State of Illinois
Department of Central Management Services
Bureau of Benefits

State of Illinois Retiree, Annuitant and Survivor

Benefits Handbook

July 1, 2015 (Originlly Published October 2011)

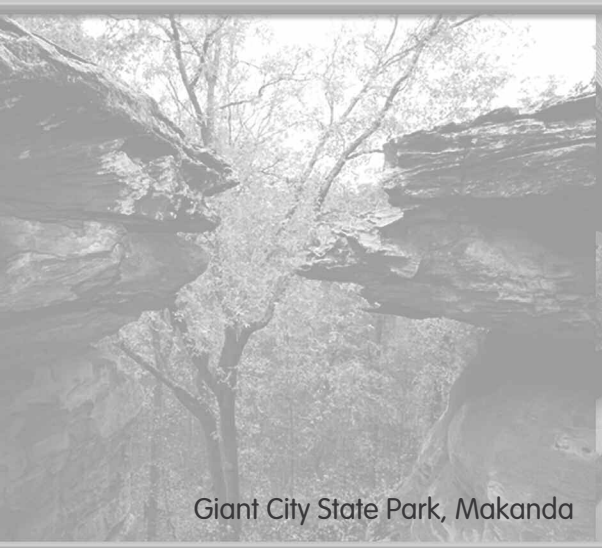
Illinois State Capitol, Springfield

Chicago Theatre, Chicago

Chicago Skyline, Chicago

State of Illinois Retiree, Annuitant and Survivor

Benefits Handbook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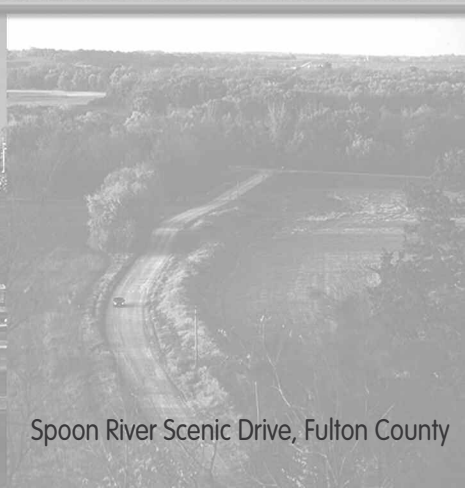
Spoon River Scenic Drive, Fulton County

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Introduction

Your Group Insurance Benefits

Annuitants, retirees and survivors who are receiving pension benefits from any of the five State retirement systems may be eligible to participate in the State Employees Group Insurance Program (Program). The five retirement systems with their contact information are listed below:

State Employees' Retirement System
2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255
Phone: (217) 785-7444
TDD: (217) 785-7218
www.state.il.us/srs

State Universities Retirement System
1901 Fox Drive
P.O. Box 2710
Champaign, IL 61825-2710
Phone: (800) 275-7877
TDD: (800) 526-0844
www.surs.org

Teachers' Retirement System
2815 West Washington
P.O. Box 19253
Springfield, IL 62794-9253
Phone: (800) 877-7896
TDD: (866) 326-0087
http://trs.illinois.gov

Judges' Retirement System
2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255
Phone: (217) 782-8500
TDD: (217) 785-7218
www.state.il.us/srs

General Assembly Retirement System
2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255
Phone: (217) 782-8500
TDD: (217) 785-7218
www.state.il.us/srs

Please read this handbook carefully as it contains vital information about your benefits.

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

Group Insurance Representative (GIR)

A Group Insurance Representative (GIR) is your retirement system's liaison to the Department. Each retirement system also has Group Insurance Preparers (GIP) who may assist the GIR with your insurance needs. GIRs and GIPs are valuable resources for answering questions you may have about your eligibility for coverage and to assist you in enrolling or changing the benefits you have selected.

Where To Get Additional Information

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

- The Department's website contains the most up-to-date information regarding benefits and links to plan administrators' websites. Visit **www.benefitschoice.il.gov** for information.
- Annual Benefit Choice Options booklet. This booklet contains the most current information regarding changes for the plan year. New benefits, changes in premium amounts and changes in plan administrators are included in the booklet. **Review this booklet carefully as it contains important eligibility and benefit information that may affect your coverage**. Visit **www.benefitschoice.il.gov** to view the booklet.
- Each individual plan administrator can provide you with specific information regarding plan coverage inclusions/exclusions.
- The Department can answer your benefit questions or

Introduction (cont.)

refer you to the appropriate resource for assistance. The Group Insurance Division can be reached at:

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

ID Cards

The plan administrators produce ID cards at the time of enrollment. Cards are mailed to the current address on file with the Bureau of Benefits. To obtain additional cards, contact the plan administrator. Links to the plan administrators' websites can be found at **www.benefitschoice.il.gov**.

Health Insurance Portability and Accountability Act (HIPAA)

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

The State contracts with business associates (health plan administrators and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits.

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

Your Responsibilities

It is your responsibility to know your benefits, including coverage limitations and exclusions, and to review the information in this publication. Referral and/or approval for treatment by a physician does not ensure coverage under the plan.

You must notify the Group Insurance Representative (GIR) at your retirement system if:

- **You and/or your dependents experience a change of address.** When you and/or your dependents move, you must provide written notification to the GIR at your retirement system. Changing your address with the retirement system does not automatically change your health plan to a plan in that geographic area. If you move out of the managed care service area, a written request to elect a new health plan is required. If you are currently enrolled in an HMO and you move to a county that does not offer that HMO plan, you have 60 days from the date of your move to change health plans. Refer to the managed care coverage map in the Benefit Choice Options booklet for health plan options available in your county.

- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union or domestic partner relationship) must be reported to your GIR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**

- **You get married or enter into a civil union, or your marriage, domestic partnership or civil union partnership is dissolved.**

- **You have a baby or adopt a child.**

- **Your dependent's employment status changes.**

- **You have or gain other coverage.** If you have group coverage provided by a plan other than the Program, or if you or your dependents gain other coverage during the plan year, you must provide that information to your GIR **immediately**.

Contact your GIR if you are uncertain whether or not a life-changing event needs to be reported. See the 'Enrollment Periods' section in this chapter for a complete listing of qualifying changes in status.

If you and/or your dependent experience a change in Medicare status or become eligible for Medicare benefits, a copy of the Medicare card must be provided to the State of Illinois Medicare Coordination of Benefits (COB) Unit. Failure to notify the Medicare COB Unit of you and/or your dependent's Medicare eligibility may result in substantial financial liabilities. Refer to the 'Medicare Section' for the Medicare COB Unit's contact information.

Retirees, annuitants and survivors should periodically review the following to ensure all benefit information is accurate:

- **Insurance Deductions.** It is your responsibility to ensure deductions are accurate for the insurance coverage you have selected/enrolled. If your annuity check is insufficient to cover your premiums, you will be billed for the cost of your current coverage and the Department will exercise its right under the State Comptroller's Act to collect delinquent group insurance premiums through involuntary withholding.

- **Beneficiary Designations.** You should periodically review all beneficiary designations and make the appropriate updates. Remember, you may have death benefits through various State-sponsored programs, each having a separate beneficiary form:

  - State of Illinois life insurance
  - Retirement benefits
  - Deferred Compensation

If You Live or Spend Time Outside Illinois

Retirees, annuitants and survivors who move out of Illinois or the country will most likely need to enroll in the Quality Care Health Plan (QCHP). For those in certain areas contiguous to the State of Illinois, some managed care health plan options may be available. Refer to the current Benefit Choice Options booklet or contact the managed care health plan directly for information on plans available. Changing your address does not automatically change your health plan.

Your Responsibilities (cont.)

Dependents Who Live Apart from the Retiree, Annuitant or Survivor

Eligible dependents who are enrolled in an HMO plan and live apart from the retiree, annuitant or survivor's residence and are out of the plan's service area for any part of a plan year will be limited to coverage for emergency services only. It is crucial that employees who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on this type of coverage.

Power of Attorney

Retirees, annuitants and survivors may want to consider having a financial power of attorney on file with both the retirement system and the health plan to allow a representative to act on their behalf. For purposes of group insurance, a financial or property power of attorney is necessary; a healthcare power of attorney does not permit changes to health insurance coverage.

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under the Program is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the retiree, annuitant or survivor and/or the dependent, as well as expenses incurred by the Program.

Chapter 1

Chapter 1: Enrollment and Eligibility Information

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Eligibility Requirements

Eligibility for the Group Insurance Program (Program) is defined by the applicable federal statute or the State Employees Group Insurance Act of 1971 (5 ILCS 375/1 et seq.) or as hereafter amended (Act), and by such policies, rules and regulations as shall be promulgated there under.

Eligibility for Basic Life and Optional Life insurance varies; see the 'Life Insurance Coverage' section in Chapter 2 for details.

Eligible Categories

The following groups are eligible to participate in the Program.

Retirees

- **State Retirees** are individuals who began receiving pension benefits from one of the State's five retirement systems prior to January 1, 1966.
- **University of Illinois Federal Retirees** (SURS retirees only) are former employees of the U of I Cooperative Extension Service of Urbana.

Annuitants

An annuitant is an individual who began receiving pension benefits on or after January 1, 1966, from one of the State's five retirement systems. All annuitants must meet the minimum vesting requirements of the appropriate retirement system based solely on prior State employment. Insurance coverage becomes effective upon commencement of the retirement or annuity benefits, or the first of the month of the application for retirement, **whichever is later**.

Annuitants are referred to as either an immediate annuitant or a deferred annuitant depending on when the individual began receiving their State pension. An **immediate annuitant** is someone whose pension begins within one year of terminating State employment. A **deferred annuitant** is someone whose pension begins one year or more after terminating State employment.

Annuitants should contact their retirement system prior to actual retirement to confirm whether they will be eligible for group insurance coverage.

Alternative Retirement Cancellation Payment (ARCP) Recipients

Alternative Retirement Cancellation Payment (ARCP) recipients are former State employees who were vested under the State Employees' Retirement System and elected the Alternative Retirement Cancellation Payment (ARCP) option per Public Act 93-0839 (between August 16, 2004, and October 31, 2004), Public Act 94-0109 (between July 1, 2005, and September 30, 2005) or Public Act 93-0839 (between June 6, 2006, and August 31, 2006).

ARCP recipients are considered annuitants for group insurance purposes and are referred to as annuitants in this handbook. Specifically, an ARCP recipient who would have otherwise qualified for an annuity within one year of leaving State service is considered an immediate annuitant. An ARCP recipient who would have otherwise qualified for an annuity more than one year from the date of leaving State service is considered a deferred annuitant. ARCP recipients should direct any benefit questions to the Department.

Survivors

A survivor is a spouse, civil union partner, unmarried child under age 18 (under age 22 if a full-time student), unmarried child over age 18 if disabled prior to age 18 or dependent parent who is certified as eligible to receive an annuity from one of the five State retirement systems as a result of the death of a State employee, retiree or annuitant.

Retired Judges

Retired State judges who become federal judges have spousal insurance options available. Contact the Judges' Retirement System for the specific options available.

General Assembly

Vested members of the General Assembly who leave the General Assembly before they are eligible to retire, but allow their contribution to remain with the General Assembly Retirement System, may continue group insurance coverage until they begin receiving their pension.

Eligibility Requirements (cont.)

Eligible As Dependents

Eligible dependents of a retiree, annuitant or survivor may participate in the Program. Dependent coverage is an additional cost for all members.

Eligible dependents include:

- **Spouse** (does not include ex-spouses, common-law spouses, persons not legally married or the new spouse of a survivor).
- **Same-Sex Domestic Partner (enrolled prior to June 1, 2011).**
- **Civil Union Partner (enrolled on or after June 1, 2011).**
- **Child from birth to age 26, including:**
  - Natural child.
  - Adopted child.
  - Stepchild or child of a civil union partner.
  - Child for whom the retiree, annuitant or survivor has permanent legal guardianship.
  - Adjudicated child for whom a U.S. court decree has established a member's financial responsibility for the child's medical, dental or other healthcare.
- **Child age 26 and older, including:**
  - Adult Veteran Child. Unmarried adult child age 26 up to, but not including, age 30, an Illinois resident, has served as a member of the active or reserve components of any of the branches of the U.S. Armed Forces and received a release or discharge other than a dishonorable discharge.
  - Other. (1) Recipient of an organ transplant after June 30, 2000, and eligible to be claimed as a dependent for income tax purposes by the retiree, annuitant or survivor, except for a dependent child who need only be eligible to be claimed for tax years in which the child is age 27 or above, or (2) an unmarried individual **continuously** enrolled as a dependent of the retiree, annuitant or survivor in the State Insurance Program (or CNA for university staff) since 2/11/83 with no break in coverage and eligible to be claimed as a dependent for income tax purposes by the retiree, annuitant or survivor. The period of time the dependent was enrolled with Golden Rule Insurance Company (prior to April 1, 1988) **does not count** toward the requirement of continuous enrollment.
  - Disabled. Child age 26 or older who is continuously disabled from a cause originating prior to age 26. In addition, for tax years in which the child is age 27 or above, eligible to be claimed as a dependent for income tax purposes by the retiree, annuitant or survivor.

NOTE: Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member.

Certification of Dependent Coverage

In addition to the following certification periods, the Group Insurance Division may ask the member to certify their dependent either randomly or during an audit anytime during the year.

Birth Date Certification. Retirees, annuitants and survivors must verify continued eligibility for dependents turning ages 26 and 30. Members with dependents turning ages 26 and 30 will receive a letter from the Department several weeks prior to the birth month that contains information regarding continuation of coverage requirements and options. The member must provide the required documentation to the Department prior to the dependent's birth date. Failure to certify the dependent's eligibility will result in the dependent's coverage being terminated effective the end of the birth month.

Annual Certification. Members are required to certify all IRS dependents in the following categories on an annual basis: Domestic Partner, Civil Union Partner, Civil Union Partner Children, Disabled, Other and Adult Veteran Child (age 26 and older).

Reinstatement of Dependent Coverage. If coverage for a dependent is terminated for failure to certify and the member provides the required documentation within 30 days from the date the termination was processed, coverage will be reinstated retroactive to the date of termination.

After 30 days the coverage will be reinstated only with a qualifying change in status (see qualifying change in status reasons in the 'Enrollment Periods' section later in this chapter).

Eligibility Requirements (cont.)

Termination of coverage for failure to certify is not a qualifying change in status. Nonretroactive reinstatement will cause a break in coverage which would prevent a dependent from qualifying for continued coverage in the Other category.

NOTE: Dependents with life insurance coverage only, as well as dependents of COBRA participants, must also certify eligibility for coverage.

Contact your GIR for questions regarding certification of a dependent.

Enrollment Periods

Retirees, annuitants and survivors may enroll, opt out or change benefit selections with supporting documentation during the following periods (see the 'Documentation Requirements' chart in this chapter):

- Initial Enrollment (upon application for annuity benefits)
- Annual Benefit Choice Period
- Qualifying Change in Status (as permitted under the Internal Revenue Code)

Initial Enrollment

Retirees, annuitants and survivors are eligible to participate in the health, dental and vision plans under the Program. Life insurance coverage options and eligibility vary; therefore, retirees, annuitants and survivors should refer to the 'Life Insurance Coverage' section in Chapter 2 for specific available options. Preexisting condition limitations do not apply to coverage under the State plan.

Active employees who notify the retirement system of their intent to retire will be given a packet of insurance information prior to their retirement date. Included in the packet will be the Participation Election Form. This form is used by the retirement system so that they will know the employee's intent to either continue their group insurance coverage or waive the coverage upon retirement. The employee must complete and return the Participation Election Form to the retirement system on or before the date of retirement in order to continue coverage without a break. Annuitants who elect the coverage, but would like to make changes to their coverage elections must also complete the Group Insurance Enrollment/Change Form.

NOTE: Spouses who are both eligible for coverage must be enrolled as a member in their own right unless they qualify for the Annuitant Waiver option (see the 'Opt Out and Waiver' section for qualifications).

With the exception of Basic Life insurance, <u>all coverage will be terminated</u> effective the date of retirement for annuitants who have not returned the required Group Insurance Enrollment/Change Form (if applicable) and/or the Participation Election Form on or before their retirement date.

Annuitants who did not submit the forms by their retirement date, but would like the group insurance coverage, have 60 days from their retirement date to elect the coverage. These annuitants must complete and return the Participation Election Form and the Group Insurance Enrollment/Change Form. **Both forms must be submitted to the retirement system within 60 days of the retirement date in order to be eligible for the coverage.**

Annuitants who do not return the Participation Election Form and the Group Insurance Enrollment/Change Form (if required) within the 60-day period must wait until a subsequent Benefit Choice Period or until they experience a qualifying change in status to elect the health, dental and vision coverage; however, they will continue to be enrolled with Basic Life coverage only.

All retirees, annuitants and survivors must provide their social security number (SSN) to be enrolled in the Program.

Upon becoming eligible for an annuity, retirees, annuitants and survivors have the following insurance options:

- Elect a health plan (includes prescription, behavioral health and vision coverage).
- Elect not to participate in the health plan by electing to opt out or waive coverage. See the 'Opt Out and Waiver of Coverage' section in this chapter for details.
- Elect to participate or not to participate in the dental plan (enrollment in the health plan is required if electing the dental coverage).
- Enroll eligible dependents. Refer to the 'Qualifiying Change in Status' section for effective dates and the 'Dependent Coverage' section for documentation requirements.
- Life-eligible annuitants and certain survivors (see the 'Life Insurance Coverage' section for eligibility criteria) may
  - add, increase, decrease or terminate Member Optional Life insurance coverage;
  - add or drop Spouse Life or Child Life coverage.

  An approved statement of health is required to increase or add coverage. AD&D coverage may be added or dropped at any time without a statement of health application. Newly eligible dependents and survivors do not need to provide statement of health approval as long as the coverage is requested within 60 days of initial enrollment.

Effective Date of Coverage Due to Initial Enrollment:

Coverage for annuitants becomes effective on the date of commencement of the retirement/annuity benefit, the first of the month that the application for retirement was received or the first day of the month that the group insurance enrollment form was received, **whichever is later**.

Survivor coverage becomes effective (1) the day after the member's death if the survivor is **currently a dependent** of the deceased annuitant, or (2) the first day of the month following the member's death **if the survivor is not a dependent** at the time of the member's death.

Enrollment Periods (cont.)

Dependents may be added to the member's coverage within 60 days. Refer to the 'Dependent Coverage, Enrolling Dependents' in this section for more information.

