

Benefits Handbook Amendment

This document is Amendment I to your Benefits Handbook.

An Amendment adds, modifies, deletes or otherwise changes a benefit listed in your Benefits Handbook. You can make the most of your coverage by reading your Amendments and keeping them with your Benefits Handbook for future reference.

1. Open Access Plan (OAP)
2. LCHP Notification Requirements-General
3. LCHP Notification Requirements-Outpatient Surgery Procedures
4. LCHP Emergency Services
5. LCHP Prescription Drugs
6. LCHP Skilled Nursing
7. LCHP Urgent Care Services
8. LCHP Covered Benefits-Adults
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10. LCHP Exclusions and Limitations
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14. End Stage Renal Disease (ESRD)
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AMENDMENT TO THE LOCAL GOVERNMENT HEALTH PLAN (LGHP)

The following is an amendment to the 2006 LGHP Benefits Handbook for LGHP members, retirees and survivors. Please review this document carefully and keep it with your Benefits Handbook for future reference.

1. On pages 34-35 under Open Access Plan (OAP), the following bullet point is added:
 - Tier II and Tier III out-of-pocket maximums cross accumulate.
2. On page 40 under Notification Requirements, the 1st through 6th paragraphs are deleted and replaced with the following:

Notification is the telephone call to the health plan 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/supply.

If using a LCHP network provider (formerly PPO provider), the medical provider is responsible for contacting the Notification Administrator on behalf of the Plan Participant.

If using a non-LCHP provider (formerly non-PPO provider), the Plan Participant must direct their non-LCHP medical Provider to contact the Notification Administrator to provide specific medical information, setting and anticipated length of stay to determine medical appropriateness.

Failure to contact the Notification Administrator prior to having a service performed may result in a **financial penalty** and risk incurring non-covered charges deemed not medically necessary.

Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare.

3. On page 40 under Notification is required for the following, the 1st bullet point is deleted and replaced with the following:

Outpatient Surgery, Procedures, Therapies & Supplies/Equipment

- Outpatient surgery and procedures including, but not limited to, items such as imaging (MRI, PET, SPECT and CAT Scan), physical, occupational or speech therapy, foot orthotics, DME supplies, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, breast reduction/enlargement, select injectable drugs, treatment for varicose veins, etc). Services must be authorized before being performed. Contact the Notification Administrator for the most up-to-date list of procedures requiring Notification.
4. On page 48 under Urgent Care or Similar Facility, the bullet is deleted and replaced with the following:
 - 100% of U&C; 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 as presented in the 2006 Benefits Handbook. The benefit

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applies to professional fees only. Facility charges are not covered when services are performed in a physician's office or an Urgent Care Center. Non-emergency medically necessary services are considered at 80% of U&C.

5. On page 52 under Prescription Drugs, the following bullets replace the last bullet in this section:

- 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 nursing home stay for custodial care must be submitted to the Prescription Drug Plan Administrator.

6. On pages 53-54 under Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home, the last bullet is deleted and replaced with the following:

- Prescription Drug charges must be submitted to the Health Plan Administrator.

7. On page 56 under Urgent Care Services, the paragraph is deleted and replaced with the following:

Urgent care is treatment 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. Facility charges are not covered when services are performed in a physician's office or urgent care centers.

8. On page 57 under Covered Benefits – Adults, the following is added:

- Human Papillomavirus (HPV) Vaccine:
 - For female adults through age 26.
 - 80% of U&C for vaccine up to the maximum benefit.
 - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

9. On page 58 under Covered Benefits – Children, the following is added:

- Human Papillomavirus (HPV) Vaccine:
 - For eligible female dependents age 9–26.
 - 80% of U&C for vaccine.
 - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

10. On page 71 under LCHP – Exclusions and Limitations, the following points are added:

39. For legal fees.
40. For treatment and services rendered in a setting other than direct patient-provider contact.

11. On page 76 under Prosthodontics, the 4th bullet point is deleted.

12. On page 85 under Medicare Eligible, the entire section is deleted and replaced with the following:

Age 65 & Over - Medicare Eligible

Plan Participants must contact their local Social Security Administration office upon turning age 65 in order to determine if they are eligible for premium-free Medicare Part A benefits based on their own or their spouse's work history. All Plan Participants are eligible for Medicare Part B benefits upon turning age 65. All **retired** Plan Participants eligible for premium-free Medicare Part A, as well as Plan Participants actively employed with an employer other than the State of Illinois and without other large group health plan coverage or Plan Participants without Current Employment Status (CES), **must** enroll in Medicare Part A and Part B when first eligible.

Plan Participants with CES with other large group health plan coverage may delay enrolling in Medicare Part B until loss of CES, loss of their large group health insurance through their current employer or retirement (whichever is first). Upon this event, a Plan Participant must enroll in

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Medicare Part B in order to avoid a reduction in benefits. See 'Medicare Part B Reduction' in this section for more information.

If Medicare Part B is not purchased at age 65 when the Plan Participant is either retired or no longer in CES, Medicare will impose a 10% penalty for each year without the purchase of Medicare Part B. The annual Medicare general enrollment period is January, February and March; however, coverage is not effective until July 1.

13. On pages 85-86 under *Under Age 65 - Medicare Due to Disability*, the entire section is deleted and replaced with the following:

Under Age 65 - Medicare Due to Disability

In order to apply for Medicare disability coverage, a Plan Participant must contact their local Social Security Administration office. Plan Participants under the age of 65 who are receiving Social Security disability benefits or Railroad Retirement Board disability benefits, will automatically be enrolled in Medicare Parts A and B when determined eligible by the Social Security Administration. If a Plan Participant is retired or without Current Employment Status (CES) and is receiving Medicare benefits, the Plan Participant must remain enrolled in Medicare Part B. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

14. On page 86 under *End Stage Renal Disease (ESRD)*, the entire section is deleted and replaced with the following:

End Stage Renal Disease (ESRD)

Plan Participants of any age may qualify for premium-free Medicare Part A on the basis of End Stage Renal Disease (ESRD) if certain criteria are met. In order to apply for Medicare ESRD coverage, a Plan Participant must contact their local Social Security Administration Office. Plan Participants who are receiving regular dialysis treatments or who have had a kidney transplant, must make application for Medicare benefits on the basis of ESRD. If it is determined that the Plan Participant

is eligible for premium-free Medicare Part A, the Plan Participant must accept the Medicare Part A coverage and notify the Central Management Services Medicare COB Unit in order to establish the coordination of benefit period and to determine the date of Medicare primacy.

When Medicare becomes the primary payer, the purchase of Medicare Part B is required. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be the primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

15. On page 86 after the *End Stage Renal Disease (ESRD)* section, add the following new section:

Medicare Part B Reduction

If Medicare Part B is not purchased, the Plan Participant's health plan (either LCHP or the Plan Participant's Managed Care health plan) will process claims as if Medicare Part B was the primary payer. When Medicare is the primary payer, the standard Medicare Part B plan pays 80% of all Medicare approved amounts. The LCHP pays up to the 20% coinsurance that remains after Medicare Part B pays. If a Plan Participant does not enroll in Medicare Part B when Medicare is primary, the LCHP **will not pay** the initial 80% of the eligible charges. The LCHP will only pay up to 20% of the eligible charges of the claim. Plan Participants enrolled in a managed care health plan should refer to the managed care plan's Certificate of Coverage for reduction information. This reduction of benefits will remain in place until the date that Medicare Part B becomes effective. Plan Participants that terminate Medicare Part B coverage will be subject to claim adjustments by the claims administrator for any claims paid at the incorrect benefit level.