

Teachers' Retirement Insurance Program Benefits Handbook



Illinois Department of Central Management Services

Bureau of Benefits

January 1, 2007

Rod R. Blagojevich, Governor
Paul J. Campbell, Director

IMPORTANT
Do not throw away

The State of Illinois intends that the terms of the Teachers' Retirement Insurance Program (TRIP) are legally enforceable and that TRIP is maintained for the exclusive benefit of its Benefit Recipients. The State reserves the right to change any of the benefits and program requirements described in this Handbook. Changes will be communicated through addenda as needed, and the annual Benefit Choice Options booklet. If there is a discrepancy between this Handbook or any other Department publications, and state or federal law, the law will control. Generally, terms that are uppercased throughout this Handbook are defined in the glossary.

This Benefits Handbook is intended to assist Plan Participants understand and become familiar with the benefits available under the Teachers' Retirement Insurance Program (TRIP).

Chapter 1 provides **enrollment and eligibility information**, regardless of the health plan that is selected.

Chapter 2 provides information regarding **health plan options**.

Chapter 3 provides information regarding the **Teachers' Choice Health Plan**.

Chapter 4 provides **reference information** such as the **glossary and index**.

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Chapter 1

Enrollment and Eligibility Information

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TRIP Benefits

The Teachers' Retirement Insurance Program (TRIP) is a comprehensive program of quality health care coverage for retired teachers and their eligible dependents. The Teachers' Retirement System's (TRS) role is to provide members with basic coverage information, enroll them in the program and collect the appropriate premiums. The State of Illinois determines coverage benefits, establishes premiums, negotiates contracts with the insurance carriers and resolves coverage and claim issues. The Department of Central Management Services (Department) is the agency that administers the Teachers' Retirement Insurance Program (TRIP), as set forth in the State Employees Group Insurance Act of 1971 (Act).

Your benefits are a very important part of your compensation package as a Benefit Recipient of the Teachers' Retirement System (TRS). **Please read this handbook carefully as it contains vital information about your benefits.** You have the opportunity to review your choices and change your coverage for each Plan Year during the annual Benefit Choice Period.

Where To Find Additional Information

TRS is a valuable resource for answering questions you may have about your eligibility for coverage and to assist you in enrolling or changing the benefits you have selected. TRS can be reached at:

Teachers' Retirement System
2815 W. Washington
P.O. Box 19253
Springfield, IL 62794-9253
(800) 877-7896
TDD/TTY: (217) 753-0329
TRS website: trs.illinois.gov

If TRS is unable to answer your questions, please refer to the following:

- Each individual Plan Administrator can provide you with specific information on plan coverage inclusions/exclusions.
- 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. **Read this booklet carefully as it contains important eligibility and benefit information that may affect your coverage.**

The Department can answer questions regarding your health insurance or refer you to the appropriate resource for assistance. The Group Insurance Division can be reached at:

DCMS Group Insurance Division
201 E. Madison 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 and cards are mailed to the Benefit Recipient's address. To obtain additional cards, contact the Plan Administrator(s) listed in the current Benefit Choice Options booklet or visit the website at www.benefitschoice.il.gov for links to current Plan Administrators.

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, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits. If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective Plan Administrator. If you are a Plan Participant in the TCHP, refer to the annual Benefit Choice Options booklet for the Notice of Privacy Practices.

Benefit Recipient Responsibilities

It is each Benefit Recipient's responsibility to know their benefits and review the information in this publication.

Notify TRS immediately when any of the following occurs:

- **Change of address.** When you and/or your Dependent Beneficiary move.
- **Life changing events.** Certain changes in your personal life may affect your eligibility or your dependent's eligibility for benefits. For this reason, it is important to keep TRS informed of any life changing events, such as marriage, birth of a child or death of a dependent. See the Enrollment section in this chapter for a complete listing of Qualifying Changes in Status.
- **Dependent loss of eligibility.** Dependent Beneficiaries who are no longer eligible under TRIP (including divorced Spouses) must be reported to TRS **immediately**. Failure to report an ineligible Dependent Beneficiary is considered a fraudulent act and will result in the loss of a premium refund, termination of Dependent Beneficiary coverage under TRIP and potentially the loss of COBRA continuation rights.

IMPORTANT: A court order stating you must provide medical coverage for a Dependent Beneficiary or a divorced Spouse does not supersede Program eligibility criteria.

- **Other Coverage.** If you have group coverage (other than Medicare) provided by a plan other than TRIP, or if you or your Dependent Beneficiaries gain other coverage during the Plan Year, you must provide that information to TRS **immediately**.