Annual Benefit Choice Period

The Benefit Choice Period is normally held annually May 1st through May 31st. During this 31-day period, employees may change their coverage elections. Coverage elected during the annual Benefit Choice Period becomes effective July 1st. Elected coverage remains in effect throughout the entire plan year, unless the employee experiences a qualifying change in status or the Department institutes a special enrollment period which would allow the member to change their coverage elections.

Retirees, annuitants and survivors may make the following changes during the annual Benefit Choice Period:

- Change health plans.
- Re-enroll in the Program following an opt out or waiver of coverage.
- Elect not to participate in the health plan. See the 'Opt Out and Waiver of Coverage' section in this chapter for details.
- Add or drop dental coverage (enrollment in the health plan is required if electing the dental coverage).
- Add or drop dependent coverage. Social security numbers are required to add dependent coverage. Refer to the 'Dependent Coverage' section for documentation requirements.
- Life-eligible annuitants and survivors (see the 'Life Insurance Coverage' section for eligibility criteria) may
  - add, increase, decrease or terminate Member Optional Life insurance coverage;
  - add or drop Spouse Life or Child Life coverage.

  An approved statement of health is required to increase or add coverage. AD&D coverage may be added or dropped at any time without a statement of health application. Newly eligible dependents and survivors do not need to provide statement of health approval as long as the coverage is requested within 60 days of initial enrollment.

Effective Date of Coverage Due to the Annual Benefit Choice Period:

All Benefit Choice health, dental and dependent coverage changes become effective July 1st. Life insurance coverage changes requiring a statement of health become effective July 1st if the approval date from the life insurance plan administrator is on or before July 1st. If the approval date is after July 1st, the effective date will be the statement of health approval date.

Qualifying Change in Status

The Department's administrative policy prohibits changes in retiree, annuitant and survivor elections during the plan year unless there is a qualifying change in status. See the 'Qualifying Change in Status' chart for allowable election changes consistent with the event. Any request to change an election mid-year must be consistent with the qualifying event the retiree, annuitant or survivor has experienced.

Qualifying change in status events include, but are not limited to:

- Events that change a retiree, annuitant or survivor's legal relationship status, including marriage, civil union partnership, death of spouse or civil union partner, divorce, legal separation, civil union dissolution or annulment.
- Events that change a retiree, annuitant or survivor's number of dependents, including birth, death, adoption, placement for adoption or termination of a domestic partner relationship.
- Events that change the employment status of the member's spouse, civil union partner or dependent. Events include termination or commencement of employment, strike or lockout, commencement of, or return from, an unpaid leave of absence or change in worksite.
- Events that cause a dependent to satisfy or cease to satisfy eligibility requirements for coverage.
- A change of residential county for the retiree, annuitant or survivor, or the retiree, annuitant or survivor's spouse, civil union partner or dependent or, a move to a foreign county by an eligible dependent.

Retirees, annuitants and survivors experiencing a qualifying change in status have 60 days to change certain benefit selections. Members must submit proper supporting documentation to their Group Insurance Representative (GIR) within 60 days in order for the change to become effective. See 'Effective Date of Coverage Due to a Qualifying Change in Status' later in this section.

See the 'Qualifying Changes in Status' chart in this chapter for a complete list of qualifying change in status events and corresponding options.

Effective Date of Coverage Due to a Qualifying Change in Status:

Coverage election changes made due to a qualifying event are effective the later of:

- The date the request for change was received by the retirement system, or
- The date the event occurred.

Enrollment Periods (cont.)

Qualifying Change in Status Effective Date Exceptions:

- **Newborns, natural or adopted**. A child is considered a newborn if they are within 60 days of birth. If the request to add the child is made within 60 days of the birth, coverage may be retroactive to the date of birth.
- **Adopted children, other than newborn**. Requests to add an adopted child who is 60 days old or older will be effective the date of the placement of the child, the filing of the adoption petition or the entry of the adoption order provided that the request is received within 60 days of the placement of the child, filing of the adoption petition or the entry of the adoption order.

Other Allowable Mid-year Changes

There are some coverage options that can be changed any time during the plan year. These include:

- Changes in Member Optional Life insurance coverage. An approved statement of health is required to add or increase coverage.
- Changes to Spouse Life or Child Life coverage. An approved statement of health is required to add coverage, unless the spouse, civil union partner or child is newly acquired.
- Changes to Accidental Death and Dismemberment (AD&D) coverage. A statement of health is not required to add or increase AD&D coverage.
- Changes to (adding or dropping) dependent coverage as long as the retiree, annuitant or survivor's dependent monthly contribution category remains 'Two or More Dependents'.

Effective Date of Coverage for Other Allowable Mid-year Changes:

The effective date for adding or dropping dependent coverage when the retiree, annuitant or survivor is in the 'Two or More Dependents' monthly contribution category is the date the request for change is received by the retirement system.

The effective date of coverage when **adding or increasing** Member Optional Life, or when **adding** Spouse Life or Child Life, will be the statement of health approval date. The life plan administrator will send a copy of the statement of health approval/denial letter to the individual who requested the change.

When **adding or increasing** AD&D coverage the effective date is the date the request was received.

When **terminating or decreasing** any Optional Life coverage outside the Benefit Choice Period, the effective date will be the date of the request. A future effective date may be requested as long as it is within 60 days of the current date.

Dependent Coverage

Enrolling Dependents

Eligible dependents may be added to the member's coverage as long as the request and required documentation is received within 60 days of the mailing of group insurance enrollment information or qualifying event, whichever is later. Dependent coverage will be effective the date the request was received by the retirement system as long as it is received within the 60-day qualifying window. Forms are available through the retirement system.

If dependents are added to the member's coverage, the dependents will be enrolled in the same health and dental plans as the retiree, annuitant or survivor. Members electing to opt out or waive the health and dental plan coverage may still enroll their dependents with Child Life and/or Spouse Life coverage only.

When both parents* are members, either member may elect to cover the dependents; however, the same dependent cannot be enrolled under both members for the same type of coverage. For example, eligible dependents may be enrolled under one parent for health and dental coverage and enrolled under the other for life coverage. **NOTE: Dependents whose coverage was terminated for nonpayment of premium under one parent cannot be enrolled under the other until all premiums due for that dependent are paid.**

* The term 'parent' includes a stepparent or a civil union partner of the child's parent.

Documentation Requirements

Documentation, including the dependent's social security number (SSN), is always required to enroll dependents. Failure to provide the required documentation in the allotted time period will result in denial of dependent coverage. If denied, the eligible dependent may be added during the next Benefit Choice Period or upon the member experiencing a qualifying change in status, as long as the documentation is provided in a timely manner.

An additional time period of 90 days is allotted to provide the SSN of newborns and adopted children; however, the election time frames still apply to request the addition of the dependent coverage. If the SSN is not provided within 90 days of the dependent's date of birth or adoption date, coverage will be terminated. Refer to the 'Documentation Requirements – Adding Dependent Coverage' chart later in this chapter for specific documentation requirements.

Qualifying Changes in Status

The State of Illinois health plans are administered in accordance with qualifying change in status rules. The chart below indicates those changes that members are allowed to make which are consistent with a qualifying change in status.

MEMBER – Qualifying Changes in Status									
	Corresponding HEALTH & DENTAL Options								
Changes affecting the Member	Opt Out of Health & Dental Coverage	Enroll or Re-Enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse or Civil Union Partner	Terminate Dependent Coverage	Terminate Spouse or Civil Union Partner Coverage	Change Health Carrier	Waive Health & Dental Coverage
Adjudicated Child: Member financially responsible			X*						
Adoption (or placement for adoption)			X*						
Birth			X*						
Custody awarded and requires dependent coverage (court ordered)			X*	X					
Custody loss (court ordered)/Court Order expires						X			
Divorce/Legal Separation/Annulment/ Dissolution of Civil Union		X				X	X		
Eligibility: Member becomes eligible for non-State group insurance coverage	O								P
Eligibility: Member loses eligibility of non-State group insurance coverage (for other than nonpayment of premium)		X	X	X	X				
Health PCP leaves network								X	
Marriage or Civil Union Partnership	O	X	X*		X**				P
Medicaid or Medicare eligibility gained	O					X	X		P
Medicaid or Medicare eligibility loss		X	X	X	X				
Premium increase 30% or greater: Member's non-State health insurance		X	X	X	X				
Premium increase 30% or greater: Member's STATE health insurance						X	X		P
Residence location: Member's county changes***								X	
Retirement	O	X		X	X	X	X	X	P

X = Eligible changes for all members.

P = Eligible changes for annuitants and survivors responsible for a portion of the State contribution.

O = Eligible changes for retirees, annuitants and survivors with 20 or more years of state service.

Newly Acquired Child = A child for which the member gained custody within the previous 60-day period, such as a new stepchild, child of a civil union partner, adopted child, adjudicated child or a child for which the member gained court-ordered guardianship.

Existing Child = A child for which the member had custody prior to the previous 60-day period, such as a natural or adopted child, adjudicated child, stepchild, child of a civil union partner or a child for which the member is guardian.

* **For Survivors only:** Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member.

** **For Survivors only:** Survivors may not add a new spouse, nor may they add a civil union partner or their children.

***Only applies to members enrolled in an HMO whose HMO plan is not available in their new county.

Qualifying Changes in Status

(Whenever the term 'Spouse' is indicated on this page it also includes a Civil Union Partner.)

SPOUSE – Qualifying Changes in Status

Changes affecting the Spouse	Corresponding HEALTH & DENTAL Options								
	Member May Opt Out of Program	Member may Enroll or Re-Enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dependent Coverage	Terminate Spouse Coverage	Change Health Carrier	Waive Health/ Dental Coverage
Coordination of spouse's open enrollment period *	O	X		X	X	X	X		P
Death of spouse		X		X			X		
Eligibility: Spouse loses eligibility for group insurance coverage		X		X	X				
Eligibility: Spouse now provided with group insurance coverage	O					X	X		P
Employment Status: Spouse gains employment	O					X	X		P
Employment Status: Spouse loses employment		X		X	X				
LOA: Spouse enters nonpay status				X	X				
LOA: Spouse returns to work from nonpay status						X	X		
Medicare eligibility: Spouse gains							X		
Medicare eligibility: Spouse loses					X				
Premium of spouse's employer increases 30% or greater, or spouse's employer significantly decreases coverage		X		X	X				
Residence/Work location: Spouse's county changes**								X	

* The member's request to change coverage must be consistent with, and on account of, the spouse's election change.
** Only applies to members enrolled in an HMO whose HMO plan is not available in their new county.

DEPENDENT (other than Spouse) – Qualifying Changes in Status

Changes affecting a Dependent (other than a Spouse)	Corresponding HEALTH & DENTAL Options								
	Member May Opt Out of Program	Member may Enroll or Re-Enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dependent Coverage	Terminate Spouse Coverage	Change Health Carrier	Waive Health/ Dental Coverage
Death of Dependent						X			
Eligibility: Dependent becomes eligible for State group coverage				X					
Eligibility: Dependent loses eligibility for non-State group coverage				X					
Eligibility: Dependent now eligible for non-State group coverage						X			
LOA: Dependent enters nonpay status				X					
LOA: Dependent returns to work from nonpay status						X			
Medicare eligibility: Dependent gains						X			
Medicare eligibility: Dependent loses				X					
Residence/Work location: Dependent's county changes*								X	

X = Eligible changes for all members. **P** = Eligible changes for annuitants and survivors responsible for a portion of the State contribution.
O = Eligible changes for retirees, annuitants and survivors with 20 or more years of state service.
Existing Child = A child for which the member had custody prior to the previous 60-day period, such as a natural or adopted child, adjudicated child, stepchild, child of a civil union partner or a child for which the member is guardian. *Only applies to members enrolled in an HMO whose HMO plan is not available in their new county.

Documentation Requirements – Adding Dependent Coverage*

Type of Dependent	Supporting Documentation Required
Adjudicated Child Birth up to, but not including, age 26	• Judicial Support Order from a judge; or • Copy of DHFS Qualified Medical Support Order with the page that indicates the member must provide health insurance through the retirement system
Adoption or Placement for Adoption Birth up to, but not including, age 26	• Adoption Decree/Order with judge's signature and the circuit clerk's file stamp, or a • Petition for adoption with the circuit clerk's file stamp
Adult Veteran Child Child age 26 up to, but not including, age 30	• Birth Certificate required, and • Proof of Illinois residency, and • Veterans' Affairs Release form DD-214 (or equivalent), and the • Eligibility Certification Statement (CMS-138) • Copy of the tax return
Disabled Child age 26 and older (onset of disability must have occurred prior to age 26)	• Birth Certificate required, and a • Letter from licensed physician detailing the dependent's limitations, ICD-9 diagnosis code, capabilities, date of onset of condition, and a • Statement from the Social Security Administration with the Social Security disability determination, and a • Copy of the Medicare card, and the • Eligibility Certification Statement (CMS-138) • Copy of the tax return
Legal Guardianship Birth up to, but not including, age 26	• Court Order with judge's signature and circuit clerk's file stamp
Natural Child Birth up to, but not including, age 26	• Birth Certificate required
Other Organ transplant recipient	• Birth Certificate required, and • Proof of organ transplant performed after June 30, 2000, and the • Eligibility Certification Statement (CMS-138) • Copy of the tax return for dependents 26 and older
Spouse or Civil Union Partner	• Marriage Certificate or tax return • Civil Union Partnership Certificate. A tax return is also required if claiming the civil union partner as a dependent.
Stepchild or Child of Civil Union Partner Birth up to, but not including, age 26	• Birth Certificate required, and • Marriage or Civil Union Partnership Certificate indicating the member is married to, or the partner of, the child's parent. A tax return is also required if claiming the civil union partner's child as a dependent.

Note: Birth Certificate from either the State or admitting hospital which indicates the member is the parent is acceptable.

* A valid social security number (SSN) is required to add dependent coverage. If the SSN has not yet been issued for a newborn or adopted child, the child will be added to the member's coverage upon receipt of the birth certificate or adoption order without the SSN. The member must provide the SSN within 90 days of the date the coverage was requested in order to continue the dependent's coverage.

Documentation Requirements – Terminating Dependent Coverage

Qualifying Event	Supporting Documentation Required
Divorce, Dissolution of Civil Union Partnership or Annulment	**Divorce Decree or Judgment of Dissolution or Annulment** filed in a U.S. Court – first and last pages with judge's signature with circuit clerk's file stamp.
Legal Separation	**Court Order** with judge's signature with circuit clerk's file stamp.
Loss of Court-Ordered Custody	**Court Order** indicating the member no longer has custody of the dependent. The order must have judge's signature with circuit clerk's file stamp.
Dependent Becomes Ineligible for Group Insurance Coverage	**Signed memorandum** from the member indicating the dependent's name, the reason for the termination and the effective date of the termination.
Domestic Partner Ineligible or Relationship Terminates	**Domestic Partner Termination Form** (available on the Benefits website).

Documentation Time Limits

Dependent health, dental and vision coverage may be added with the corresponding effective date when documentation is provided to the GIR within the allowable time frame as indicated below. If documentation is provided outside the time frames, adding dependent coverage will not be allowed until the next annual Benefit Choice Period or until the member experiences a qualifying change in status. Refer to the 'Life Insurance Coverage' section for effective dates of life coverage.

When adding Dependent coverage due to or during the:	If the coverage is requested…	And if the documentation is provided…	Dependent coverage will be effective…
Initial Enrollment Period	Day 1 – 60 from the benefit begin date	Day 1 – 60 from the benefit begin date	The date the request was received by the retirement system
Annual Benefit Choice Period (Normally held May 1 – May 31 each year)	During the Benefit Choice Period	Within 10 days of the Benefit Choice Period ending	July 1st
Qualifying Change in Status (Exception for birth or adoption – noted below)	Before, or the day of, the event	1 – 60 days after the event	Date of the event
	Day 1 – 60 after event		Date the request was received by the retirement system
Birth of Child (Natural or Adopted)	From birth up to 60 days after the birth	From birth to 60 days after the birth	Date of birth
Adopted Children (Other than newborn)	Within 60 days of the event	Within 60 days of the event	Date of placement of the child, filing of the petition or the entry of the adoption order

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under the Program is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the retiree, annuitant, survivor and/or the dependent, as well as expenses incurred by the Program.

Opt Out and Waiver of Coverage

Retirees, annuitants and survivors may opt out or waive coverage during certain enrollment periods.

The election to opt-out or waive coverage will terminate health, dental and vision coverage for the member and any enrolled dependents. Annuitants and survivors who are eligible for Basic Life will continue, and/or be enrolled in, the Basic Life coverage regardless of their election to opt out or waive the health, dental and vision coverage. The member's elected Optional Life coverage will also continue to be in force. Annuitants and survivors should refer to the 'Life Insurance Coverage' section for Basic and Optional Life eligibility requirements.

Annuitants and survivors who have opted out/waived may elect to enroll/re-enroll in the health, dental and vision coverage during a subsequent Benefit Choice Period or upon experiencing a qualifying change in status.

Retirees, annuitants and survivors who opt out of the Program or waive coverage will not be eligible for the following:

- Free influenza immunizations offered annually
- COBRA continuation of coverage
- Smoking Cessation Program

Opting Out of Coverage

Applies to all Retirees, Annuitants and Survivors

In accordance with Public Act 92-0600, retirees, annuitants and survivors may elect to opt out of the State's coverage during the annual Benefit Choice Period or upon experiencing a qualifying change in status.

Annuitant and survivors electing to opt out of health coverage (which includes the termination of vision and prescription coverage) will remain enrolled in the dental and life insurance coverage. Members who opt out of the health coverage and do not want the dental coverage may only elect to opt out of the dental coverage during the annual Benefit Choice Period.

Members choosing this opt-out election cannot be enrolled as a dependent in any other plan administered by the Department and must provide proof of other major medical insurance by an entity other than the Department. Proof of other coverage must accompany the Opt Out Election Certificate available on the Benefits website. **NOTE:** An application for other health coverage is not acceptable proof of other coverage.

Opt Out with Financial Incentive

Applies only to Annuitants not eligible for Medicare (includes annuitants with less than 20 years of service) – Survivors are not eligible for the incentive

In accordance with Public Act 98-0019, effective July 1, 2013, annuitants who have other comprehensive medical coverage and meet the following criteria may elect to OPT OUT of the Program and receive a financial incentive of $150 per month (annuitants with less than 20 years of state service) or $500 per month (annuitants with 20 years or more of state service), less applicable withholding. In order to be eligible to receive the incentive, the annuitant must be receiving a retirement annuity from one of the five state retirement systems **and be ineligible for Medicare**. Proof of other coverage will be required on an annual basis in order to continue receiving the incentive. The Department will send a notice each year requesting proof of other coverage. The Opt Out with Financial Incentive application and associated forms are available on the Benefits website.

