pays $100.00 for up to a 90 day supply.
- **Non-Preferred Brand** Participant pays $150.00 for up to a 90 day supply.

Any prescribed medication not covered under the Prescription Drug Preferred Provider Agreement may be eligible under the medical benefits portion of this Plan, subject to Utilization Review approval, deductible and Co-Insurance.

Prescriptions are valid for one (1) year from the date of issuance as required by law. A new physician’s order must be issued to obtain any prescriptions over one (1) year.
<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Prior Authorization Required</th>
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<tbody>
<tr>
<td>A.D.H.D./Narcolepsy agents (e.g. Dexedrine, Ritalin, Cylert)</td>
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<tr>
<td>Aids-Related Drugs (Medication used for treatment or suppression of HIV, e.g. Retrovir, Crixivan)</td>
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<tr>
<td>Anabolic Steroids (Medication used to promote building of muscle (e.g. Anadrol-50, Durabolin, Nandrolone, Oxandrin, Winstrol)</td>
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<tr>
<td>Anti-obesity (Medications used for the purpose of weight loss, e.g. Phentermine, Meredia, Xenical)</td>
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<tr>
<td>Biologics (Certain injectables, e.g., allergens, serums, vaccines)</td>
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<tr>
<td>Compounds with legend ingredients (Medications mixed together using at least one ingredient that requires a prescription)</td>
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<tr>
<td>Cosmetic Drugs:</td>
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<tr>
<td>— Acne (topical—Metro Gel, 75%)</td>
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<tr>
<td>— Tretinoin (Retin-A) (Anti-acne cream)</td>
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<tr>
<td>Diabetic Supplies:</td>
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<td>— Blood Sugar Diagnostics (e.g. Blood Test Strips)</td>
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<tr>
<td>— Insulin</td>
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<tr>
<td>— Insulin Syringes/Needles</td>
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<tr>
<td>Fluoride Preps (Oral fluoride, e.g. Fluoritab, Karidium, Luride, Lozi tabs, Phos-Flur)</td>
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<tr>
<td>Immunosuppressives (Medication used for the suppression of the body's immune system. Typically used for patient post transplant or with autoimmune diseases—e.g. Imuran, Neoral, Sandimunne.)</td>
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<tr>
<td>Lamisil (Anti-Fungal)</td>
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<tr>
<td>Lotronex (Females Only)</td>
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<tr>
<td>Migraine Drugs (e.g. Imitrex, Zomig, Amerge, Maxalt)</td>
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<tr>
<td>Misc. Medical Supplies—Legend</td>
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<tr>
<td>Multiple Sclerosis (e.g. Avonex, Betaseron, Copaxone). Injectable forms if medication included.</td>
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<tr>
<td>Non-Insulin Injectables (Legend injectables other than insulin).</td>
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<tr>
<td>Nutritional/Dietary Supplements—Legend</td>
<td></td>
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<tr>
<td>Prenatal Prescription Vitamins (e.g. Natafort)</td>
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<tr>
<td>Relenza (Limit 2 inhalers every 180 days—at retail only, mail excluded)</td>
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<tr>
<td>Smoking Cessation products—Legend (e.g. Zyban)</td>
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<tr>
<td>Syringes (non-insulin)</td>
<td>Three treatments per lifetime</td>
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<tr>
<td>Tamiflu (Limit 20 per 180 days—mail excluded, excluded at mail)</td>
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<tr>
<td>Vitamins Legend—Non Prenatal (e.g. Prescription Niacin, Prescription Vitamin K)</td>
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The preceding list is subject to change.

For questions regarding coverage, contact HR Generalist-Health & Risk at (309) 672-6071.
For Pharmacy locations, contact MEDTRAK at 1-800-771-4648.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

The Plan Administrator is the County of Peoria, 324 Main St., Room 502, Peoria, Illinois 61602, (309) 672-6071. COBRA continuation coverage for the Plan is administered by Consoicate, Inc., 2828 N. Monroe, P.O. Box 1068, Decatur, Illinois 61525-1068, 217-423-7788 or 800-798-2422. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.
The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

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

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you,
you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse’s employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

**IMPORTANT:**

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

**NOTICE PROCEDURES:**

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

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

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

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a)  
   (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b)  the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
   
   (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
   
   (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

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

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a qualified Beneficiary’s COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

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

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

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

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Your County Operations Committee does hereby recommend passage of the following resolution:

Re: Peoria County's Employee Health Plan Summary Plan Document Update

RESOLUTION

WHEREAS, the County of Peoria has a self-insured employee health fund; and

WHEREAS, in 2019 the County Board approved plan design changes effective January 1, 2020; and

WHEREAS, the Summary Plan Document (SPD) incorporates the administrative language necessary to implement these changes; and

WHEREAS, your County Administrator has recommended the attached changes to the SPD in order to implement the plan design changes that were previously approved in 2019 for the 2020 Plan Year; and

WHEREAS, your County Operations Committee recommends adoption of the recommended changes outlined in the attached.

NOW THEREFORE BE IT RESOLVED, by the County Board of Peoria County that the recommendation of the County Administrator and your County Operations Committee for the attached Employee Health Plan SPD changes are hereby adopted.