- **Change in Medicare Status.** You must provide a copy of your and/or your Dependent Beneficiary's Medicare card to TRS when a change in Medicare status occurs.

If you are unsure whether or not a life-changing event needs to be reported to TRS, contact TRS for assistance.

Members should periodically review the following to ensure all benefit information is accurate:

- **Health Plan Deductions.** It is your responsibility to ensure deductions are accurate for the coverages you have selected/enrolled.

If You Live or Spend Time Outside Illinois

Plan Participants who move out of state or the country will most likely need to enroll in the Teachers' Choice Health Plan (TCHP). For those in certain areas contiguous to the State of Illinois, some managed care health plan options may be available. Contact the managed care health plan directly for information regarding availability. Changing your address does not automatically change your health plan.

Penalty for Fraud

Falsifying information/documentation in order to obtain/continue coverage under TRIP is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums TRIP made on behalf of Plan Participants, as well as expenses incurred by TRIP.

Notes

Information for Benefit Recipients

ID Cards

Benefit Recipients will receive a new health ID Card from the appropriate Plan Administrator at the time of enrollment or upon a change of health plans.

Cost of Participation in the Program

The cost of health coverage varies based upon the type of plan selected and the accessibility of a managed care plan to your permanent residence.

Premiums

The law requires that the premium for coverage be deducted from the annuity received by the Benefit Recipient. If the annuity is insufficient to cover the premium, a direct pay statement will be sent which requires the Benefit Recipient to submit monthly payments. Premium payment is required through the month of cancellation or death. Premium amounts for the plan year will appear annually in the most recent TRIP Benefit Choice Options booklet.

Change in Residence

Notify TRS immediately of any change in address, as residence determines plan availability.

Survivors

Potential Survivors must immediately notify TRS of the annuitant's death. The TRS Survivor Benefit Department will send information to the Benefit Recipient's designated beneficiary. The completed enrollment application must be returned to TRS, along with the Survivor Benefit Option letter, within 30 days of the date of the letter. If coverage is elected, it will be reinstated retroactive to the date coverage was terminated as a Dependent Beneficiary, thereby eliminating any lapse in coverage.

Power of Attorney

Benefit Recipients may want to consider having a Power of Attorney for Property on file with both TRS and the health plan to allow a representative to act on the Benefit Recipient's behalf.

Medicare

Refer to the Medicare section in Chapter 2 for important information regarding Medicare. Note: In order to receive the Medicare Primary Premium, Plan Participants must be enrolled in both Medicare Parts A and B or the higher premium will be assessed.

Change in Medicare Status

Plan Participants must enroll in Medicare upon becoming eligible. A copy of the Medicare card or Notice of Award letter must be provided to TRS. Failure to provide the information will impact the premium paid and the benefits received.

Retroactive Policy

Corrections to eligibility that result in a premium refund will only be processed retroactively up to six months, with six months adjustment on premium.

It is the Benefit Recipient's responsibility to immediately advise TRS of changes in eligibility for coverage under the Program including enrollment in Medicare. **Failure to notify TRS of changes in eligibility (including death) or errors in premium payments in a timely manner will result in application of the Retroactive Policy.** There are no exceptions to this policy.

A Dependent Beneficiary who is determined ineligible, such as a divorced spouse, will have coverage terminated retroactive to the date they became ineligible.

Notes

This section contains benefit eligibility information which applies to all TRIP **health** plans.

Eligibility Requirements

Eligibility is defined by 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. If there is any change in eligibility information (qualifying change in status, Medicare eligibility, residential address) notify TRS immediately at (800) 877-7896. Failure to notify TRS of eligibility changes may result in loss of benefits and/or premiums.

Eligible as Benefit Recipient

To be eligible, Annuitants must be receiving a monthly benefit or retirement annuity from TRS and have at least eight years of creditable service under Article 16 (TRS) of the Illinois Pension Code; or (I) have been enrolled in the health insurance program offered prior to January 1, 1996; or (II) be the Survivor of a Benefit Recipient who had at least eight years of creditable service under Article 16 (TRS) of the Illinois Pension Code; or (III) be a Survivor of a Benefit Recipient who was enrolled in the TRS program prior to January 1, 1996; or (IV) be a recipient of a TRS disability benefit.

Benefit Recipients enrolled in any of the TRIP health plans are not eligible for health coverage as a Member under the State Employees Group Insurance Program.