Annuitant Waiver

Applies to Annuitants who have been a Dependent for One Year or More

Public Act 93-553 changed the State Employees Group Insurance Act to allow an annuitant who is currently enrolled as a dependent of their State-covered spouse or civil union partner to remain a dependent and waive coverage in their own right. To qualify for this waiver, the annuitant must be enrolled as a dependent under their State-covered spouse or civil union partner for a year or more.

The annuitant must indicate the election to continue as a dependent on the retirement system's Participation Election Form. Annuitants who do not return the form within the required timeframe will have their coverage as a dependent of their spouse/civil union partner terminated. The spouse/civil union partner cannot carry Spouse Life on the annuitant; instead, the annuitant will have Basic Life coverage as a member.

Waiver Option

At the time an annuitant or survivor files an annuity application they will receive a Participation Election Form from the retirement system, in addition to other group insurance forms. Annuitants who would like to waive the health, dental and vision coverage must select the applicable box on the election form indicating the desire to waive the coverage.

Opt Out and Waiver of Coverage (cont.)

Retirees, annuitants and survivors who are currently enrolled in the health, dental and vision coverage but wish to waive the coverage must wait until either the annual Benefit Choice Period or until they experience a qualifying change in status. Waivers requested due to a qualifying change in status will be effective the later of either the date of the receipt of the request or the date of the qualifying event. Waivers requested during the annual Benefit Choice Period will be effective July 1st.

Premium Payment

The State covers the majority of the cost of health and dental insurance coverage for retirees, annuitants and survivors, and all of the cost for vision and Basic Life insurance coverage. The amount a retiree, annuitant or survivor contributes each month is based upon the coverage elections in effect on the 1st of the month. Premiums will not be prorated when a member changes their coverage elections or terminates from the Program on a day other than the 1st. Annuitants and survivors whose annuity check is insufficient to have premiums deducted will be direct billed.

Additional information about member-paid premiums is outlined below. **It is your responsibility to verify the accuracy of premiums paid, whether deducted from the annuity or direct billed, and to notify your GIR of any errors.**

Retiree, Annuitant and Survivor Contributions

Member Coverage Contributions

Contribution amounts for retirees, annuitants and survivors are based on years of service and Medicare status. Effective July 1, 2013, all members are responsible for a member-paid contribution for their health coverage.

Optional Coverage Contributions

All retirees, annuitants and survivors are responsible for a portion of the cost of elective dental and dependent coverage, as well as the full cost of any Optional Life coverage. Premiums for optional coverage are established annually and reflected in the Benefit Choice Options booklet. These contributions/premiums are subject to change each plan year.

Special provisions apply for the following types of dependents **if they cannot be claimed as a dependent under the IRS tax code**: adult veteran children age 26 through age 29, domestic partners, civil union partners and children of civil union partners.

- The premium for a **non-IRS domestic partner, a non-IRS civil union partner or the non-IRS child(ren) of a civil union partner**, is the 'One Dependent' or 'Two or More Dependent' rate depending on the number of non-IRS dependents in these categories being covered.
- The premium for a **non-IRS adult veteran child ages 26 through 29** is 100% of the cost of coverage (member's portion plus the State contribution).

The value of the coverage for a domestic partner, civil union partner and any children of the civil union partner is considered "imputed income" and will be reported as income at the end of each calendar year. The premiums for these dependents and imputed income amounts are indicated in the Domestic Partner/Civil Union Partner FAQ located on the Benefits website.

Reciprocal Service Credit

Retirees, annuitants and survivors under certain circumstances use creditable service established in the five retirement systems to qualify for or reduce their cost of health benefits. Contact the retirement system for more information regarding reciprocal service credit.

State Contribution

The following contributions are required from all members, regardless of years of service:

- For each retired employee, annuitant or survivor with primary coverage under the State program, the monthly premium shall be equal to two percent (2%) of the monthly annuity received by the retired employee, annuitant or survivor from any and all of the five State retirement systems;
- For each retired employee, annuitant or survivor with primary coverage under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97), the monthly premium shall be equal to one percent (1%) of the monthly annuity received by the retired employee, annuitant or survivor from any and all of the five State retirement systems;
- For each retired employee, annuitant or survivor, age 65 or older, whose primary coverage would otherwise be coverage under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97), except for their inability to contribute to Medicare while actively working, the monthly premium shall be equal to one percent (1%) of the monthly annuity received by the retired employee, annuitant or survivor from any and all of the five State retirement systems.

Premium Payment (cont.)

Additional contributions are required for individuals with less than 20 years of service.

The following individuals are required to pay an additional 5% of the cost of coverage for each year of service less than 20 years upon which their annuity is based:

SERS

- SERS annuitants who retire on or after January 1, 1998, and have between 8 and 20 years of creditable service.
- ARCP recipients who had between 8 and 20 years of creditable service at the time they elected the ARCP option.
- Survivors of a deceased annuitant in one of the above categories.
- Survivors of a deceased employee who would have been eligible for one of the above categories on the date of death.

SURS

- SURS annuitants who retired on or after January 1, 1998, and have between 5 and 20 years of creditable service.
- Survivors of a deceased annuitant in one of the above categories.
- Survivors of a deceased employee who would have been eligible for one of the above categories on the date of death.

TRS *

- TRS annuitants who retired on or after July 1, 1999, and have between 5 and 20 years of creditable service.
- Survivors of a deceased annuitant in one of the above categories.
- Survivors of a deceased employee who would have been eligible for one of the above categories on the date of death.

The following individuals are required to pay an additional 12.5% of the cost of coverage for each year of service less than 8 years of creditable service they served as a regional superintendent or an assistant regional superintendent:

TRS

- TRS regional superintendent annuitants who retire under TRS on or after July 1, 1998, and have less than 8 years of creditable service.

The following individuals are eligible for coverage but are required to pay 100% of the cost:

GARS

- Former members of the General Assembly who have vested and allowed their contributions to remain with the General Assembly Retirement System, but are not receiving an annuity.

Annuitants and Survivors Direct Billed

Billing Procedure and Time Frames

Annuitants and survivors whose annuity check is not sufficient to deduct premiums will be direct billed. When this occurs, a bill will be generated for the premium amount due. Bills are generated and mailed the first week of each month. Payment must be made by the final due date to ensure continuation of coverage.

* This information applies only to TRS retirees that have qualifying state service. Most retired teachers are covered under the terms of the Teachers' Retirement Insurance Program (TRIP) and should reference the TRIP Benefits Handbook. Please contact TRS for further information.

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under the Program is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the retiree, annuitant, survivor and/or the dependent, as well as expenses incurred by the Program.

Premium Payment (cont.)

Nonpayment of Premium

If payment is not received by the final due date, coverage will be terminated effective the last day of the current month. The Department will exercise its right under the State Comptroller's Act to collect delinquent group insurance premiums through involuntary withholding.

A member who retires but still owes outstanding premiums to CMS will not be eligible for coverage upon retirement, nor will they be eligible for coverage at any time in the future, under the State group insurance plan.

Annuitants, survivors and their dependents who were terminated for nonpayment of premium are not eligible to re-enroll in the Program, be covered under another member, nor are they eligible for continuation of coverage through COBRA.

COBRA Participants

While a plan participant is on COBRA, a monthly bill is generated by the Department for the premium amount due. Bills are mailed the first week of each month and must be paid by the due date to ensure continuation of coverage. Plan participants who do not receive a bill should contact the Department for assistance. Failure to submit payment will result in termination of coverage retroactive to midnight the last day of the month for which full payment was received.

Premium Refunds

Premium refunds based on corrections to a retiree, annuitant or survivor's insurance elections may be processed retroactively up to six months. Members who fail to notify their GIR within 60 days of a dependent's ineligibility will not receive a premium refund.

Premium Underpayments

Underpaid premiums are the responsibility of the annuitant or survivor and must be paid in full, regardless of the time period for which the underpayment occurred.

Termination

The coverage of a retiree, annuitant or survivor will only terminate upon the benefit ceasing, the member's death or coverage being terminated for nonpayment of premium. When a dependent experiences an event which terminates their coverage, such as a member's death, the dependent's health, dental and vision coverage, in most cases, can be continued under the Consolidated Omnibus Budget Reconciliation Act (COBRA). See the 'COBRA Coverage' section for more information.

Termination of Retiree, Annuitant and Survivor Coverage

Retiree, annuitant and survivor coverage terminates at midnight:

- On the date of member's death.
- On the last day of the month for which payment is not received following the issuance of a final notice of premium due from the Department (member and all dependents will be ineligible for COBRA).
- On the last day of the month in which the annuity or survivor benefit ceases.

Termination of Dependent Coverage

An enrolled dependent's coverage terminates at midnight:

- Simultaneous with termination of the retiree, annuitant or survivor's coverage.
- On the last day of the month in which a dependent loses eligibility.
- On June 30th for dependents who are voluntarily terminated during the Benefit Choice Period (these dependents will be ineligible for COBRA).
- On the requested date of a voluntary termination of a dependent (these dependents will be ineligible for COBRA).
- On the date of dependent's death.
- On the last day of the month in which the retiree, annuitant or survivor fails to certify continued eligibility for coverage of the dependent child.
- On the day preceding the dependent's:
  - enrollment in the Program as a member.
  - divorce or civil union partnership dissolution from the retiree, annuitant or survivor. The divorce or civil union partnership dissolution terminates the coverage for the spouse or civil union partner and all applicable stepchildren or children of the civil union partner.

NOTE: Retirees, annuitants and survivors who fail to notify their GIR within 60 days of the dependent's ineligibility will not receive a premium refund, nor will the dependent be eligible for COBRA.

COBRA Coverage

Overview

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Sections 367.2, 367e and 367e.1 of the Illinois Insurance Code provides eligible covered members and their eligible dependents the opportunity to **temporarily** extend their health coverage when coverage under the health plan would otherwise end due to certain qualifying events. COBRA rights are restricted to certain conditions under which coverage is lost. The election to continue coverage must be made within a specified election period. If elected, coverage will be reinstated retroactive to the date following termination of coverage.

An initial notice is provided to all new members upon enrollment in the Program. This notice is to acquaint individuals with COBRA law, notification obligations and possible rights to COBRA coverage if loss of group health coverage should occur. If an initial notice is not received, members should contact their Group Insurance Representative (GIR).

Eligibility

Covered members and dependents who lose coverage due to certain qualifying events (see the 'COBRA Qualifying Events' chart at the end of this section) are considered qualified beneficiaries and may be allowed to continue coverage under the provisions of COBRA. A **qualified beneficiary** is an individual (including the member, spouse, civil union partner, domestic partner or child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member. **Any voluntary termination of coverage will render the member and any dependents ineligible for COBRA coverage**.

Coverage available under COBRA for qualified beneficiaries is identical to the health, dental and vision insurance coverage provided to employees. Individuals converting to COBRA who elected not to participate in the dental plan prior to becoming eligible for COBRA may not enroll in the dental plan until the annual Benefit Choice Period. The life insurance coverage in force on the date of termination is not available through COBRA; however, the member and/or dependent may be eligible to convert or port their life insurance coverage. See the Life Insurance Coverage Certificate for details.

Covered dependents retain COBRA eligibility rights even if the member chooses not to enroll. Qualified beneficiaries electing continuation of coverage under COBRA will be enrolled as a member. **NOTE: If the member's spouse, civil union partner, domestic partner or dependent child(ren) live at another address, the Department must be advised immediately so that notification can be sent to the proper address(es).**

Retirees, annuitants and survivors who have opted out or waived health, dental and vision insurance coverage, and their dependents, are not eligible to participate in COBRA.

Notification of COBRA Eligibility

The member or qualified beneficiary must notify the retirement system GIR within 60 days of the date of the termination event, or the date on which coverage would end, whichever is earlier. Failure to notify the GIR within 60 days will result in disqualification of COBRA continuation coverage.

The Department will send a letter to the qualified beneficiary regarding COBRA rights within 14 days of receiving notification from the GIR of the termination. Included with the letter will be an enrollment form, premium payment information and important deadlines. If a letter is not received within 30 days and you notified your GIR within the 60-day period, you should contact the Department immediately for information.

COBRA Enrollment

Individuals have 60 days from the date of the COBRA eligibility letter to elect enrollment in COBRA and 45 days from the date of election to pay all premiums. Failure to complete and return the enrollment form or to submit payment by the due dates will terminate COBRA rights. If the enrollment form and all required payments are received by the due dates, coverage will be reinstated retroactive to the date of the qualifying event.

Medicare or Other Group Coverage - Impact on COBRA

Qualified beneficiaries who become eligible for Medicare or obtain other group insurance coverage (which does not impose preexisting condition limitations or exclusions) after enrolling in COBRA are required to notify the Department in writing of their Medicare eligibility or other group coverage.

COBRA Coverage (cont.)

These individuals are ineligible to continue COBRA coverage and will be terminated from the COBRA program.

The Department reserves the right to retroactively terminate COBRA coverage if an individual is deemed ineligible. Premiums will not be refunded for coverage terminated retroactively due to ineligibility.

COBRA Extensions

Disability Extension

Qualified beneficiaries covered under COBRA who have been determined to be disabled by the Social Security Administration (SSA) may be eligible to extend coverage from 18 months to 29 months at an increased cost. Enrolled nondisabled family members are also eligible for the extension. See 'Premium Payment under COBRA' later in this section for premium information.

To be eligible for the extension, the qualified beneficiary must either (1) become disabled during the first 60 days of COBRA continuation coverage or (2) been determined disabled prior to the date of COBRA eligibility. In either case, the determination must have been made by the Social Security Administration (SSA) and a copy of the SSA determination letter must be submitted to the Department within 60 days of the date of the SSA determination letter or the first day of COBRA coverage, whichever is later.

The affected qualified beneficiary must also notify the Department of any SSA final determination loss of disability status. This notification must be provided **within 30 days** of the SSA determination letter.

Second Qualifying Event Extension

If a member who experienced a qualifying event that resulted in an 18-month maximum continuation period experiences a second qualifying event before the end of the original 18-month COBRA coverage period, the spouse, civil union partner, domestic partner and/or dependent child (must be a qualified beneficiary) may extend coverage an additional 18 months for a maximum of 36 months.

Waiver of COBRA Rights and Revocation of that Waiver

A qualified beneficiary may waive rights to COBRA coverage during the 60-day election period and can revoke the waiver at any time before the end of the 60-day period. Coverage will be retroactive to the qualifying event.

Premium Payment under COBRA

The qualified beneficiary has 45 days from the date coverage is elected to pay all premiums. Individuals electing COBRA are considered members and will be charged the member rate. A divorced or widowed spouse (including a former civil union partner) who has a dependent child on their coverage would be considered the member and charged the member rate, with the child being charged the applicable dependent rate. If only a dependent child elects COBRA, then each child would be considered a member and charged the member rate.

Once the COBRA enrollment form is received by the Department and the premium is paid, coverage will be reinstated retroactive to the date coverage was terminated. The Department will mail monthly billing statements to the member's address on file on or about the 5th of each month. Bills for the current month are due by the 25th of the same month. Final notice bills (those with a balance from a previous month) are due by the 20th of the same month. Failure to pay the premium by the final due date will result in termination of coverage retroactive to the last day of the month in which premiums were paid.

It is the member's responsibility to promptly notify the Department in writing of any address change or billing problem.

The State does not contribute to the premium for COBRA coverage. Most COBRA members must pay the applicable premium plus a 2% administrative fee for participation. COBRA members who extend coverage for 29 months due to SSA's determination of disability must pay the applicable premium plus a 50% administrative fee for all months covered beyond the initial 18 months.

COBRA Coverage (cont.)

Adding Dependents - Second Qualifying Event Limitations

Newly-acquired dependents, including spouses, civil union partners, children of civil union partners and stepchildren, may be added to existing COBRA coverage. Even though these dependents are eligible for COBRA coverage, unless they are a newborn child or newly adopted child, they are not considered "qualified beneficiaries" and therefore would be ineligible for an extension if a second qualifying event would occur.

Existing dependents who are not enrolled on the first day the member becomes eligible for COBRA continuation coverage are not considered qualified beneficiaries. These dependents may only be added during the annual Benefit Choice Period and are also not eligible for second qualifying event extensions.

Documentation requirements must be met to add dependents. See the 'Documentation Requirements – Adding Dependent Coverage' chart in this chapter for details.

Termination of Coverage under COBRA

COBRA coverage terminates when the earliest of the following occurs:

- Maximum continuation period ends.
- Failure to make timely payment of premium.
- Covered member or dependent becomes a participant in another group health plan which does not impose a preexisting condition exclusion or limitation (for example, through employment or marriage).
- Covered member or dependent becomes entitled to Medicare. Special rules apply for End-Stage Renal Disease. Contact the Department for more information.
- Covered member or dependent reaches the qualifying age for Medicare.
- Covered dependent gets divorced from COBRA member (includes when the COBRA member's civil union partnership with the covered dependent is dissolved).
- Covered dependent child or domestic partner loses eligibility.
- Upon the member's death for any dependent not considered a qualified beneficiary.

Refer to the 'COBRA Qualifying Events' chart in this chapter for more information.

Conversion Privilege for Health Coverage

When COBRA coverage terminates, members may have the right to convert to an individual health plan. This conversion privilege applies to health coverage only. Members are eligible for this conversion unless group health coverage ended because:

- the required premium was not paid, or
- the coverage was replaced by another group health plan, including Medicare, or
- the COBRA coverage was voluntarily terminated.

Approximately two months before COBRA coverage ends, the Department will send a letter providing instructions on how to apply for conversion. To be eligible for conversion, members must have been covered by the current COBRA health plan for at least 3 months and requested conversion within 31 days of exhaustion of COBRA coverage. The converted coverage, if issued, will become effective the day after COBRA coverage ended. Contact the appropriate health plan administrator for information regarding conversion. The Department is not involved in the administration or premium rate structure of coverage obtained through conversion.

COBRA Coverage (cont.)

COBRA QUALIFYING EVENTS

A COBRA qualifying event is any of the events shown below that result in a loss of coverage.
The term 'Spouse' in this chart includes civil union partners; 'Ex-spouse' includes civil union partners whose partnership has been dissolved.

