

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. **Alternative Retirement Cancellation Payment (ARCP)**
2. **Domestic Partner Coverage**
3. **Qualifying Change in Status for Leave of Absence**
4. **Employees Off Payroll**
5. **Insurance Coverage While on a Leave of Absence**
6. **Termination of Member Coverage**
7. **Termination of Dependent Coverage**
8. **Open Access Plan (OAP)**
9. **QCHP Notification Requirements-General**
10. **QCHP Notification Requirements-Outpatient Surgery Procedures**
11. **QCHP Emergency Services**
12. **QCHP Prescription Drugs**
13. **QCHP Skilled Nursing**
14. **QCHP Urgent Care Services**
15. **QCHP Covered Benefits-Adults**
16. **QCHP Covered Benefits-Children**
17. **QCHP Exclusions and Limitations**
18. **QCDP Prosthodontic Limitations**
19. **Age 65 & Over-Medicare Eligible**
20. **Under Age 65-Medicare Due to Disability**
21. **End Stage Renal Disease (ESRD)**
22. **Medicare Part B Reduction**

AMENDMENT TO THE STATE OF ILLINOIS GROUP INSURANCE PROGRAM

The following is an amendment to the 2004 State of Illinois Benefits Handbook for State employees, retirees and survivors. Please review this document carefully and keep it with your Benefits Handbook for future reference.

1. *On pages 15 and 16 under Special Provisions, the following replaces the first sentence:*

ARCP

Employees vested under the State Employees Retirement System who elected the Alternative Retirement Cancellation Payment (ARCP) per Illinois Public Act 93-0839 (between August 16, 2004 and October 31, 2004), Illinois Public Act 94-0109 (between July 1, 2005 and September 30, 2005), or Illinois Public Act 94-0839 (between June 6, 2006 and August 31, 2006) may be eligible for coverage under the Program.

2. *On page 18 under Eligible as Dependents, the following type of dependent is added:*

Domestic Partner

Effective July 1, 2006, unrelated, same-sex individuals who reside in the same household and have a financial and emotional interdependence, consistent with that of a married couple for a period of not less than one year and continue to maintain such arrangement may be eligible for medical, dental and vision benefits. The minimum age of a domestic partner is 19 years old. Neither the member, nor the domestic partner, may be married at the time of enrollment. If either partner gets married at any time after enrollment, the domestic partner's coverage must be terminated. If both parties are State members, one may not waive coverage as a member to become a dependent of the other member. The Domestic Partnership Affidavit (CMS-510) must be completed and submitted, along with two forms of documentation to prove domestic partnership. Dependent children of the domestic partner cannot be added to the member's coverage unless the member legally adopts or obtains legal guardianship of the children. If an enrolled domestic partner is not considered a tax dependent as defined by the IRS, the value of the domestic partner coverage (the portion the State contributes toward the cost) is reported as imputed income and will be subject to federal and state taxes. The effective date of coverage for an approved domestic partner is the first day of the pay period following the signature date on the Domestic Partner Enrollment Form if enrolling mid year or, July 1st if enrolling during the annual Benefit Choice Period. If the domestic partner becomes ineligible for benefits, it is the member's responsibility to notify their agency Group Insurance Representative.

Benefits Handbook Amendment

3. On page 28 under the Waive Health and Dental Coverage for the Leave of Absence: Member entering non-pay status qualifying event, the member type is changed to the following:

Member Qualifying Change in Status chart

A 'P' which indicates that this is an eligible change for a part-time employee, and/or a survivor or annuitant required to pay a Member premium.

4. On page 33 under Employees off Payroll, the 3rd paragraph is deleted and replaced with the following:

Failure to submit payment may result in termination of coverage and the filing of an involuntary withholding order to collect the unpaid premium.

5. On page 35 under Insurance Coverage While on a Leave of Absence, the 1st paragraph is deleted and replaced with the following:

Employees may choose, within 60 days of the leave, to drop dependent health coverage and/or optional life coverage. Full-time employees must maintain coverage for themselves unless they are on a leave of absence that requires the employee to pay 100% of the premium. Employees should contact their Group Insurance Representative (GIR) for options.

6. On page 39 under Termination of Member Coverage, the 5th bullet point is deleted and replaced with the following:

- The end of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid or collected through involuntary withholding (COBRA ineligible).

7. On page 39 under Termination of Dependent Coverage, the 5th bullet point is deleted and replaced with the following:

- On the last day of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid or collected through involuntary withholding (COBRA ineligible).

Also on page 39 under Termination of Dependent Coverage, add the following bullet:

- On the date a newly acquired dependent was added, if not on the first day of a pay period, if the member is subsequently terminated for non-payment of premium for the next pay period.

8. On page 51 under Open Access Plan (OAP), the following bullet point is added:

- Tier II and Tier III out-of-pocket maximums cross accumulate.

9. On page 56 under Notification Requirements, the 1st through 5th 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 QCHP 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-QCHP provider (formerly non-PPO provider), the Plan Participant must direct their non-QCHP medical Provider to contact the Notification Administrator to provide specific

Benefits Handbook Amendment

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.**

10. On page 57 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.

11. On page 64 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 2004 Benefits Handbook. The benefit 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.

12. On page 69 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.

13. On page 70 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.

14. On page 72 under Urgent Care Services, the last 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.

15. On page 73 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.

Benefits Handbook Amendment

16. On page 74 under Covered Benefits – Children, the following is added:

- Human Papillomavirus (HPV) Vaccine:
 - For eligible female dependents age 9–26.
 - 90% of U&C for vaccine.
 - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

17. On page 87 under QCHP – Exclusions and Limitations, the following points are added:

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

18. On page 92 under Prosthodontics, the 4th bullet point is deleted.

19. On page 103 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 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.

20. On pages 103-104 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.

Benefits Handbook Amendment

21. *On page 104 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.

22. *On page 104 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 QCHP 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 QCHP 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 QCHP **will not pay** the initial 80% of the eligible charges. The QCHP 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.