Eligible as Dependent Beneficiaries

A Benefit Recipient may enroll an eligible Dependent Beneficiary in TRIP. Eligible dependents include the Benefit Recipient's:

- **Spouse** (does not include ex-spouses, common-law spouses, same-sex partners or those not legally married).
- **Parents** - If they are dependent upon the Benefit Recipient for more than one-half of their support and are eligible to be claimed by the Benefit Recipient as a Dependent for income tax purposes.
- **Unmarried children under age 19, including:**
 - **Natural children.** Natural children are not required to live with the Benefit Recipient in order to be eligible.
 - **Adopted children.** Adopted children are not required to live with the Benefit Recipient in order to be eligible.
 - **Stepchildren.** Stepchildren must live with the Benefit Recipient in a parent-child relationship at least 50% of the time in order to be eligible.
 - **Children for whom the Benefit Recipient has permanent legal guardianship.** Children for which the Benefit Recipient has permanent legal guardianship must live with the Benefit Recipient in a parent-child relationship in order to be eligible.
- **Unmarried dependents age 19 to 23, who meet ALL the following conditions:**
 - Enrolled as a full-time student in an accredited school. Dependents turning age 19 in June, July or August are eligible to continue coverage during the summer months if the dependent intends to enroll as a full-time student during the Fall semester.
 - Financially dependent upon the Benefit Recipient for at least one-half of their support.
 - Eligible to be claimed as a Dependent for income tax purposes by the Benefit Recipient.

- **Unmarried Dependent Beneficiaries age 19 and older who are mentally or physically handicapped and meet ALL the following conditions:**
 - Financially dependent upon the Benefit Recipient for at least 1/2 of their support.
 - Continuously disabled from a cause originating prior to age 19 (or prior to age 23 if enrolled as a full-time student).
 - Eligible to be claimed as a Dependent for income tax purposes by the Benefit Recipient.

Recertification of Dependent Beneficiary Eligibility

Failure to meet the eligibility requirements and/or submit recertification documentation attesting to the Dependent's continued eligibility will result in the Dependent Beneficiary's coverage being terminated.

Annual/Semi-Annual Recertification

- **Parent Category** - Annual recertification of the Dependent Beneficiary's eligibility in the Parent Category is required.
- **Student Category** - Semi-annual recertification of the Dependent Beneficiary's eligibility in the Student Category is required. Recertifications are required in the fall and in the spring.
- **Handicapped Category** - Annual recertification of the Dependent Beneficiary's eligibility in the Handicapped Category is required (the Handicapped Category is defined in the Enrollment section of this Chapter).

Birth Date Recertification

Benefit Recipients must verify continued eligibility for Dependent Beneficiaries turning age 19 or 23. Benefit Recipients with Dependent Beneficiaries turning age 19 or 23 will receive a recertification letter from TRS requesting the dependent's eligibility to be verified several weeks prior to the Dependent Beneficiary's birth month. The Benefit Recipient must provide the required documentation to TRS prior to the Dependent Beneficiary's birth date. Failure to recertify the eligibility timely will result in the Dependent's coverage being terminated effective the end of the birth month.

Reinstatement of Dependent Beneficiary Coverage

If coverage for the Dependent Beneficiary is terminated for failure to recertify and the Benefit Recipient provides the required documentation within 30 days from the date the termination is processed, coverage will be reinstated retroactive to the date of termination. If the documentation is not provided within the 30-day period, coverage will be reinstated effective the first of the month following the date the documentation is received by TRS, but not retroactive to the date of termination.

Contact TRS for questions regarding recertification of a Dependent Beneficiary.

Enrollment Periods

- Initial Enrollment
- Annual Benefit Choice Period
- Qualifying Change in Status

Re-enrollment in TRIP is limited. Benefit Recipients or Dependent Beneficiaries who were previously covered under TRIP and terminated coverage may re-enroll **only** upon turning age 65, becoming eligible for Medicare or upon coverage being terminated by a former group plan.

Initial Enrollment

Benefit Recipients may initially enroll in TRIP, as well as enroll any eligible Dependents, when one or more of the following occur:

- **Upon application of annuity benefits.** An enrollment application must be submitted to TRS no later than 30 days after the effective date of the pension benefits. Coverage will be effective the first day of the first full month of benefits or the first day of the month when the enrollment application is received, whichever is later. The effective date may be delayed up to 4 months after the effective date of the pension benefits; however, TRS must receive the enrollment form within 30 days of the effective date of the pension benefits.
- **The Benefit Recipient becomes eligible for Medicare.** Benefit Recipients who become eligible for Medicare are eligible to apply for coverage. Benefit Recipients must apply within 6 months from the date they became Medicare eligible. If the Benefit Recipient is Medicare eligible due to turning 65, TRS will mail enrollment information approximately 60 days prior to the Benefit

Recipient's 65th birthday. Coverage will be effective the first day of the month in which the Benefit Recipient becomes Medicare eligible or the first day of the month when the enrollment application is received by TRS, whichever is later.