Qualifying Events	Maximum Eligibility Period
MEMBER	
Member's loss of eligibility	18 months
DEPENDENT	
Member's termination of benefits	18 months
Legal separation from member*	36 months
Loss of eligibility as a dependent child or domestic partner	36 months
Member's death	
• Spouse under age 55	36 months
• Spouse age 55 or older if already enrolled in Medicare	36 months
• Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Dependent child	36 months
• Domestic partner	36 months
Dissolution of Marriage or Civil Union Partnership*	
• Ex-Spouse under age 55	36 months
• Ex-Spouse age 55 or older if already enrolled in Medicare	36 months
• Ex-Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Stepchild or Child of a Civil Union Partner	36 months

* Dropping a spouse's coverage during the annual Benefit Choice Period in anticipation of a divorce, civil union partnership dissolution or legal separation will result in the spouse losing coverage effective July 1st. The spouse will be eligible for COBRA only once the divorce, dissolution or legal separation actually occurs. Spouses whose coverage was terminated due to a divorce, dissolution or legal separation must contact our office within 30 days of the event in order to be offered COBRA coverage.

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under COBRA is considered a fraudulent act. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.

COBRA Coverage (cont.)

A qualified beneficiary is an individual (including the member, spouse, civil union partner, domestic partner or child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member.

SECOND QUALIFYING EVENTS

The events shown below will extend coverage for a **qualified beneficiary** if it occurs during the original 18-month COBRA period.

The term 'Spouse' in this chart includes civil union partners; 'Ex-spouse' includes civil union partners whose partnership has been dissolved.

Qualifying Events	Maximum Eligibility Period
COBRA MEMBER	
SSA Disability determination within the first 60 days of COBRA	Additional 11 months for a maximum of 29 months
COBRA DEPENDENT	
Loss of eligibility as a dependent child or domestic partner	Additional 18 months for a maximum of 36 months
Legal separation from COBRA member*	Additional 18 months for a maximum of 36 months
COBRA member's death	
• Spouse under age 55	
• Spouse age 55 or older if already enrolled in Medicare	
• Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Dependent child	Additional 18 months for a maximum of 36 months
• Domestic partner	
Divorce from/Dissolution of civil union partnership with COBRA member*	
• Ex-Spouse under age 55	
• Ex-Spouse age 55 or older if already enrolled in Medicare	
• Ex-Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Stepchild or Child of Civil Union Partner	Additional 18 months for a maximum of 36 months

* Dropping a spouse's coverage during the annual Benefit Choice Period in anticipation of a divorce, civil union partnership dissolution or legal separation will result in the spouse losing coverage effective July 1st. The spouse will be eligible for COBRA only once the divorce, dissolution or legal separation actually occurs. Spouses whose coverage was terminated due to a divorce, dissolution or legal separation must contact our office within 30 days of the event in order to be offered COBRA coverage.

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under COBRA is considered a fraudulent act. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.

Chapter 2

Chapter 2: Health, Dental, Vision and Life Coverage Information

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Health Plan Options

Overview

The State offers a variety of health plans from which to choose. Each plan provides health, behavioral health and prescription drug benefits; however, the benefit levels, exclusions and limitations differ. When making choices, members should consider health status, coverage needs and service preferences. Dependents will have the same health and dental plan as the member under whom they are enrolled.

The annual Benefit Choice Options booklet provides a listing of the health plans available and the Illinois counties in which they provide coverage.

Types of Health Plans

The types of health plans available are:

- Managed Care Plans
  - Health Maintenance Organizations (HMOs)
  - Open Access Plans (OAPs)
- Quality Care Health Plan (QCHP)

Disease Management Programs and Wellness Offerings

Disease management programs are utilized by the health plans as a way to improve the health of plan participants. Plan participants may be contacted by their health plan to participate in these programs.

Wellness options and preventive measures are offered and encouraged by the health plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help plan participants take control of their personal health and well-being. Information about the various offerings is available on the plan administrators' websites.

Managed Care Health Plans

Managed care is a method of delivering healthcare through a system of network providers. Managed care plans provide comprehensive health benefits at lower out-of-pocket costs by utilizing network providers. Managed care health plans coordinate all aspects of a plan participant's healthcare including medical, prescription drug and behavioral health services.

There are two types of managed care plans, health maintenance organizations (HMOs) and open access plans (OAPs). Members who enroll in an HMO must select a primary care physician/provider (PCP) from the health plan's provider directory, which can be found on the plan's website. Plan participants should contact the physician's office or the HMO plan administrator to find out if the PCP is accepting new patients. Plan participants are required to use participating physicians and hospitals for maximum benefits. Annuitants, retirees and survivors enrolled in an OAP do not need to select a PCP. For complete information on specific plan coverage or provider networks, contact the managed care health plan and review the SPD.

Ordinarily, managed care plans only cover members within the State; however, plans that have networks outside the State of Illinois may provide coverage. Members should contact the managed care plan administrator to ascertain if coverage is available outside their geographic area. Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on out-of-area coverage.

The open access health plans are self insured, meaning all claims are paid by the State of Illinois even though managed care health plan benefits apply. These plans are not regulated by the Illinois Department of Insurance and are not governed by the Employees Retirement Income Security Act (ERISA).

In order to have the most detailed information regarding a particular managed care health plan, members should ask the plan administrator for its summary plan description (SPD) which describes the covered services, benefit levels, and exclusions and limitations of the plan's coverage. The SPD may also be referred to as a certificate of coverage or a summary plan document.

Members should pay particular attention to the managed care plan's exclusions and limitations. It is important that plan participants understand which services are not covered under the plan. Members deciding to enroll in a managed care health plan should read the SPD <u>before</u> seeking medical attention. It is the plan participant's responsibility to become familiar with all of the specific requirements of the health plan.

Health Plan Options (Managed Care Health Plans cont.)

Most managed care health plans impose benefit limitations on a plan year basis (July 1 through June 30); however, some managed care health plans impose benefit limitations on a calendar year basis (January 1 through December 31).

Refer to the annual Benefit Choice Options booklet for plan administrator information.

Health Maintenance Organization (HMO)

HMO members must choose a primary care physician/provider (PCP) who will coordinate the healthcare, hospitalizations and referrals for specialty care. In most cases a referral for specialty care will be restricted to those services and providers authorized by the designated PCP. Additionally, referrals may also require prior authorization from the HMO. To receive the maximum hospital benefit, your PCP or specialist must have admitting privileges to a network hospital.

Like any health plan, HMOs have plan limitations including geographic availability and participating provider networks. HMO coverage is offered in certain counties called service areas. There is no coverage outside these service areas unless preapproved by the HMO. When traveling outside of the health plan's service area, coverage is limited to life-threatening emergency services. For specific information regarding out-of-area services or emergencies, call the plan administrator. **NOTE:** When an HMO plan is the secondary plan and the plan participant does not utilize the HMO network of providers or does not obtain the required referral, the HMO plan is not required to pay for services. Refer to the plan's description of coverage for additional information.

Managed care health plan provider networks are subject to change. Annuitants, retirees and survivors will be notified in writing by the plan administrator when a PCP network change occurs. Annuitants, retirees and survivors will have 60 days from the date the provider leaves the network to make a health plan change. If the designated PCP leaves the HMO network*, you must choose another PCP within that plan.

When an HMO member's primary care physician (PCP) leaves the plan's network, the member will only be allowed to change health plans if the HMO network experienced a significant change in the number of medical providers offered, as determined by CMS.

Annuitants, retirees and survivors who change their health plan outside the Benefit Choice Period, regardless of the basis for the change, will be responsible for any deductibles required by the new plan (including prescription deductibles), even if the plan participant met all deductibles while covered by the previous health plan.

* The opportunity to change health plans applies only when the PCP leaves the network. This opportunity does not apply to specialists or womens' healthcare providers who are not the designated PCP.

HMO Out-of-Pocket Maximums

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year for eligible medical, behavioral health and prescription drug charges. Charges that apply toward the out-of-pocket maximum for HMOs are:

- Medical and prescription copayments
- Medical coinsurance.

Open Access Plans (OAPs)

Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted. Members enrolled in an OAP can mix and match providers and tiers.

- Tier I offers a managed care network which provide enhanced benefits and require copayments which mirror HMO copayments.
- Tier II offers another managed care network, in addition to the managed care network offered in Tier I, and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
- Tier III covers all providers which are not in the managed care network of Tiers I or II (i.e., out of network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of pocket costs. Tier III has a higher plan year deductible and has a higher coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, plan participants who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services (i.e., allowable charges), which could result in much higher out-of-pocket costs. When using out-of-network providers, it is recommended that the participant obtain a preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and be eligible for benefit coverage.

Health Plan Options (Managed Care Health Plans cont.)

Members who use providers in Tiers II and III will be responsible for the plan year deductible. **In accordance with the Affordable Care Act, these deductibles will accumulate separately from each other and will not 'cross accumulate.'** This means that amounts paid toward the deductible in one tier will not apply toward the deductible in the other tier.

OAP Out-of-Pocket Maximums

Eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year after the plan's out-of-pocket maximum has been satisfied. Charges that apply toward the out-of-pocket maximum for an OAP plan (only applies to Tier I and Tier II providers) are:

- Annual medical plan year deductible (Tier II)
- Medical and prescription copayments
- Medical coinsurance.

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

Quality Care Health Plan (QCHP)

The Quality Care Health Plan (QCHP) is the State's self-insured health plan offering a comprehensive range of benefits. All claims and costs are paid by the State through a third-party administrator. For complete information regarding specific plan coverage and the provider's network, refer to the summary plan description on the Benefits website. Benefit enhancements are available by utilizing the:

- Nationwide QCHP physician, hospital, ancillary services and transplant network.
- Pharmacy network.
- Behavioral health network.

Each of these three components is discussed separately in this section. Each component has its own plan administrator.

Member Responsibilities

- **The member is always responsible for:**
  - Any amount required to meet **plan year deductibles, additional deductibles** and **coinsurance** amounts.
  - Any amount over the **allowable charges**.
  - Any penalties for failure to comply with the **notification requirements**.
  - Any charges NOT covered by the plan or determined by the plan administrator to be not **medically necessary** services.

NOTE: Specific dollar amounts and percentages that apply to deductibles, "additional deductibles" and coinsurance are updated each year in the Benefit Choice Options booklet.

Plan Requirements

Plan Year Deductible

The plan year deductible requirement applies to all medical and behavioral health services, except preventive services. The plan year deductible for retirees, annuitants and survivors is a set amount that may change each plan year. **To verify the retiree, annuitant, survivor plan year deductible or the family plan year deductible**, review the current Benefit Choice Options booklet. The plan year runs from July 1 through June 30.

Each family member's plan year deductible will accumulate toward a family plan year deductible. Once the family as a unit has satisfied the family plan year deductible, no further plan deductibles for any family member will be required for eligible charges incurred for the remainder of that plan year. The member plan year deductible and/or the family plan year deductible accumulate toward the annual out-of-pocket maximum.

Additional Deductibles

Besides the plan year deductible, plan participants must pay additional deductibles for the following:

- Each emergency room visit that does not result in a hospital admission
- QCHP hospital admission
- Non-QCHP hospital admission
- Transplant hospital admission

Even though these additional deductibles do not apply toward the plan year deductible, they do accumulate toward the annual out-of-pocket maximum.

Health Plan Options (Quality Care Health Plan (QCHP))

Coinsurance

Coinsurance is the percentage of eligible charges that plan participants must pay after the annual plan year deductible has been met. Eligible charges are charges for covered services and supplies which are medically necessary.

Out-of-Pocket Maximum

Eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year after the plan's out-of-pocket maximum has been satisfied. There are two separate out-of-pocket maximums: in-network and out-of-network. Coinsurance and deductibles apply to one or the other, but not both. Charges that apply toward the out-of-pocket maximum for the QCHP plan are:

- Annual medical plan year deductible
- Annual prescription plan year deductible
- Prescription copayments
- Medical coinsurance
- QCHP additional medical deductibles

The following do not apply toward out-of-pocket maximums:

- Notification penalties.
- Ineligible charges (i.e., amounts over the allowable charge, charges for noncovered services and charges for services deemed not to be medically necessary).
- The portion of the Medicare Part A deductible the plan participant is responsible to pay.

Medical Necessity

- **QCHP covers charges for services and supplies that are medically necessary. Medically necessary services and supplies are those which are:**
  - provided by a hospital, medical facility or prescribed by a physician or other provider and are required to identify and/or treat an illness or injury.
  - consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
  - generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.
  - the most appropriate supply or level of service which can be safely provided to the patient.
  - not solely for the convenience of the patient, physician, hospital or other provider.
  - repeated only as indicated as medically appropriate.
  - not redundant when combined with other treatment being rendered.

Predetermination of Benefits

Predetermination of benefits ensures that medical services/stays will meet medical necessity criteria and be eligible for benefit coverage. The plan participant's physician must submit written detailed medical information to the medical plan administrator. For questions regarding a predetermination of benefits, contact the plan administrator.

Benefits are based on the plan participant's eligibility and plan provisions in effect at the time services are rendered. Precise claim payment amounts can only be determined upon receipt of the itemized bill and are subject to standard claim payment policies including, but not limited to, multiple and incidental procedure reductions, allowable charges and claim bundling and unbundling of procedures.

Allowable Charges

The maximum amount the plan will pay an out-of-network healthcare professional for billed services is referred to as allowable charges. The amount that is over the allowable charges amount is not considered eligible for payment by the plan and therefore cannot be applied to the plan year deductible nor the out-of-pocket maximum. **The plan participant will be responsible for the entire amount that is over and above the allowable charges amount. Allowable charges are usually applied when using out-of-network providers.**

When processing any given claim, the plan administrator takes the following into account:

- Complexity of the services.
- Any unusual circumstances or complications that require additional skill, time or experience.
- Prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical-cost experience.

Health Plan Options (QCHP cont.)

Allowable charges apply to medical services, procedures and/or supplies.

IMPORTANT: The amount of the claim that will be paid is based on the allowable charges amount or the actual charge made by the provider, whichever is less, for out-of-network services.

Quality Care Health Plan (QCHP) Network

The Quality Care Health Plan (QCHP) network includes hospitals, physicians and ancillary providers throughout Illinois, as well as nationwide. The network provides quality inpatient and outpatient care at negotiated rates, which result in savings to plan participants. The network is subject to change any time during the plan year.

Medical Case Management

The Medical Case Management (MCM) Program is designed to assist plan participants requiring complex care in times of serious or prolonged illness. There is no additional cost to the plan participant for this service.

The referral to the MCM Program is made through either the MCM administrator, the QCHP plan administrator or by request from a plan participant. Once referred, the plan participant is assigned a case manager who serves as a liaison and facilitator between the patient, family, physician and other healthcare providers. The case manager is a registered nurse or other healthcare professional with extensive clinical background. The case manager can effectively minimize the fragmentation of care.

Upon completing the MCM review, the case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. To reach the MCM plan administrator, call the toll-free number listed in the plan administrator section of the current Benefit Choice Options booklet located on the Benefits website.

Notification Requirements

Notification is the telephone call to the notification administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility or for an outpatient procedure, therapy service or supply. If using a QCHP network provider, the medical provider is responsible for contacting the notification administrator on behalf of the plan participant.

If using a non-QCHP provider, the plan participant may request that their non-QCHP medical provider contact the notification administrator to provide specific medical information, setting and anticipated length of stay to determine medical appropriateness. The plan participant may also make notification, after which a medically qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information.

Regardless of where services are rendered, it is the plan participant's responsibility to ensure that notification has occurred. Failure to contact the notification administrator prior to having a service performed may result in a financial penalty and risk incurring noncovered charges. Notification is required for all plan participants including those with Medicare or other insurance as primary payer.

Contact information for the notification administrator can be found in the plan administrator section of the current Benefit Choice Options booklet. The toll-free number is also printed on your identification card. You can call seven days a week, twenty-four hours a day.

- **Notification is required for the following:**

  (Contact the notification administrator for the most up-to-date list of procedures requiring notification).

  - **Outpatient Surgery, Procedures, Therapies and Supplies/Equipment.** Outpatient surgery and procedures include, but are not limited to, items such as imaging (MRI, PET, SPECT and CAT scan), physical, occupational or speech therapy, foot orthotics, durable medical equipment (DME) supplies, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, select injectable drug treatment for varicose veins, etc.).
  - **Any Elective Inpatient Surgery or Non-Emergency Admission.** Notification must be made at least seven days before admission. The admission and length of stay must be authorized before entering the facility.
  - **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission.** Notification must be made at least seven days before admission. A review of the care being rendered will be conducted to determine if the services are skilled in nature.
  - **Emergency or Urgent Admission.** Notification must be made within two business days after the admission.
  - **Hospice Admission.** Notification must be made prior to the admission.

Health Plan Options (QCHP cont.)

- **Potential Transplants.** Notification must be made prior to beginning evaluation services. Benefits are only available through the QCHP transplant network of hospitals/facilities.

✦ **Notification is *Not:***

- **A final determination of medical necessity**. If the notification administrator should determine that the setting and/or anticipated length of stay are no longer medically necessary and NOT eligible for coverage, the physician will be informed immediately. The plan participant will also receive written confirmation of this determination.
- **A guarantee of benefits**. Regardless of notification of a procedure or admission, there will be no benefit payment if the plan participant is ineligible for coverage on the date services were rendered or if the charges are deemed ineligible.
- **Enrollment of a newborn for coverage**. Contact your GIR to enroll a newborn within 60 days of birth.
- **A determination of the amount which will be paid for a covered service**. Benefits are based upon the plan participant's eligibility status and the plan provisions in effect at the time the services are provided.

NOTE: For authorization procedures and time limits for behavioral health services, see the 'Behavioral Health' section later in this chapter.

Benefits for Services Received While Outside the United States

The plan covers eligible charges incurred outside of the United States for services that are generally accepted as medically necessary within the United States. All plan benefits are subject to plan provisions and deductibles. The benefit for facility and professional charges is paid at the non-QCHP rate. Notification is not required for medically necessary services rendered outside of the United States; however, medical necessity must be established prior to reimbursement. **Payment for the services will most likely be required from the member at the time the services are rendered.**

Plan participants must file a claim with the plan administrator for reimbursement. When filing a claim, enclose the itemized bill with a description of the services translated to English and the total amount of billed charges, along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number. Reimbursement in American dollars will be based on the conversion rate of the billed currency on the date services were rendered.

Generally, Medicare will not pay for healthcare obtained outside the United States and its territories. When Medicare does not pay, QCHP becomes the primary payer and standard benefit levels will apply.

Hospital Bill Audit Program

The Hospital Bill Audit Program applies to QCHP and non-QCHP hospital charges. Under the program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill is eligible for 50% of the resulting savings. There is no cap on the savings amount. Related nonhospital charges, such as radiologists and surgeons are not eligible charges under this program. This program applies only when QCHP is the primary payer.

Reimbursement documentation required:

- Original incorrect bill,
- Corrected copy of the bill, and
- Member's name, telephone number and last four digits of the SSN.