RESPECTFULLY SUBMITTED,

COUNTY OPERATIONS COMMITTEE
AGENDA BRIEFING

COMMITTEE: County Operations Committee
MEETING DATE: September 24, 2019

ISSUE: Establish both the employer and employee medical health premiums, effective January 1, 2020 through December 31, 2020. Also create a new health savings account benefit for those employees on the Qualified High Deductible Plan.

BACKGROUND/DISCUSSION:
In 2019 staff began a three-phase approach to achieve sustainability in the Employee Health Fund. First, an RFP was conducted and contracts were approved for the PPO, Pharmacy, Third Party Administrator and Wellness services for the self-insured plan. A fully-insured model was also reviewed but in the end was cost-prohibitive. Second, the Board approved plan design changes to the three current plans in an effort to reduce costs, remain compliant with PPACA (healthcare reform) and implement new best practices. Finally, phase three was an actuary study by Nyhart to review premium costs and structure. After reviewing the results of this study, it is recommended that the premium increase 8% in 2020 and the current structure remains the same. These costs will continue to be evaluated in 2020 and additional recommendations may be made for implementation in 2021.

Previous year increases averaged 5%; however, the fund subsidized the premium by $169 for every employee on the plan. (This subsidy represents the deficit between revenues and expenditures.) Raising the premium 8% in 2020 reduces this subsidy to approximately $100 and slows future reductions in fund balance. The Collective Bargaining Agreements with the FOP (Corrections & Lieutenants) and PBL (Deputies) requires the County to negotiate premium increases, which is currently in progress.

The chart below reflects the monthly 2020 premiums by plan type at an 8% increase for the Standard Plan and the Qualified High Deductible Plan. Staff recommends that the premium for the IMRF Medicare Eligible Retiree Plan remain flat.

### Premium Cost Sharing

#### 2020 Proposed

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<td>184.13</td>
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<td>Single</td>
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<table>
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<tr>
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<th>Subsidized</th>
<th>Total Cost</th>
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</thead>
<tbody>
<tr>
<td><strong>IMRF Medicare Eligible Retiree Plan</strong></td>
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In addition, in an effort to incentivize current participants to remain on or move to the Qualified High Deductible Health Plan during open enrollment in Fall 2019, staff and the health plan consultant recommend that the County makes a one-time contribution of $500 for single coverage and $1,000 for Member +1 or Member +2 coverage into a health savings account in 2020 for current employees (new hires during 2020 will receive $250 and $500 respectively). A health savings account (HSA) is a type of savings account that lets employees set aside money on a pre-tax basis to pay for qualified medical expenses. Unlike flexible spending, the balance in the account rolls over each year. The employee can also make additional pre-tax contributions up to the annual IRS limit. The account is owned by the employee but only those employees on a qualified high deductible health plan can enroll under current IRS regulations.

COUNTY BOARD GOALS:

STAFF RECOMMENDATION:
To approve insurance premiums for both the employer and employee share, effective January 1, 2020 through December 31, 2020 at an 8% premium increase from 2019 for the Standard Plan and Qualified High Deductible Plan. The IMRF Medicare Eligible Retiree Plan is recommended to remain flat. In addition, approve a one-time distribution of $500 for single coverage and $1,000 for Member +1 or Member +2 coverage in a health savings account in 2020 for current employees who remain on or join the Qualified High Deductible Plan, with new hires during 2020 receiving $250 and $500 respectively.

COMMITTEE ACTION:

PREPARED BY: Shauna Musselman, Asst. County Administrator
DEPARTMENT: County Administration
DATE: September 18, 2019
Your County Operations Committee does hereby recommend passage of the following resolution:

Re: Peoria County's Employee Health Plan Premium Adoption and Health Savings Account Benefit for 2020

RESOLUTION

WHEREAS, the County of Peoria has a self-insured employee health fund; and

WHEREAS, the IRS allows employers to provide a contribution into a Health Savings Account for participants on a Qualified High Deductible Health Plan; and

WHEREAS, the continuing rise of medical and prescription costs continue to exceed the employee health fund revenues, which is not sustainable long term; and

WHEREAS, your County Administrator has recommended the attached health plan premium increase of 8% from the 2019 level effective January 1, 2020 through December 31, 2020 for the Standard Plan and Qualified High Deductible Health Plan as well as a one-time contribution of $500 for single and $1,000 for member+1 and member +2 for current employees hired prior to January 1, 2020 to a Health Savings Account for participants on the Qualified High Deductible Health Plan (those hired after January 1, 2020 will receive $250 for single and $500 for member +1 and member +2 for the 2020 plan year); and

WHEREAS, your County Operations Committee recommends adoption of the premiums at a 8% increase and the Health Savings Account contribution as outlined above and in the attached agenda briefing, effective January 1, 2020 through December 31, 2020.

NOW THEREFORE BE IT RESOLVED, by the County Board of Peoria County that the recommendation of the County Administrator and your County Operations Committee for the attached Employee Health Plan premiums and Health Savings Account contribution is hereby adopted.

RESPECTFULLY SUBMITTED,

COUNTY OPERATIONS COMMITTEE