

# State of Illinois Employees Benefits Handbook Amendment (Amendment V)

This document is an amendment to the State of Illinois Employees Benefits Handbook released in October 2011. An amendment adds, modifies, deletes or otherwise changes a benefit listed in the Benefits Handbook. As changes occur, the online handbook will be modified to reflect the changes. Those updates and changes will be included in this amendment document as they occur. If you have a printed copy of the online handbook, you should refer to this amendment to ensure you have the most up-to-date information.

## AMENDMENT TO THE STATE OF ILLINOIS GROUP INSURANCE PROGRAM – 07/01/2013

### The following amends the Benefits Handbook:

1. The term 'usual and customary (U&C)' was replaced with 'allowable charges' throughout the handbook.
2. A new section (Quality Care Health Plan (QCHP) Summary of Benefits and Exclusions) was added behind the 'Health Plan Options' section of the handbook. The addition of these pages have caused the remaining pages to be renumbered beginning with page 39. The index has been updated to reflect the page number changes.
3. On page 34, under 'Health Plan Options', the 'Open Access Plan (OAP)' section was expanded to give more information regarding how an OAP works.
4. After page 38, a section that lists the benefits covered under the QCHP, as well as the plan's exclusions, was added.
5. On page 39 (new page 49), in the 'Prescription Coverage' section, the following changes were made to the headings and to the text throughout those sections:
  - 'Managed Care Plans (Fully-Insured)' was changed to a more accurate description of 'Health Maintenance Organizations (HMOs)'
  - 'Self-Insured Managed Care Plans and the Quality Care Health Plan (QCHP)' was changed to 'Open Access Managed Care Plans and the Quality Care Health Plan (QCHP)'
6. On page 41 (new page 51), in the 'Prescription Coverage' section, under "Maintenance Medication", the references to 'two copayments' for a 90-day supply were changed to 'two and a half copayments' in accordance with the AFSCME bargaining contract that went into effect July 1, 2013.
7. On page 54 (new page 64), in the 'Flexible Spending Accounts' section, under "Claim Submission," references to needing an employee's signature when submitting claims for reimbursement were deleted since the signature is no longer required.

The "FSA Account Statements," section was also updated to reflect that statements are mailed or emailed every quarter instead of every month.
8. On pages 62 through 65 (new pages 72-74), the 'Medicare' section was updated to indicate that beginning July 1, 2013, members who are enrolled in the Quality Care Health Plan (QCHP) and who have Medicare as their primary insurance must satisfy the annual plan year deductible before the QCHP will pay the standard benefits.

The 'Medicare' section was also updated to clarify that members enrolled in QCHP who have Medicare as their primary insurance must utilize QCHP network providers in order to receive the in-network benefit level after Medicare pays its portion. Members who use providers who are not in the QCHP network will have benefits paid at the out-of-network benefit level after Medicare pays their portion.

9. On pages 69 and 70 (new pages 78-79), in the 'Claims Appeal Process' section, the option for a second level of internal appeals was removed in order to bring the appeal process in line with industry standards and mirror PPACA, NCQA and URAC guidelines.
10. On page 73 (new page 82), the term 'allowable charges' was added to the glossary with the following definition:

"The maximum amount the plan will pay an out-of-network healthcare professional for billed services."
11. On pages 77 and 78 (new pages 86-87), the page numbers associated with the terms listed in the index were updated since additional pages were added to the 'Health Plan Options' section.