Submit Documentation to:

Hospital Bill Audit Program
DCMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

Quality Care Health Plan – Medical Benefits Summary

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

This document contains a brief overview of some of the benefits available under the Quality Care Health Plan (QCHP). Contact the plan administrator for more information or coverage requirements and/or limitations. **In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator. The information below indicates the requirements and benefit levels of the covered services, supplies and therapies for the standard benefit level (60% of allowable charges). There is a 85% enhanced benefit level for utilizing network providers.**

Acupuncture

- Charges for treatment of diagnosed chronic pain with a written referral from a physician or dentist. Coverage is subject to frequency limitations. **Note:** Chronic pain is defined as pain that persists longer than the amount of time normally expected for healing.

Ambulance (See Exclusion #5 and #43)

- Transportation charges to the nearest hospital/facility for emergency medically necessary services for a patient whose condition warrants such service. The plan administrator should be notified as soon as possible for a determination of coverage. Medically necessary transportation charges (emergency ground or air ambulance) will be paid at the 85% benefit level after the annual plan year deductible has been met. Services that are determined not to be medically necessary will not be covered.
- Transportation services eligible for coverage:
  - From the site of the disabling illness, injury, accident or trauma to the nearest hospital qualified to provide treatment (includes air ambulance when medically necessary).
  - From a remote area, by air, land or water (inside or outside the United States), to the nearest hospital qualified to provide emergency medical treatment.
  - From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest hospital equipped to treat the injury, trauma or illness.

Behavioral Health

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Plan participants must call the behavioral health plan administrator within 48 hours to avoid a financial penalty. Authorization requirements still apply when plan participants have other coverage, such as Medicare.

- **Inpatient services** must be authorized prior to admission or within 48 hours of an emergency admission to receive in-network or out-of-network benefits. Authorization is required with each new admission. Failure to notify the behavioral health plan administrator of an admission to an inpatient facility within 48 hours will result in a financial penalty and risk incurring noncovered charges.
- **Partial hospitalization and intensive outpatient treatment** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required before beginning each treatment program. Failure to notify the behavioral health plan administrator of a partial hospitalization or intensive outpatient program will result in a financial penalty and risk incurring noncovered charges.
- **Outpatient services** received at the in-network benefit level must be provided by a QCHP network provider. Most routine outpatient services (such as therapy sessions and medication management) will be covered without the need for prior authorization. Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a plan participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the plan participant's provider to discuss the treatment if a review will be applied. Outpatient services received at the out-of-network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.
- **Electroconvulsive therapy, psychological testing**

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

and applied behavioral analysis must be authorized to receive in-network or out-of-network benefits. Failure to obtain authorization will result in the risk of incurring noncovered charges.

- **Residential services** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required with each new residential admission. Failure to notify the behavioral health plan administrator of an admission to a residential facility will result in a financial penalty and risk incurring noncovered charges.

Breast Reconstruction Following Mastectomy

- The plan provides coverage, subject to and consistent with all other plan provisions, for services following a mastectomy, including:
  - Reconstruction of the breast (including implants) on which the mastectomy was performed.
  - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.
  - Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a provider covered under the plan.
  - Mastectomy bras are covered following surgery or a change in prosthesis.

Cardiac Rehabilitation

- Phase I and Phase II when ordered by a physician.

Chiropractic Services

- Maximum of thirty (30) visits per plan year will be covered.
- No coverage for chiropractic services considered to be maintenance in nature, in that medical information does not document progress in the improvement of the condition.

Christian Science Practitioner

- Coverage for the services of a Christian Science Nurse or Practitioner.
  - A Christian Science Nurse is a nurse who is listed in a Christian Science Journal at the time services are given and who: (a) has completed nurses' training at a Christian Science Benevolent Association Sanitarium; or (b) is a graduate of another School of Nursing; or (c) had three consecutive years of Christian Science Nursing, including two years of training.
  - A Christian Science Practitioner is an individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.

Circumcision

- Charges for professional services.
- Charges for circumcision are considered to be covered services when billed as a separate claim for the newborn as long as the newborn is enrolled in the plan and the surgery is performed within the first thirty (30) days following birth.

Dental Services (See Exclusion #14 and # 15)

- **Accidental Injury:**
  - Coverage for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within three months of original accidental injury. The appropriate facility benefit applies.
- **Nonaccidental:** Coverage limited to:
  - Anesthesia and facility charges for dependent children age six and under.
  - A medical condition that requires anesthesia and facility charges for dental care (not anxiety or behavioral related conditions). Professional services are not covered under the medical plan.

Diabetic Coverage

- Charges for dietitian services and consultation when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

- Charges for routine foot care by a physician when diagnosed with diabetes.
- Charges for insulin pumps and related supplies when deemed medically necessary.

Dialysis

- Charges for hemodialysis and peritoneal dialysis.

Durable Medical Equipment (DME) (See Exclusion #5)

- **Short-term Rental:**
  - Rental fees up to the purchase price for items that temporarily assist an impaired person during recovery. Examples include canes, crutches, walkers, hospital beds and wheelchairs.
- **Purchase:**
  - Charges to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the purchase price.
- DME exclusions include, but are not limited to:
  - Repairs or replacements due to negligence or loss of the item.
  - Newer or more efficient models.
- DME is eligible for coverage when provided as the most appropriate and lowest cost alternative as required by the person's condition.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

The facility in which emergency treatment is rendered and the level of care determines the benefit level (hospital, urgent care center, physician office). For emergency transportation services, refer to the 'Ambulance' section.

- **Emergency Room:**
  - 85% of allowable charges after the special emergency room deductible at a QCHP or non-QCHP facility. The special deductible applies to each visit to an emergency room which does not result in an inpatient admission.
- **Physician's Office:**
  - 85% of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Nonemergency medically necessary care is considered at 60% of allowable charges.
- **Urgent Care or Similar Facility:**
  - 85% of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. This benefit applies to professional fees only. Facility charges not covered when services are performed in a physician's office or urgent care center. Nonemergency medically necessary care is considered at 60% of allowable charges.

Eye Care (See Exclusion #11 and #27)

- Charges for treatment of injury or illness to eye.

Foot Orthotics

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Must be custom molded or fit to the foot and ordered by a physician or podiatrist.

Hearing Services

- Diagnostic hearing exams performed by an audiologist are covered up to $150 and hearing aids are covered up to $600 every three plan years.
- Professional service charges for the hearing exam associated with the care and treatment of an injury or an illness.

Hospice

- Written notification of the terminal condition is required from the attending physician.

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

- Inpatient hospice requires notification. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Inpatient Hospital/Facility Services

(See Exclusions #3, #6, #8, #32)

- Hospital/facility charges.

NOTE: Failure to provide notification of an upcoming admission or surgery will result in a financial penalty and denial of coverage for services not deemed medically necessary. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of infertility. Infertility is defined as the inability of opposite sex partners to conceive after one consecutive year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

- Predetermination of Benefits:
  - A written predetermination of benefits must be obtained from the health plan administrator prior to beginning infertility treatment to ensure optimum benefits. Documentation required from the physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy and the proposed plan of treatment with physicians' current procedural terminology (CPT) codes.
- Infertility Benefits:
  - Coverage is provided only if the plan participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this plan.
- Coverage for assisted reproductive procedures include, but is not limited to:
  - Artificial insemination, invitro fertilization (IVF) and similar procedures which include but are not limited to: gamete intrafallopian tube transfer (GIFT), low tube ovum transfer (TET) and uterine embryo lavage.
  - A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
  - A maximum of four (4) procedures per lifetime for any of the following: invitro fertilization, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and other similar procedures.
  - If a live birth results from an invitro procedure, two additional procedures are eligible for coverage.
  - Eligible medical costs associated with sperm or egg donation by a person covered under the plan may include, but are not limited to, monitoring the cycle of a donor and retrieval of an egg for the purpose of donating to a covered individual.
  - Retrieval does not count toward the number of maximum attempts.
- Infertility treatment exclusions include, but are not limited to:
  - Medical or nonmedical costs of anyone NOT covered under the plan.
  - Nonmedical expenses of a sperm or egg donor covered under the plan including, but not limited to transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryopreservation and storage of sperm or embryo or fees payable to a donor.
  - Infertility treatment deemed experimental or unproven in nature.
  - Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization.
  - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a plan participant or not.
  - Pre-implantation genetic testing.

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

Lab and Radiology

- Outpatient:
  - Charges at a physician's office, hospital, clinic or urgent care center.
- Inpatient:
  - If billed by a hospital as part of a hospital confinement, paid at the appropriate hospital benefit level.
- Professional charges:
  - Professional charges associated with the interpretation of the lab or radiology procedures.

Medical Supplies (See Exclusions #3, #5, #19)

- Medical supplies include, but are not limited to ostomy supplies, surgical dressings and surgical stockings.

Morbid Obesity Treatment (See Exclusion #12)

- Charges for professional services.
- Obesity surgery is eligible for coverage dependent on medical necessity and predetermination of benefits.

Newborn Care (See Exclusion #41)

- Charges for professional services in an office or hospital setting.
- Benefits are available for newborn care only if the dependent is enrolled no later than 60 days following the birth.

Occupational Therapy/Physical Therapy (See Exclusion #10)

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Covered if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or physician.

Outpatient Hospital/Facility Services, including Surgery

(See Exclusions #3, #4, #6)

- Covered if performed at a hospital/facility.
- Covered if performed at an ambulatory surgical treatment center which is licensed by the Department of Public Health, or the equivalent agency in other states, to perform outpatient surgery.

Physician Services

- Charges for medical treatment of an injury or illness.

Physician Services – Surgical

(See Exclusions #12, #13, #16)

- Inpatient Surgery:
  - Follow-up care by the surgeon is considered part of the cost of the surgical procedure and is NOT covered as a separate charge.
- Outpatient Surgery:
  - If surgery is performed in a physician's office, the following will be considered as part of the fee:
  - Surgical tray and supplies.
  - Local anesthesia administered by the physician.
  - Medically necessary follow-up visits.
- Plastic and reconstructive surgery is limited for the following:
  - An accidental injury.
  - Congenital deformities evident at infancy.
  - Reconstructive mammoplasty following a mastectomy.
- Assistant surgeon:
  - A payable assistant surgeon is a physician who assists the surgeon, subject to medical necessity.
  - Up to 20% of allowable charges of eligible charges.
- Multiple surgical procedures:
  - Standard plan guidelines are used in processing

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

claims when multiple surgical procedures are performed during the same operative session.

- Charges for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the plan administrator for a predetermination of benefits.

Podiatry Services (See Exclusion #9)

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

Prescription Drugs

- Drug charges if billed by a physician's office and not obtained at a pharmacy.
- Prescription drugs obtained as part of a skilled care facility stay are payable by the health plan administrator.
- Prescription drugs obtained as part of a hospital stay are payable at the appropriate facility benefit level.
- Prescription drugs billed by a skilled nursing facility, extended care facility or a nursing home must be submitted to the prescription drug plan administrator.

Preventive Services

Routine preventive care services which do NOT require a diagnosis or treatment are covered at 100% when utilizing a network provider. Out-of-network preventive care is covered at the out-of-network benefit level. Your doctor will determine the tests and frequency that are right for you based on your age, gender and family history. In-network preventive services are not subject to the plan year deductible.

NOTE: Claims which indicate a diagnosis are not considered preventive and are subject to the plan year deductible and coinsurance.

Prosthetic Appliances

A prosthetic appliance is one which replaces a body part. Examples are artificial limbs and artificial eyes.

- Charges for:
  - The original prosthetic appliance.
  - Replacement of a prosthetic appliance due to growth or a change in the person's medical condition.
  - Repair of a prosthetic appliance due to normal wear and usage and no longer functional.
- No payment will be made if the appliance is damaged or lost due to negligence.
- Prosthetic appliances exclusions include, but are not limited to:
  - Appliances not recommended or approved by a physician.
  - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
  - Items considered cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
  - Experimental or investigational appliances.

Skilled Nursing Service – Home Setting

- Contact the Notification/Medical Case Management plan administrator for a determination of benefits.
- The benefit for skilled nursing service will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home within the same geographic region.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.

Skilled Nursing – In a Skilled Nursing Facility, Extended Care Facility or Nursing Home

(See Exclusions #3, #5, #19)

- Benefits are subject to skilled care criteria and will be allowed for the most cost-effective setting or the level of care required as determined by the Notification/Medical Case Management plan administrator.
- Must be a licensed healthcare facility primarily engaged in providing skilled care.

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

- Notification is required at least seven days prior to admission or at time of transfer from an inpatient hospital stay.
- Benefits are limited to the average cost of available facilities within the same geographic region.
- The service must be medically necessary.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.
- Prescription drug charges must be submitted to the health plan administrator.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

Notification is required. Refer to 'Notification Requirements' in the 'Quality Care Health Plan' section of the Benefits Handbook for more information.

- Charges for medically necessary speech therapy ordered by a physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature with the ability to improve communication.
- The person must have the potential for communication.

Transplant Services
(Notification Required)

In order for any organ, tissue or bone marrow transplant to be covered under the plan, one of the designated procedure specific transplant hospitals must be utilized. The transplant candidate must contact the Notification/Medical Case Management plan administrator of the potential transplant. Once notification occurs, the Medical Case Manager (MCM) will coordinate all treatments and further notification is not required. Those refusing to participate in the MCM program will be notified that coverage may be terminated under the plan for treatment of the condition.

The transplant benefit includes all diagnostic treatment and related services necessary to assess and evaluate the transplant candidate. All related transplant charges submitted by the transplant hospital are covered at 85% of the contracted rate.

In some cases, transplants may be considered nonviable for some candidates, as determined by the MCM plan administrator in coordination with the transplant hospital.

- Transplant exclusions include, but are not limited to:
  - Investigational drugs, devices or experimental procedures.
  - Charges related to the search for an unrelated bone marrow donor.
  - A corneal transplant is not part of the transplant hospital benefit; however, standard benefits apply under the medical portion of the coverage.

Transplant Coordination of Donor/Recipient Benefits

- When both the donor and the recipient are covered under the plan, both are entitled to benefits under the plan, under separate claims.
- When only the recipient is covered, the donor's charges are covered as part of the recipient's claim if the donor does not have insurance coverage, or if the donor's insurance denies coverage for medical expenses incurred.
- When only the recipient is covered and the donor's insurance provides coverage, the plan will coordinate with the donor's plan.
- When only the donor is covered, only the donor's charges will be covered under the plan.
- When both donor and recipient are members of the same family and are both covered by the plan, no deductible or coinsurance shall apply.

The transplant hospital network is subject to change throughout the year. Call the Notification/Medical Case

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 85% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

Management plan administrator for current transplant hospitals.

Transplant – Transportation and Lodging Benefit

- The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.
- The plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been accepted as a candidate for transplant services.
- Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

  Organ Transplant Reimbursement
  DCMS Group Insurance Division
  801 S. 7th Street
  P.O. Box 19208
  Springfield, IL 62794-9208

- The plan participant has twelve months from the date expenses were incurred to submit eligible charges for reimbursement. Requests submitted after the twelve-month limit will not be considered for reimbursement.

Urgent Care Services

Urgent care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. If a facility fee is billed, the emergency room deductible applies.

NOTE: See Emergency Services for medically necessary emergency care.

Quality Care Health Plan (QCHP) Exclusions and Limitations

No benefits are available:

1. For services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a nurse midwife who has completed an organized program of study recognized by the American College of Nurse Midwives or by a Christian Science Practitioner.

2. For services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this document to be a covered service in effect at the time the service was rendered. Excluded services and supplies include, but are not limited to: sports-related health checkups, employer-required checkups, wigs and hairpieces.

3. For care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable by the plan.

4. For charges for the services, room and board or supplies that exceed allowable charges.

5. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, nonhospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps, transportation services or any other services or items determined by the plan to be for personal convenience.

6. For rest, convalescence, custodial care or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.

7. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).

8. For private room charges which are not medically necessary as determined by the plan administrator.

9. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.

10. For chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.

11. For keratotomy or other refractive surgeries.

12. For the diagnosis or treatment of obesity, except services for morbid obesity, as approved by the plan administrator.

13. For sexual dysfunction, except when related to an injury or illness.

14. For services relating to the diagnosis, treatment, or appliance for temporomandibular joint disorders or syndromes (TMJ), myofunctional disorders or other orthodontic therapy.

15. For an internal accidental injury to the mouth caused by biting on a foreign object and outpatient services for routine dental care.

16. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless it is a physician's opinion that such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the woman or her unborn child.

17. For cosmetic surgery or therapies, except for the repair of accidental injury, for congenital deformities evident in infancy or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.

18. For services rendered by a healthcare provider specializing in behavioral health services who is a candidate in training.

19. For services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.

20. For treatment or services which are investigational, experimental or unproven in nature including, but not limited to, procedures and/or services: which are performed in special settings for research purposes or in a controlled environment; which are being studied for safety, efficacy and effectiveness; which are awaiting endorsement by the appropriate national medical specialty organization; which medical literature does not accept as a reasonable alternative to existing treatments; or, that do not yet meet medical standards of care.

21. For services due to bodily injury or illness arising out of or in the course of a plan participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.

22. For court mandated services if not a covered service under this plan or not considered to be medically necessary by the appropriate plan administrator.

23. For services or supplies for which a charge would not have been made in the absence of coverage or for services or supplies for which a plan participant is not required to pay.

24. For services arising out of war or an act of war, declared or undeclared, or from participation in a riot, or incurred during or as a result of a plan participant's commission or attempted commission of a felony.

25. For services related to the reversal of sterilization.

26. For lenses (eye glasses or removable contact lenses) except initial pair following cataract surgery.

27. For expenses associated with obtaining, copying or completing any medical or dental reports/records.

28. For services rendered while confined within any federal hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.

29. For charges imposed by immediate relatives of the patient or members of the plan participant's household as defined by the Centers for Medicare and Medicaid Services.

30. For services rendered prior to the effective date of coverage under the plan or subsequent to the date coverage is terminated.

31. For private duty nursing, skilled or unskilled, in a hospital or facility where nursing services are normally provided by staff.

32. For services or care provided by an employer-sponsored health clinic or program.

33. For travel time and related expenses required by a provider.

34. For facility charges when services are performed in a physician's office.

35. For residential treatment for behavioral health services incurred prior to July 1, 2014.

36. For the treatment of educational disorders relating to learning, motor skills, communication and pervasive development conditions.

37. For nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neuro feedback, hypnosis, sleep therapy, employment counseling, back-to-school, return to work services, work hardening programs, driving safety and services, training, educational therapy or nonmedical ancillary services for learning disabilities, developmental delays, autism (except as provided under covered expenses) or mental retardation.

38. For telephone, email and internet consultations and telemedicine.

39. For expenses associated with legal fees.

40. For medical and hospital care and cost for the infant child of a dependent, unless this infant is otherwise eligible under the plan.

41. For transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to any such surgery.

42. For transportation between healthcare facilities because of patient's choice; transportation of patients who have no other available means of transportation; transportation that is not medically necessary; or Medicar or similar type of transportation when used for patient's convenience.

Prescription Coverage

Overview

Plan participants enrolled in any State health plan have prescription drug benefits included in the coverage. **Regardless of the plan chosen, a prescription deductible applies to each plan participant each plan year.** An annual prescription deductible must be satisfied before the prescription copayments apply; however, if the cost of the prescription is less than the plan's prescription copayment, the plan participant will pay the cost of the prescription. Once the prescription deductible has been satisfied, the participant will pay the copayment of the prescription. However, if a plan participant elects a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the brand copayment.

Members who change health plans outside the annual Benefit Choice Period will be responsible for satisfying the prescription deductible of the new health plan even if they previously met the prescription deductible of their previous health plan.

Prior authorization may be required for a select group of medications. If a prescription is presented for one of these medications, the pharmacist will indicate that a prior authorization is needed before the prescription can be filled. To receive a prior authorization, the prescribing physician must provide medical information including a diagnosis to the prescription drug plan administrator for review. Once a prior authorization is in place, the prescriptions may be filled until the authorization expires, usually one year.

Plan participants who have additional prescription drug coverage, including Medicare, should contact their prescription plan administrator for coordination of benefits (COB) information.

Formulary List

All prescription medications are compiled on a formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level requires a different copayment amount. Each plan maintains a formulary list of medications. Formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of network pharmacies that participate in the various health plans, plan participants should visit the website of their health plan. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Health Maintenance Organizations (HMOs)

Health maintenance organizations (HMOs) use a separate prescription benefit manager (PBM) to administer their prescription drug benefits. Members who elect one of these health plans must utilize a pharmacy participating in the plan's pharmacy network or the full retail cost of the medication will be charged. If the member uses a nonparticipating pharmacy, partial reimbursement may be provided if the plan participant files a claim with the health plan. It should be noted that most plans do not cover over-the-counter drugs or drugs prescribed by medical professionals (including dentists), other than the plan participant's primary care physician (PCP) or any specialist the plan participant was referred to by their PCP. **Members should direct prescription benefit questions to the respective health plan administrator. Refer to the annual Benefit Choice Options booklet for specific information regarding deductible and copayment amounts.**

Open Access Managed Care Plans and the Quality Care Health Plan (QCHP)

Open access managed care plans and the Quality Care Health Plan (QCHP) have prescription drug benefits administered through the self-insurance plans' prescription benefit manager (PBM). Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or out-of-pocket maximums. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Members enrolled in the QCHP or an open access managed care plan are limited to a 60-day maximum supply per fill. Members may receive a 90-day supply of medication for two copayments by utilizing the mail order option. See the 'Mail Order Prescriptions' section for details.

Prescription Drug Step Therapy (PDST) is required for members who have their prescription drug benefits administered through QCHP or one of the open access

managed care plans are subject to a coverage tool called PDST for specific drugs. PDST requires the member to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still treat the member's condition effectively.

Members taking a brand medication that requires step therapy, which has not received prior authorization approval, will receive a rejection at a retail or mail order pharmacy as the plan requires a generic in that drug class be tried first. If the physician believes the original brand medication is needed, he/she may request a review to override the step therapy requirement.

Compound drugs are covered under the prescription drug plan. Compound drugs purchased from a network pharmacy are subject to the non-preferred copayment. If the compound drug contains an ingredient not covered by the plan, the entire compound drug will be denied.

Injectable and intravenous medications may be obtained through a retail network pharmacy or through the prescription drug plan administrator's mail order pharmacy.

If a network pharmacy does not stock a particular drug or supply and is unable to obtain it, call the prescription drug plan administrator for further direction.

Prepackaged prescriptions – A copayment is based on a 1 to 30-day supply as prescribed by the physician. Since manufacturers sometimes prepackage products in amounts that may be more or less than a 30-day supply as prescribed, more than one copayment may be required.

- **Example A** (more than a 30-day supply): Manufacturers commonly prepackage lancets in units of 100. If the 30-day prescription is for 90 units, two copayments are required since the prepackaged amount exceeds the 30-day supply as required by the prescription.
- **Example B** (less than a 30-day supply): Manufacturers commonly prepackage certain supplies, such as inhalers and tubes of ointment. Since the packaged medication may be less than a 30-day supply, more than one packaged unit may be required; therefore, more than one copayment will be required.

Prescribed medical supplies are supplies necessary for the administration of prescription drugs such as covered hypodermic needles and syringes. Copayments may apply.

Diabetic supplies and insulin that are purchased with a prescription are covered through the plan and are subject to the appropriate copayment.

Some diabetic supplies are also covered under Medicare Part B. If the plan participant is not Medicare Part B primary, the appropriate copayment must be paid at the time of purchase at a network pharmacy. If Medicare Part B is primary, the plan participant is responsible for the Medicare coinsurance at the time of purchase. The claim must first be submitted to Medicare for reimbursement. Upon receipt of the Medicare Summary Notice (MSN), a claim may be filed with the prescription drug plan administrator for any secondary benefit due. If the diabetic supplies are billed by a physician or medical supplier, the supplies would be paid by the health plan administrator.

Insulin pumps and their related supplies are not covered under the prescription drug plan. In order to receive coverage for these items, contact the health plan administrator listed in the current Benefit Choice Options booklet.

Nonmaintenance Medication

In-Network Pharmacy

Retail pharmacies that contract with the prescription benefit manager (PBM) and accept the copayment amount for medications are referred to as in-network pharmacies. Plan participants who use an in-network pharmacy must present their prescription ID card/number or they will be required to pay the full retail cost. If, for any reason, the pharmacy cannot verify eligibility when they submit the claim electronically, the plan participant will need to submit a claim form to the plan administrator.

The maximum supply of **nonmaintenance medication** allowed at one fill is 60 days, although two copayments will be charged for any prescription that exceeds a 30-day supply. A list of in-network pharmacies, as well as claim forms, is available on the Benefits website.

Out-of-Network Pharmacy

Pharmacies that do not contract with the plan administrator are referred to as out-of-network pharmacies. In most cases, prescription drug costs will be higher when an out-of-network pharmacy is used. If a medication is purchased at an out-of-network pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges may be obtained by submitting a paper claim and the original prescription receipt to the PBM. Reimbursement will be provided at

the applicable brand or generic in-network price minus the appropriate in-network copayment. Claim forms are available on the Benefits website.

Maintenance Medication

The **Maintenance Medication Program (MMP)** was developed to provide an enhanced benefit to plan participants who use maintenance medications. The MMP is comprised of a Maintenance Pharmacy Network and a Mail Order Pharmacy. When plan participants use a Maintenance Network pharmacy or the Mail Order Pharmacy for their maintenance medications, they will receive a **90-day supply of medication (equivalent to 3 fills) for only two and a half copayments.** A maintenance medication is medication that is taken on a regular basis for conditions such as high blood pressure and high cholesterol. To determine whether a medication is considered a maintenance medication, contact a maintenance network pharmacy or the PBM.

Maintenance Pharmacy Network

The **Maintenance Pharmacy Network** is a network of retail pharmacies that contract with the PBM to accept the copayment amount for maintenance medication. When plan participants use the Maintenance Pharmacy Network for maintenance medications they will receive a **90-day supply of medication (equivalent to 3 fills) for only two and a half copayments.** Pharmacies in this network may also be an in-network retail pharmacy as described in the 'Non-Maintenance Medication' section. **If a plan participant uses an in-network pharmacy that is not part of the Maintenance Pharmacy network to purchase maintenance medication, only the first two 30-day fills (or only the first 60-day fill) will be covered at the regular copayment amount; subsequent fills will be charged at two times the copayment rate.** A list of pharmacies participating in the Maintenance Pharmacy Network is available on the Benefits website.

Mail Order Pharmacy

The **Mail Order Pharmacy** provides participants the opportunity to receive medications directly from the PBM. **Both maintenance and nonmaintenance medications may be obtained through the mail order process.** When plan participants use the Mail Order Pharmacy for maintenance medications they will receive a **90-day supply of medication (equivalent to 3 fills) for only two and a half copayments.** To utilize the Mail Order Pharmacy, plan participants must submit an original prescription from the attending physician. For maintenance medication, the prescription should be written for a 90-day supply and include up to three 90-day refills totaling one year of medication. The original prescription must be attached to a completed Mail Order form and sent to the address indicated on the form. Order forms can be obtained by contacting the PBM or by accessing the Benefits website.

Special Note Regarding Medications for Nursing Home/Extended Care Facility Patients

Due to the large amounts of medication generally administered at nursing homes and extended care facilities, many of these types of facilities cannot maintain more than a 30-day supply of prescriptions per patient. In order to avoid being charged a double copayment for a 30-day supply, the patient or person who is responsible for the patient's healthcare (such as a spouse, civil union partner, power of attorney or guardian) should submit a letter requesting an 'exception' to the double copayment for their medication. The effective date of the exception is the receipt date of the request. **NOTE:** Since each request is based on a specific list of medications, any newly prescribed medication(s) must be sent as another request.

Request Requirements

- Must be in the form of a letter.
- Must include the patient's name, a list of all medications the patient is taking and the dosage of each medication.

Submit Documentation to:

DCMS Group Insurance Division
Member Services Unit
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

Coordination of Benefits

This Program coordinates with Medicare and other group plans. The appropriate copayment will be applied for each prescription filled.

Exclusions and Limitations

The Program reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

Behavioral Health

Overview

Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders. Eligible charges are for those covered services deemed medically necessary by the plan administrator. The coverage of behavioral health services (mental health and substance abuse) complies with the federal Mental Health Parity and Addiction Equity Act of 2008. This federal law requires health plans to cover behavioral health services at benefit levels equal to those of the plan's medical benefits.

Coverage for behavioral health services is provided under all of the State plans. There are no restrictions regarding the number of visits and hospital days allowed per plan year. The charges for behavioral health services are included in a plan participant's annual plan deductible if applicable and annual out-of-pocket maximum. Covered services for behavioral health must still meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedule. Please contact the managed care plan for specific benefit information.

Quality Care Health Plan (QCHP)

Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the Quality Care Health Plan (QCHP) benefit schedule for in-network and out-of-network providers. Please contact the behavioral health plan administrator for specific benefit information and for a listing of in-network hospital facilities and participating providers.

Authorization Requirements for Behavioral Health Services

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Plan participants must call the behavioral health plan administrator within 48 hours to avoid a financial penalty. Authorization requirements still apply when plan participants have other coverage, such as Medicare.

- **Inpatient services** must be authorized prior to admission or within 48 hours of an emergency admission to receive in-network or out-of-network benefits. Authorization is required with each new admission. Failure to notify the behavioral health plan administrator of an admission to an inpatient facility within 48 hours will result in a financial penalty and risk incurring noncovered charges.
- **Partial hospitalization and intensive outpatient treatment** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required before beginning each treatment program. Failure to notify the behavioral health plan administrator of a partial hospitalization or intensive outpatient program will result in a financial penalty and risk incurring noncovered charges.
- **Outpatient services** received at the in-network benefit level must be provided by a QCHP network provider. Most routine outpatient services (such as therapy sessions and medication management) will be covered without the need for prior authorization. Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a plan participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the plan participant's provider to discuss the treatment if a review will be applied. Outpatient services received at the out-of-network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.
- **Electroconvulsive therapy, psychological testing and applied behavioral analysis** must be authorized to receive in-network or out-of-network benefits. Failure to obtain authorization will result in the risk of incurring noncovered charges.
- **Residential services** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required with each new residential admission. Failure to notify the behavioral health plan administrator of an admission to a residential facility will result in a financial penalty and risk incurring noncovered charges.

Dental Coverage

Overview

The Quality Care Dental Plan (QCDP) is designed to offer plan participants coverage for basic dental services regardless of the health plan chosen. Retirees, annuitants and survivors who opt out of the health plan are not eligible for dental coverage.

Each plan participant is subject to an **annual dental plan deductible** for all dental services, except those listed in the Dental Schedule of Benefits as 'Diagnostic' or 'Preventive'. Once the deductible has been met, the plan participant is subject to a maximum annual dental benefit. See the current Benefit Choice Options booklet for the amount of the maximum benefit.

- Plan participants may go to any dentist.
- The maximum benefit amount paid for eligible services is listed in the Dental Schedule of Benefits. Dental procedure codes that are not listed in the Dental Schedule of Benefits are not covered by the plan and are not eligible for payment. Members are responsible for all charges over the scheduled amount and/or over the annual maximum benefit. The Dental Schedule of Benefits is available on the Benefits website at **www.benefitschoice.il.gov.**
- Plan participants may obtain dental identification cards from the dental plan administrator.

Retirees, annuitants and survivors **may enroll in the dental plan** at the time of initial enrollment, upon opting into the health plan or during the annual Benefit Choice Period. A monthly premium will apply for dental coverage.

Members **may opt out of the dental plan** at the time of initial enrollment or during the annual Benefit Choice Period. The election to drop coverage will remain in effect the entire plan year, **without exception**.

Choosing a Provider

With QCDP, plan participants can choose any dental provider for services; however, plan participants will receive enhanced benefits, resulting in lower out-of-pocket costs, when they receive services from a network provider. There are two separate networks of providers that a plan participant may utilize for dental services: the PPO network and the Premier network.

- **PPO Network:** If you receive services from a PPO dentist, your out-of-pocket expenses will often be less because these providers accept a reduced PPO fee (less any deductible). If the PPO fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.
- **Premier Network:** If you receive services from a Premier dentist, your out-of-pocket expenses may be less because Premier providers accept the allowed Premier fee (less any deductible). If the allowed fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.

Out-of-Network Services

If you receive services from a dentist who does not participate in either the PPO or Premier network, , the amount paid by the plan will be in accordance with the Schedule of Benefits.

Preventive and Diagnostic Services

Preventive and diagnostic services are not subject to the annual deductible and include, but are not limited to:

- Two periodic oral examinations per person per plan year.
- Two adult or child prophylaxis (scaling and polishing of teeth) per person per plan year.
- Two bitewing radiographs per person per plan year.
- One full mouth radiograph per person every three plan years.

Prosthodontics

Prosthodontics, which include implants, crowns, bridges and dentures, are subject to the following limitations:

- Prosthodontics to replace missing teeth are covered **only for teeth that are lost while the person is covered under this plan**.
- Immediate dentures are covered only if five or more teeth are extracted on the same day.
- Permanent dentures to replace immediate dentures are covered only if placed in the person's mouth within two years from the placement of the immediate denture.

Dental Coverage (cont.)

- Replacement dentures are covered only under one of the following circumstances:
  - Existing denture is at least 5 years old, or
  - Structural changes in the person's mouth require new dentures.
- Replacement crowns are covered only when the existing crown is at least 5 years old.
- Replacement bridges are covered only when the existing bridge is at least 5 years old.

Child Orthodontics

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. A maximum lifetime benefit for child orthodontia applies regardless of the number of courses of treatment. The annual plan year deductible will need to be satisfied unless it was previously satisfied for other dental services incurred during the plan year.

The maximum lifetime benefit amount applies to each plan participant and does not start over with each course of treatment. A course of treatment can be for any orthodontic services, not only the placement of braces. For example, a child may have a retaining device when they are 8 years old and then have braces installed when they are 15. The benefit amount for the retainer plus the benefit amount for the braces can not exceed the maximum lifetime benefit amount allowed.

The benefit amount that will be paid for orthodontic treatment depends on the length of treatment plan as determined by the orthodontist. The length of treatment time frames and the asociated benefit amount allowed is listed in the annual Benefit Choice Options booklet.

Twenty-five percent (25%) of the applicable orthodontia benefit, based on the length of treatment, will be reimbursed after the initial banding. The remaining benefit will be prorated over the remaining length of treatment period.

Provider Payment

If you use a network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Employees who use a network provider and do not have any out-of-pocket costs for their visit will not receive an explanation of benefits (EOB). The employee may, however, view their EOB on the dental plan administrator's website.

Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. Coordination of benefits applies to any other dental coverage.

Pretreatment Estimate

For both prosthodontics and orthodontics, although not required, a pretreatment estimate is strongly encouraged to assist plan participants in determining the benefits available. To obtain a pretreatment estimate plan participants should contact their dental provider.

Benefits for Services Received While Outside the United States

The plan covers eligible charges incurred for services received outside of the United States. All plan benefits are subject to plan provisions and deductibles.

Payment for the services may be required at the time service is provided and a paper claim must be filed with the dental plan administrator. When filing the claim, enclose the itemized bill with a description of the service translated to English and converted to U.S. currency along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.

Dental Exclusions and Limitations

No benefits shall be payable for:

1. Dental services covered under the health plan.
2. Services rendered prior to the plan participant's effective date of coverage or subsequent to the date of termination of coverage.
3. Services not listed in this plan description or for services rendered prior to the date a service or procedure became a covered benefit as indicated in this plan description.
4. Services performed to correct congenital and /or developmental conditions including but not limited to malformations, retention of deciduous (baby) teeth, impaction or absence of permanent teeth, cleft palate, mandibular prognathism or retrognathism, enamel hypoplasia, amelogenesis imperfecta, fluorosis, and anodontia (i.e., the absence of teeth) are excluded from coverage.
5. Dental services relating to the diagnosis or treatment, including appliances, for temporomandibular joint disorders (TMJ) and myofunctional disorders, craniofacial pain disorders and orthognathic surgery. However, occlusal guards are covered.
6. Services not necessary or not consistent with the diagnosis or treatment of a dental condition, as determined by the dental plan administrator.
7. Orthodontia of deciduous (baby) teeth or adult orthodontia.
8. Services compensable under the Workers' Compensation Act or Employer's Liability Law.
9. Procedures or surgeries undertaken for primarily cosmetic reasons.
10. Construction of duplicate dentures.
11. Replacement of a fixed or removable prosthesis for which benefits were paid under this plan for the same tooth/teeth, if the replacement occurs within five years from the date the expense was incurred, unless:
    - The replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth;
    - The prosthesis is a stayplate or a similar temporary prosthesis and is being replaced by a permanent prosthesis; or
    - The prosthesis, while in the oral cavity, has been damaged beyond repair, as a result of injury while eligible under the plan.
12. Customization of dental prosthesis, including personalized, elaborate dentures or specialized techniques.
13. Expenses associated with obtaining, copying or completing any dental or medical reports.
14. Charges for procedures considered experimental in nature.
15. Service or care performed by a family member or other person normally residing with the participant.
16. Services provided or paid for by a governmental agency or under any governmental program or law, except for charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its amendments.
17. General anesthesia, conscious sedation and intravenous sedation services (with the exception of children under age 6) unless medically necessary. Supporting documentation from a physician will be reviewed by the dental plan administrator.
18. Fixed or removable prosthodontics for a patient under age 18.
19. Sealants for adults age 18 and over.
20. Amalgam and resin-based composite fillings more than once per surface in a 12-month interval.

Vision Coverage

Overview

The vision plan is designed to assist with the costs of well-vision care and to encourage the maintenance of vision through regular eye exams. Periodic eye exams can detect and prevent ailments not only in the eyes, but throughout the body. The plan provides coverage when glasses or contacts are required. For more information, contact the vision plan administrator.

Eligibility

All plan participants covered by any of the health plans offered by the State Employees Group Insurance Program are eligible for vision care benefits. Benefit levels are published on an annual basis in the Benefit Choice Options booklet.

Frequency of Benefits

Each service component is available once every 24 months from the last time the benefit component was used, except for the eye examination, spectacle lenses and contact lens benefit which are available once every 12 months from the last time used. Each service component is independent and may be obtained at separate times from separate providers. For example, a plan participant may receive an eye examination from one provider and purchase frames/lenses from a different provider.

Provider Services

Materials and services obtained from a network provider are paid at the network provider coverage benefit level. Applicable copayments and additional charges must be paid at the time of service. Eligible services or materials may be obtained from any licensed optometrist, ophthalmologist or optician. A directory of network providers can be found on the plan administrator's website.

If an out-of-network provider is used, the plan participant must pay the provider in full and request reimbursement from the vision plan administrator. To request reimbursement, send an itemized receipt and a claim form requesting reimbursement to the vision plan administrator. Reimbursement will be paid up to the maximum allowance amount as detailed in the schedule of benefits, out-of-network provider coverage chart in the annual Benefit Choice Options booklet. Out-of-network provider benefits are paid directly to the covered member. Claim forms are available on the Benefits website and through the plan administrator.

Life Insurance Coverage

Overview

There are two types of life coverage available: Basic Life and Optional Life. Life insurance options change upon retirement. For more information regarding life insurance coverage and benefits, consult the State of Illinois Group Term Life Certificate of Insurance or contact the life insurance plan administrator.

Basic and Optional Life Coverage

Basic term life insurance coverage is provided automatically at no cost to immediate and deferred annuitants and eligible survivors through the State Employees Group Insurance Program. Immediate annuitants and certain survivors may purchase Optional Life insurance coverage. All premiums for Optional Life insurance coverage are at the member's expense. Rates are published each year in the Benefit Choice Options booklet.

- **Basic Life.** Term coverage amounts vary – see eligibility in this section.
- **Member Optional Life**. Options vary – see eligibility in this section. Any amount requested above four times the Basic Life amount will require satisfactory evidence of insurability.
- **Accidental Death and Dismemberment (AD&D)**. Accidental Death and Dismemberment (AD&D) is available to members in either (1) an amount equal to their Basic Life amount, or (2) the combined amount of their Basic and Member Optional Life, subject to a total maximum of five times the Basic Life insurance amount or $3,000,000, whichever is less.
- **Spouse Life**. Term coverage amounts vary – see eligibility in this section. Spouse Life applies to civil union partners, but does not apply to domestic partners.
- **Child Life**. Term coverage amounts vary – see eligibility in this section. All dependent children age 25 and under are eligible for Child Life coverage, except individuals enrolled in the Other category. Children in the Disabled category are eligible for life coverage as long as they continue to meet eligibility requirements.

Eligibility for retirees and annuitants is below:

Retirees (prior to 1/1/1966) and their survivors:

- Basic Life coverage is not provided.
- Not eligible for Member Optional Life, AD&D, Child Life or Spouse Life coverage.

Deferred Annuitants (on or after 1/1/1966):

- Basic Life
  - **Under age 60** – Annuitants are insured for an amount equal to their annual basic salary as of the last day of employment.
  - **Upon turning age 60** – Basic Life coverage reduces to $5,000.
- Not eligible for Member Optional Life, AD&D, Child Life or Spouse Life coverage.

Immediate Annuitants (on or after 1/1/1966):

- Basic Life
  - **Under age 60** – Annuitants are insured for an amount equal to their basic annual salary as of the last day of employment.
  - **Upon turning age 60** – Basic Life coverage reduces to $5,000.
- Member Optional Life
  - **Under age 60** - Annuitants may elect up to eight times their basic amount.
  - **Upon turning age 60** – Member Optional Life ($5,000 increments) in excess of four times the basic amount terminates.
- AD&D - Basic or Combined.
- Child Life - $10,000 per child.
- Spouse Life
  - **Under age 60** – Spouse Life is $10,000.
  - **Upon turning age 60** – Spouse Life coverage reduces to $5,000.

Eligibility for survivors is below:

Survivors of Immediate Annuitants and of Deceased Employees:

- Individuals who became a survivor **prior to 09/22/79:**
  - Basic Life coverage is $2,000.
  - Member Optional Life - May elect up to four times their basic amount of $2,000.
  - AD&D - Basic or Combined
  - Child Life - $2,000 per child.
  - Spouse Life - $5,000.

Life Insurance Coverage (cont.)

Eligibility for survivors continued:

- Individuals who became a survivor **on or after 09/22/79:**
  - Basic Life coverage is not provided.
  - Member Optional Life is $5,000.
  - Not eligible for AD&D, Spouse Life or Child Life coverage.

Survivors of Deferred Annuitants:

- Individuals who became a survivor **prior to 09/22/79**:
  - Basic Life coverage is $2,000.
  - Not eligible for Member Optional Life, AD&D, Child Life or Spouse Life coverage.
- Individuals who became a survivor **on or after 09/22/79**:
  - Basic Life coverage is not provided.
  - Not eligible for Member Optional Life, AD&D, Child Life or Spouse Life coverage.

Changes to Coverage

Changes to life insurance coverage may be made at any time during the plan year.

Statement of Health Approval

When an immediate annuitant or eligible survivor requests to increase Member Optional Life, or requests to add Spouse Life or Child Life coverage, evidence of insurability (an approved statement of health application) is required. If approved, coverage will be effective the date of approval by the life insurance plan administrator.

A statement of health is not required for newborns added within 60 days of birth or for newly-acquired dependents including a (spouse, civil union partner, child of the civil union partner, adopted child, stepchild or child for whom the annuitant or survivor has obtained legal guardianship) added within 60 days of the qualifying event. Statement of health applications are available on the Benefits website.

Effective Date of Life Coverage Change

When **increasing** Member Optional Life, or when **adding** Member Optional Life, Spouse Life or Child Life, the effective date of the coverage will be the statement of health approval date. The life plan administrator will send a letter to the member and the GIR that indicates whether the statement of health application was approved or denied.

When **adding or increasing** AD&D coverage the effective date will be the date the request was received by the GIR.

When **terminating or decreasing** any Optional Life coverage outside the Benefit Choice Period, the effective date will be the date the request was received by the GIR. A future effective date may be requested as long as it is within 60 days of the current date.

Requests made during the Benefit Choice Period to add, increase, decrease or terminate any Optional Life coverage will be effective July 1st.

Accelerated Benefits

Life insurance benefits may be paid prior to death under certain circumstances. Accelerated benefits offer access to a portion of life insurance benefits if the member is diagnosed with a terminal illness and has a life expectancy of 24 months or less. Contact your Group Insurance Representative (GIR) or the life insurance plan administrator for more information.

Beneficiary Form

A life insurance beneficiary form must be completed and updated periodically. It is the member's responsibility to contact the life insurance plan administrator with any changes to the beneficiary designation and/or beneficiary address.

Continuing Optional Life Coverage upon Turning 60

Upon turning age 60, Basic Life and Member Optional Life coverage drops to $5,000 each per unit. The combined amount of Basic Life and Member Optional Life insurance that has been terminated may be continued by converting to an individual whole life insurance policy. Member Optional Life insurance coverage may be ported in lieu of converting.

In order to continue life coverage, the annuitant must contact the life insurance plan administrator within 31 days of the date they attain the age of 60. Should the annuitant choose to continue coverage through one of the available insurance products, the full premium must be paid by the annuitant directly to the plan administrator. Once the annuitant makes the selection, the Program is no longer involved in the administration or premium rate structure of these insurance products. Contact the life insurance plan administrator for additional information regarding conversion and portability options.

Chapter 3

Chapter 3: Miscellaneous

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Smoking Cessation Program

Overview

Eligible plan participants are entitled to receive a rebate towards the cost of a smoking cessation program. The maximum rebate is $200, limited to one per plan year and available only upon completion of a smoking cessation program. Please note that many managed care plans offer smoking cessation programs separate from the State's Smoking Cessation Program. Members who utilize a smoking cessation program through their managed care plan are not eligible for the Smoking Cessation Program benefit through the Department. Contact the managed care plan for more information regarding their smoking cessation program options and limitations.

Eligibility

The Smoking Cessation Program is available to all retirees, annuitants and survivors who are eligible for benefits under the State Employees Group Insurance Program and their enrolled dependents. Members who opt out or waive health coverage under the Program are not eligible for the Smoking Cessation Program.

Ineligible for Reimbursement

The following therapies are not eligible for reimbursement unless they are an integral part of a smoking cessation program.

- Hypnosis (even if an integral part, will not be reimbursed unless performed by a medical doctor);
- Acupuncture;
- Prescription drug therapy;
- Nonprescription drug therapy;
- Aricular therapy.

Reimbursement Documentation Requirements

- Receipt indicating payment for the smoking cessation program.
- Program certificate verifying the number of sessions and date of completion of the smoking cessation program.
- Member's name, address, agency name and agency telephone number.

Submit Documentation to:

Smoking Cessation Program
DCMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

For More Information

The Department of Central Management Services (Department) is the plan administrator of the Smoking Cessation Program. Questions regarding the Smoking Cessation Program should be directed to the Department at (800) 442-1300.

Coordination of Benefits

If a plan participant enrolled in the Program is entitled to primary benefits under another group plan, the amount of benefits payable under the Program may be reduced. The reduction may be to the extent that the total payment provided by all plans does not exceed the total allowable expense incurred for the service. Allowable expense is defined as a medically necessary service for which part of the cost is eligible for payment by this plan or one of the plans identified below.

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

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

The State of Illinois coordinates benefits with the following:

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

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

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

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

Order of Benefit Determination

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

Member

The plan that covers the plan participant as an active member is primary:

1. over the plan that covers the plan participant as a dependent.
2. over the plan that covers the plan participant as a retiree.
3. over the plan that covers the plan participant under COBRA.
4. if it has been in effect the longest, back to the original effective date under the employer group, whether or not the insurance company has changed over the course of coverage.

Dependent Children of Parents Not Separated or Divorced

The following "Birthday Rule" is used if a child is covered by more than one group plan. The plans must pay in the following order:

1. The plan covering the parent whose birthday* falls earlier in the calendar year is the primary plan.
2. If both parents have the same birthday, the plan that has provided coverage longer is the primary plan.

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

NOTE: Some plans not covered by state law may follow the Gender Rule for dependent children. This rule states that the father's coverage is the primary carrier. In the event of a disagreement between two plans, the Gender Rule applies.

Coordination of Benefits (cont.)

Dependent Children of Separated or Divorced Parents

If a child is covered by more than one group plan and the parents are separated or divorced, the plans must pay in the following order:

1. The plan of the parent with custody of the child;
2. The plan of the spouse of the parent with custody of the child;
3. The plan of the parent not having custody of the child.

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

Dependent Children of Parents with Joint Custody

The Birthday Rule applies to dependent children of parents with joint custody.

Medicare

Overview

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

If you do not enroll in Medicare Parts A and B, you will be responsible for the portion of your healthcare costs that Medicare would have covered.

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

Medicare has the following parts:

- **Part A** is insurance that helps pay for inpatient hospital facility charges, skilled nursing facility charges, hospice care and some home healthcare services. Medicare Part A does not require a monthly premium contribution from plan participants with enough earned work credits. Plan participants without enough earned work credits have the option to enroll in Medicare Part A and pay a monthly premium contribution.
- **Part B** is insurance that helps pay for outpatient services including physician office visits, labs, x-rays and some medical supplies. Medicare Part B requires a monthly premium contribution.
- **Part C** (also known as Medicare Advantage) is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll in a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Part D** is insurance that helps pay for prescription drugs. Generally, Medicare Part D requires a monthly premium contribution.

Medicare Due to Age

Plan Participants Age 65 and older

The State of Illinois Group Insurance Program requires all plan participants to contact the SSA and apply for Medicare benefits three months prior to turning age 65.

Medicare Part A

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

If the SSA determines that a plan participant is eligible for premium-free Medicare Part A, **the State of Illinois Group Insurance Program requires that the plan participant accept the Medicare Part A coverage** and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

If the SSA determines that a plan participant is **not eligible** for Medicare Part A benefits at a premium-free rate, the State of Illinois Group Insurance Program does not require the plan participant to purchase Medicare Part A coverage; however, the State does require the plan participant to provide a written statement from the SSA advising of his/her Medicare Part A ineligibility. The plan participant is required to submit a copy of the SSA statement to the Medicare COB Unit.

Medicare Part B

Most plan participants are eligible for Medicare Part B upon turning the age of 65.

In order to apply for Medicare benefits, plan participants should contact the local SSA office or call the SSA at (800) 772-1213. Plan participants may enroll in Medicare Part A on the SSA website at www.socialsecurity.gov.

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

Medicare (cont.)

The State of Illinois Group Insurance Program requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a premium-free rate. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Due to Disability

Plan Participants Age 64 and Under

Plan participants are automatically eligible for Medicare (Parts A and B) disability insurance after receiving Social Security disability payments for a period of 24 months.

Medicare Part A

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

Medicare Part B

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part B coverage. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Due to End-Stage Renal Disease (ESRD)

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

Plan participants must contact the State of Illinois Medicare Coordination of Benefits (COB) Unit at (800) 442-1300. The State of Illinois Medicare COB Unit calculates the 30-month coordination period in order for plan participants to sign up for Medicare benefits on time to avoid additional out-of-pocket expenditures.

Medicare Part A

Plan participants who become eligible for Medicare benefits on the basis of ESRD are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

Medicare Part B

The State of Illinois Group Insurance Program requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a premium-free rate. Plan participants who become eligible for Medicare benefits on the basis of ESRD are required to accept the Medicare Part B coverage when Medicare is determined to be the primary payer. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Coordination with the Quality Care Health Plan (QCHP)

When Medicare is the primary payer, QCHP will coordinate benefits with Medicare as follows:

Medicare Part A - Hospital Insurance

In-Network Provider: After Medicare Part A pays, QCHP pays 85% of the Medicare Part A deductible after the QCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part A pays, QCHP pays 60% of the Medicare Part A deductible after the QCHP annual plan deductible has been met.

Medicare Part B - Medical Insurance

In-Network Provider: After Medicare Part B pays, QCHP pays 85% of the balance after the QCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part B pays, QCHP pays 60% of the balance after the QCHP annual plan deductible has been met.

Failure to Enrool in Medicare (Medicare Parts A and B Reduction)

If you do not enroll in Medicare Parts A and B, you will be responsible for the portion of your healthcare costs that Medicare would have covered. Failure to enroll or remain enrolled in Medicare when Medicare is determined to be the primary payer over the QCHP will result in a reduction

of eligible benefit payments by the QCHP plan. For in-network provider claims, Cigna will estimate the portion of the claim that Medicare would have paid. QCHP will then pay 85% of the 20% claim balance (after the QCHP annual plan year deductible has been satisfied). For out-of-network provider claims, QCHP will pay 60% of the 20% of the claim balance (after the QCHP plan year deductible has been satisfied). The difference between the total charge and the amount QCHP pays is the plan participant's responsibility.

Services and Supplies Not Covered by Medicare

Services and supplies that are not covered by Medicare will be paid by QCHP in the same manner (i.e., same benefit levels and deductibles) as if the plan participant did not have Medicare (provided the services and supplies meet medical necessity and benefit criteria and would normally be eligible for QCHP coverage).

Medicare Crossover

Medicare crossover is an electronic transmittal of claim data from Medicare (after Medicare has processed their portion of the claim) to the QCHP plan administrator for secondary benefits.

In order to set up Medicare Crossover, plan participants must contact the QCHP plan administrator and provide the Medicare Health Insurance Claim Number (HICN) located on the front side of their Medicare identification card.

Medicare COB Unit Contact Information

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

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

Private Contracts with Providers who Opt Out of Medicare

Some healthcare providers choose to opt out of the Medicare program. When a plan participant has medical services rendered by a provider who has opted out of the Medicare program, a private contract is usually signed explaining that the plan participant is responsible for the cost of the medical services rendered. Neither providers nor plan participants are allowed to bill Medicare. Therefore, Medicare will not pay for the service (even if it would normally qualify as being Medicare eligible) or provide a Medicare Summary Notice to the plan participant. If the service(s) would have normally been covered by Medicare, the QCHP plan administrator will estimate the portion of the claim that Medicare Part B would have paid. The QCHP plan administrator will then pay 85% of the 20% claim balance (after the QCHP annual plan year deductible has been satisfied) for services rendered by in-network QCHP providers. For out-of-network QCHP provider claims, QCHP will pay 60% of the 20% (after the QCHP plan year deductible has been satisfied). The difference between the total charge and what QCHP pays is the plan participant's responsibility.

Subrogation and Reimbursement

Overview

Department plans will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. These plans also do not provide benefits to the extent that there is other coverage under nongroup medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

However, the plans will provide benefits otherwise payable under one of these plans, to or on behalf of its covered persons, but only on the following terms and conditions:

- In the event of any payment under one of these plans, the plan shall be subrogated to all of the covered person's rights of recovery against any person or entity. The covered person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The covered person shall do nothing after loss to prejudice such rights. The covered person shall cooperate with the plan and/or any representatives of the plan in completing such documents and in providing such information relating to any accident as the plan by its representatives may deem necessary to fully investigate the incident. The plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the covered person.
- The plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the covered person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the plan.
- The plan, by payment of any proceeds to a covered person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the covered person or a representative. The covered person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the plan secure said lien.
- The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the covered person as a result of the injuries sustained, including but not limited to the following:
  - Payments made directly by a third party tortfeasor or any insurance company on behalf of a third party tortfeasor or any other payments on behalf of a third party tortfeasor.
  - Any payments or settlements or judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a covered person or other person.
  - Any other payments from any source designed or intended to compensate a covered person for injuries sustained as the result of negligence or alleged negligence of a third party.
  - Any Workers' Compensation award or settlement.
- The parents of any minor covered person understand and agree that the State's plan does not pay for expenses incurred for injuries received as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor covered person are conditional upon the plan's express right of reimbursement. No adult covered person hereunder may assign any rights that such person may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of the adult covered person without the express prior written consent of the plan. In the event any minor covered child is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the plan of the existence of any claim on behalf of the minor child against the third party tortfeasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any claim against the third party tortfeasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tortfeasor or other person or entity to the plan, or at their election, to prosecute a claim for medical expenses on behalf of the plan.

Subrogation and Reimbursement (cont.)

In default of any obligation hereunder by the adult covered persons/parents, the plan is entitled to recover the conditional benefits advanced plus costs (including reasonable attorneys' fees), from the adult covered persons/parents.

- No covered person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by a covered person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to nonmedical expense damages.
- No covered person under the plan shall incur any expenses on behalf of the plan in pursuit of the plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits paid hereunder without regard to any claim of fault on the part of any covered person, whether under comparative negligence or otherwise.
- The benefits under this plan are secondary to any coverage under no-fault, medical payments or similar insurance.
- This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.
- In the event that a covered person shall fail or refuse to honor its obligations hereunder, the plan shall have a right to suspend the covered person's eligibility and be entitled to offset the reimbursement obligation against any entitlement for future medical benefits, regardless of how those medical benefits are incurred. The suspension and offset shall continue until such time as the covered person has fully complied with his obligations hereunder.

Claim Filing

In general, most dental, medical and behavioral health providers file claims for reimbursement with the insurance carrier. Out-of-network vision claims and pharmacy expenses typically must be filed by the member. In situations where a claim is not filed by the provider, the member must file the claim within a specific period of time.

All claims should be filed promptly. Claim forms are available on the plan administrators' website and on the Benefits website.

- In-network **QCHP** medical and behavioral health claims must be filed within 90 days from the date in which the charge was incurred.
- Out-of-network **QCHP** medical and behavioral health claims must be filed within 180 days from the date in which the charge was incurred.
- Out-of-network **dental claims** must be filed no later than one-year from the ending date of the plan year in which the charge was incurred.
- Out-of-network **pharmacy claims for the open access plans (OAPs) and QCHP** must be filed no later than one-year from the ending date of the plan year in which the charge was incurred.
- Out-of-network **vision claims** are required to be filed no later than one year from the date of service in order to be considered for reimbursement.

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

Claim Filing Procedures

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

- Complete the claim form obtained from the appropriate plan administrator.
- Attach the itemized bill from the provider of services to the claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.
- If the person for whom the claim is being submitted has primary coverage under another group plan or Medicare, the explanation of benefits (EOB) or the Medicare Summary Notice (MSN) from the other plan must also be attached to the claim.
- The plan administrator may communicate directly with the plan participant or the provider of services regarding any additional information that may be needed to process a claim.
- The benefit check will be sent and made payable to the member (not to any dependents), unless otherwise indicated by law, or benefits have been assigned directly to the provider of service.
- If benefits are assigned, the benefit check will be made payable to the provider of service and mailed directly to the provider. An EOB is sent to the plan participant to verify the benefit determination.
- QCHP claims are adjudicated using industry standard claim processing software and criteria. Claims are reviewed for possible bundling and unbundling of services and charges.

Claim Appeal Process

Under the State Employees Group Insurance Program (Program) there are formal procedures to follow in order to file an appeal of an adverse benefit determination. **The appropriate plan administrator will provide more information regarding the plan administrator's internal appeal process.**

Categories of Appeal

There are two separate categories of appeals: medical and administrative. The plan administrator determines the category of appeal and will send the plan participant written notification regarding the category of appeal, the plan participant's appeal rights and information regarding how to initiate an appeal from the plan administrator.

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

Quality Care Health Plan (QCHP) and Open Access Managed Care Plans Appeal Process

Members enrolled in either the Quality Care Health Plan (QCHP) or one of the open access managed care plans may utilize an internal appeal process which may be followed by an external review, if needed. For urgent care situations, the plan participant may bypass the internal appeal process and request an expedited external review (see "Expedited External Review- Medical Appeals Only" for urgent care situations in the box).

Expedited External Review - Medical Appeals Only

For medical appeals involving urgent care situations, the plan participant may make a written or oral request for expedited external review after the plan administrator makes an adverse benefit determination, even if the plan administrator's internal appeal process has not been exhausted. The external reviewer will review the request to determine whether it qualifies for expedited review. If the external reviewer determines that the request qualifies for expedited review, the external reviewer will provide a final external review decision within 72 hours after the receipt of the request. If the external reviewer decides in favor of the plan participant, the decision shall be final and binding on the plan administrator.

Step 1: Internal Appeal Process

The internal appeal process is available through the health plan administrator. The plan administrator's internal appeal process must be followed before the plan participant may seek an external review, except for urgent care situations. For urgent care situations, the plan participant may request an expedited external review (see "Expedited External Review- Medical Appeals Only" for urgent care situations).

First-Level Internal Appeals

First-level appeals must be initiated with the plan administrator within 180 days of the date of receipt of the initial adverse benefit determination. All appeals will be reviewed and decided by an individual(s) who was not involved in the initial claim decision. Each case will be reviewed and considered on its own merits. If the appeal involves a medical judgment, it will be reviewed and considered by a qualified healthcare professional. In some cases, additional information, such as test results, may be required to determine if additional benefits are available. Once all required information has been received by the plan administrator, the plan administrator shall provide a decision within the applicable time frame: 15 days for pre-service authorizations, 30 days for post-service claims, or 72 hours for urgent care claims.

Claim Appeal Process (cont.)

Step 2: External Review Process

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

Administrative Appeals

For administrative appeals, if, after exhausting every level of review available through the plan administrator, the plan participant still feels that the final benefit determination by the plan administrator is not consistent with the published benefit coverage, the plan participant may appeal the plan administrator's decision to CMS' Group Insurance Division. For an appeal to be considered by CMS' Group Insurance Division, the plan participant must appeal in writing within sixty (60) days of the date of receipt of the plan administrator's final internal adverse benefit determination. All appeals must be accompanied by all documentation supporting the request for reconsideration.

Submit Administrative Appeal Documentation to:

CMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

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

Medical Appeals

External Review

For medical appeals, if, after exhausting every level of review available through the plan administrator, the plan participant still feels that the final benefit determination is not consistent with the published benefit coverage, the plan participant may request an independent external review of the plan administrator's decision. A request for an external review must be filed in writing within four (4) months of the date of receipt of the plan administrator's final internal adverse benefit determination. The plan administrator will provide more information regarding how to file a request for external review. The plan participant will be given the opportunity to submit additional written comments and supporting medical documentation regarding the claim to the external reviewer. The external reviewer will provide a final external review decision within 45 days of the receipt of the request. If the external reviewer decides in favor of the plan participant, the decision shall be final and binding.

Appeal Process for Fully-Insured Managed Care Health Plans

The Department of Central Management Services (CMS) does not have the authority to review or process fully-insured managed care health plan appeals. Fully-insured managed care health plans must comply with the Managed Care Reform and Patient Rights Act. In order to file a formal appeal, refer to the process outlined in the managed care health plan's summary plan document (SPD) or certificate of coverage. Specific timetables and procedures apply. Plan participants may call the customer service number listed on their identification card to request a copy of such documents.

Assistance with the Appeal Process

For questions regarding appeal rights and/or assistance with the appeal process, a plan participant may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). A consumer assistance program may also be able to assist the plan participant. Requests for assistance from the consumer assistance program should be sent to:

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

or

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

Chapter 4

Chapter 4: Reference

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Glossary

Additional Deductible: Deductibles that are in addition to the annual plan deductible.

Admission: Entry as an inpatient to an accredited facility, such as a hospital or skilled care facility, or entry to a structured outpatient, intensive outpatient or partial hospitalization program.

Adverse Claim Determination: A denial, reduction, termination of or failure to pay for a benefit, whether in whole or in part. Adverse claim determinations include rescissions of coverage.

Allowable Charges: The maximum amount the plan will pay an out-of-network healthcare professional for billed services.

Allowable Expense: A medically necessary service for which part of the cost is eligible for payment by this plan or another plan(s).

Annuitant: A member who began receiving an annuity on or after January 1, 1966.

Authorization: The result of a review that approves treatment as meeting medical necessity criteria and appropriateness of care.

Benefit: The amount payable for services obtained by plan participants and dependents.

Benefit Choice Period: A designated period when members may change benefit coverage elections, ordinarily held May 1 through May 31.

Certificate of Coverage: A document containing a description of benefits provided by licensed insurance plans. Also known as a summary plan description (SPD).

Certificate of Creditable Coverage: A certificate that provides evidence of prior health coverage.

Civil Union: Civil union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Civil Union Partner: A party to a civil union.

Claim: A paper or electronic billing. This billing must include full details of the service received, including name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis and any other information which a plan may request in connection with services rendered.

Claim Payment: The benefit payment calculated by a plan, after submission of a claim, in accordance with the benefits described in this handbook and the annual Benefit Choice Options booklet.

Coinsurance: The percentage of the charges for eligible services for which the plan participant is responsible after any applicable deductible has been met.

Coordination of Benefits: A method of integrating benefits payable under more than one group insurance plan.

Copayment: A specific dollar amount the plan participant is required to pay for certain services covered by a plan.

Covered Services: Services that are eligible for benefits under a plan.

Creditable Coverage: The amount of time a plan participant had continuous coverage under a previous health plan.

Custodial Care: Room and board or other institutional or nursing services which are provided for a patient due to age or mental or physical condition mainly to aid in daily living; or, medical services which are given merely as care to maintain present state of health and which cannot be expected to improve a medical condition.

Deductible: The amount of eligible charges plan participants must pay before insurance payments begin.

Deferred Annuitant: Person who began receiving an annuity one year or more after terminatiing State employment.

Department: The Department of Central Management Services, also referred to as DCMS.

Dependent: A member's spouse, civil union partner, child or other person as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Glossary (cont.)

For purposes of the health plan only, the term dependent also includes a domestic partner.

Diagnostic Service: Tests performed to diagnose a condition due to symptoms or to determine the progress of an illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms (ECG), electroencephalograms (EEG), radioisotope tests and electromyograms.

Domestic Partner: An unrelated, same-sex individual, age 19 or older, who resides in the same household and has a financial and emotional interdependence consistent with that of a married couple for a period of not less than one year.

Eligible Charges: Charges for covered services and supplies which are medically necessary and based on charges as determined by a plan administrator.

Emergency Services: Services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries such that in the opinion of the prudent layperson might result in permanent disability or death if not treated immediately.

Evidence of Insurability: Documentation that an individual's health condition is satisfactory for coverage. May require proof of age or a statement of health status from the physician. Evidence of insurability is generally required to add Child Life or Spouse Life insurance and to increase Member Optional Life insurance.

Exclusions and Limitations: Services not covered under the State Employees Group Insurance Program, or services that are provided only with certain qualifications, conditions or limits.

Experimental: Medical services or supplies in which new treatments or products are tested for safety and effect on humans.

Explanation of Benefits (EOB): A statement from a plan administrator explaining benefit determination for services rendered.

Final Internal Determination: The final benefit determination made by a plan administrator after a plan participant has exhausted all appeals available through the plan administrator's formal internal appeals process.

Fiscal Year (FY): Begins on July 1 and ends on June 30.

Formulary (Prescription Drugs): A list of drugs and ancillary supplies approved by the prescription drug plan administrator for inclusion in the prescription drug plan. The formulary list is subject to change.

Fully Insured: All claims and costs are paid by the insurance company.

Generic Drug: Therapeutic equivalent of a brand name drug and must be approved by the U.S. Food and Drug Administration for safety and effectiveness.

Group Insurance Representative (GIR): An individual who provides information and/or materials and processes enrollment changes related to benefits.

Hospice: A program of palliative and supportive services for terminally ill patients that must be approved by a plan administrator as meeting standards including any legal licensing requirements.

Hospital: A legally constituted and licensed institution having on the premises organized facilities (including organized diagnostic and surgical facilities) for the care and treatment of sick and injured persons by or under the supervision of a staff of physicians and registered nurses on duty or on call at all times.

Identification Card: Document identifying eligibility for benefits under a plan.

Immediate Annuitant: Person who began receiving an annuity within one year of terminatiing State employment.

Independent External Review: An external review, conducted by an independent third party of a plan administrator's adverse claim determination or final internal determination.

Initial Enrollment Period: The 60-day period beginning with the benefit begin date.

Injury: Damage inflicted to the body by external force.

Inpatient Services: A hospital stay of 24 or more hours.

Intensive Outpatient Program (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual,

group or family psychotherapy and adjunctive services such as medical monitoring.

Investigational: Procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or Federal Government agency for general use by the medical community at the time they are rendered to a covered person, and (c) with respect to drugs, combination of drugs and/or devices, which have not received final approval by the Food and Drug Administration at the time used or administered to the covered person.

Itemized Bill: A form submitted for claim purposes; must have the name of the patient, description, diagnosis, date and cost of services provided.

Medical Documentation: Additional medical information required to substantiate the necessity of procedures performed. This could include daily nursing and doctor notes, additional x-rays, treatment plans, operative reports, etc.

Medicare: A federally operated insurance program providing benefits for eligible persons.

Medicare Summary Notice (MSN): A quarterly statement from Medicare explaining benefit determination for services rendered.

Member: Employee, annuitant, retired employee, survivor or COBRA participant.

Non-IRS: Any dependent who is not considered a qualifying child or a qualifying relative, as defined by the IRS, and cannot be claimed as a dependent for income tax purposes.

Nonpreferred Brand Drug: Prescription drugs available at the highest copayment. Many high cost specialty drugs fall under the nonpreferred drug category.

Out-of-Pocket Maximum: The maximum dollar amount paid out of pocket for covered expenses in any given plan year. After the out-of-pocket maximum has been met the plan begins paying at the 100% of allowable charges for eligible covered expenses.

Outpatient Services (Behavioral Health Services): Care rendered for the treatment of mental health or substance abuse when not confined to an inpatient hospital setting.

Outpatient Services (Medical/Surgical): Services provided in a hospital emergency room or outpatient clinic, at an ambulatory surgical center or in a doctor's office.

Partial Hospitalization (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy. Services are medically supervised and essentially the same intensity as would be provided in a hospital setting except that the patient is in the program less than 24 hours per day.

Physician/Doctor: A person licensed to practice under the Illinois Medical Practice Act or under similar laws of Illinois or other states or countries; a Christian Science Practitioner listed in the Christian Science Journal at the time the medical services are provided.

Plan: A specifically designed program of benefits.

Plan Administrator: An organization, company or other entity contracted to review and approve benefit payments, pay claims, and perform other duties related to the administration of a specific plan.

Plan Participant: An eligible person enrolled and participating in the Program.

Plan Year: July 1 through the following June 30.

Preexisting Condition: Any disease, condition, (excluding maternity) or injury for which the individual was diagnosed, received treatment/services, or took prescribed drugs during the three months immediately preceding the effective date of coverage.

Preferred Brand Drug: A list of drugs, biologicals and devices approved by the pharmacy benefit manager for inclusion in the prescription drug plan. These drugs are proven to be both clinically and cost effective. The preferred brand drug list is subject to change.

Prescription Drugs: Medications which are lawfully obtained with a prescription from a physician/doctor or dentist.

Glossary (cont.)

Pretreatment Estimate (Dental): A provider's statement, including diagnostic x-rays and laboratory reports describing planned treatment and expected charges which is reviewed by the dental plan administrator for verification of eligible benefits.

Preventive Service: Routine services which do not require a diagnosis or treatment of an illness or injury.

Primary Care Physician/Primary Care Provider (PCP): The physician or other medical provider a plan participant selects under a managed care plan to manage all healthcare needs.

Professional Services: Eligible services provided by a licensed medical professional, including but not limited to a physician, radiologist, anesthesiologist, surgeon, physical therapist, etc.

Program: The State Employees Group Insurance Program as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Provider: Any organization or individual which provides services or supplies to plan participants. This may include such entities as hospitals, pharmacies, physicians, laboratories or home health companies.

Quality Care Health Plan (QCHP) Hospital: A hospital or facility with which the Quality Care Health Plan plan has negotiated favorable rates.

Qualified Beneficiary: A qualified beneficiary is an individual (including member, spouse, civil union partner, domestic partner and child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member.

Retiree: A member who retired before January 1, 1966, and began to receive an annuity.

Schedule of Benefits: A listing of specific services covered by the Quality Care Dental Plan and the vision plan.

Second Opinion: An opinion rendered by a second physician prior to the performance of certain nonemergency, elective surgical procedures or medical treatments.

Self Insured: All claims and costs are paid by the State of Illinois.

Skilled Nursing Service: Noncustodial professional services provided by a registered nurse (RN) or licensed practical nurse (LPN) which require the technical skills and professional training of such a licensed professional acting within the scope of their licensure.

Spouse: A person who is legally married to the member as defined under Illinois law and pursuant to the Internal Revenue Service Code.

Spouse Life: Term life insurance coverage that covers the member's spouse or civil union partner, but does not cover a domestic partner.

State Employees Group Insurance Act: The statutory authority for benefits offered by the Department (5 ILCS 375/1 et seq.).

Statement of Health: A form which a plan participant completes and submits to the life insurance plan administrator to have a determination made of health status for life insurance coverage.

Survivor: Spouse, civil union partner, dependent child(ren) or dependent parent(s) of a deceased member as determined by the appropriate state retirement system.

Surgery: The performance of any medically recognized, noninvestigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by a plan.

Urgent Care Claim: Any claim for medical care or treatment with respect to the application of the time periods for making nonurgent care determinations could:
1) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2) in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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** Note: The original version of the October 1, 2011, Benefits Handbook inadvertently omitted the above reservation of rights due to an oversight during the graphic design process. This omission in no way represents and should not be construed as a lapse of, suspension of or exception to this reservation of rights. The State of Illinois has continuously maintained this reservation of rights since at least 1994 through the present. The State of Illinois continues to apply this reservation of rights on an ongoing basis, effective until such time as the State expressly waives or terminates this reservation of rights in writing.*

Printed by the Authority of the State of Illinois. 5/15 IOCI 15-0661