- **The Benefit Recipient ineligible for Medicare.** Benefit Recipients who are Medicare ineligible have 30 days from their 65th birthday to apply for coverage. Coverage will be effective the first day of the month in which the Benefit Recipient reaches age 65 or the first day of the month when the enrollment application is received by TRS, whichever is later.
- **Coverage is terminated by a former group plan.** Benefit Recipients who are eligible to enroll in TRIP but instead continue coverage with another plan, may enroll if the other plan terminates coverage. The Benefit Recipient has 30 days following the loss of other coverage to submit the enrollment application, along with a letter from the former plan stating the effective date of termination, to TRS. Termination of coverage must be initiated by the former group plan. Termination for non-payment of premium does not qualify as loss of coverage by the group plan and therefore is not an eligible enrollment event. The effective date of the coverage is the first day of the month following cancellation of coverage with the other plan.
- **Annual Benefit Choice Period, if the Benefit Recipient has never previously been enrolled in TRIP.** Benefit Recipients who are eligible for, but have never enrolled in, one of the health plans under TRIP may do so during the annual Benefit Choice Period. The coverage becomes effective July 1st.

Annual Benefit Choice Period

The annual Benefit Choice Period is normally held May 1st through May 31st. During this 31-day period, Benefit Recipients may change health plans or add eligible dependent coverage. All changes initiated during the annual Benefit Choice Period become effective July 1st.

As required by TRIP contractual obligations, coverage elected during the annual Benefit Choice Period remains in effect throughout the entire year unless the Benefit Recipient experiences a Qualifying Change in Status. Benefit Recipients who were previously covered under TRIP and subsequently terminated coverage may re-enroll **only** upon turning age 65, becoming eligible for Medicare or upon coverage being terminated by a former group plan, and therefore, **cannot** re-enroll during the annual Benefit Choice Period.

Qualifying Change in Status

Benefit Recipients may change health plans or add Dependent coverage upon experiencing a Qualifying Change in Status that is consistent with the qualifying event. The time frame allowed to submit change requests vary. Refer to the specific events below for details.

Benefit Recipients may change health plans when:

- The Benefit Recipient is enrolled in an HMO and their Primary Care Physician (PCP) leaves the plan.
- A change in permanent residence occurs that changes the availability of the managed care plan.

The request to change health plans must be received within 60 days of the event. **The effective date of the change is the first day of**

the month following the event, with an exception for newborn coverage, which is effective the first day of the month in which the event occurred.

Benefit Recipients may enroll a dependent upon experiencing one of the following events:

- Marriage, adoption or birth. The enrollment request must be received within 31 days of the event.
- The Dependent Beneficiary turns age 65 and is not eligible for Medicare. The enrollment request must be received within 30 days of the 65th birthday.
- The Dependent Beneficiary becomes eligible for Medicare. The enrollment request must be received within 6 months of Medicare eligibility.
- The Dependent Beneficiary's other coverage is terminated by the plan. The Benefit Recipient must already be enrolled in TRIP in order to add the Dependent Beneficiary. The enrollment request must be received within 30 days of the coverage termination date.
- Initial enrollment of the Benefit Recipient into TRIP. Refer to Initial Enrollment in this section for enrollment time periods.

Dependent Beneficiary Enrollment

Benefit Recipients may enroll eligible dependents upon initial enrollment in TRIP, during the annual Benefit Choice Period (only if not previously enrolled in TRIP) or upon experiencing a Qualifying Change in Status. Dependent Beneficiaries will be enrolled in the same health plan as the Benefit Recipient.

Benefit Recipients must contact TRS in order to obtain the required enrollment forms. Completed enrollment forms must be submitted to TRS in a timely manner. Refer to Enrollment Periods in this section for enrollment deadlines. In addition to the required enrollment forms, proper documentation must be provided.

Documentation Requirements

Supporting documentation must be submitted to TRS within 31 days of the request to add Dependent Beneficiary coverage being submitted to TRS. Failure to provide the required documentation in a timely manner will result in denial of Dependent Beneficiary coverage.

Unmarried Children Under Age 19

Natural Children - A copy of the birth certificate is required for a newborn child. If the Benefit Recipient is not listed on the birth certificate, a copy of the Public Aid order or court order establishing a **Benefit Recipient's** financial responsibility for the child's medical or other health care is required.

Stepchildren - Proof/evidence the child resides with the Benefit Recipient (e.g., copies of records, such as school, child care, social services or medical, etc.), **and** a birth certificate indicating that the Benefit Recipient's Spouse is the child's natural parent **and** a marriage certificate indicating the child's parent is the Benefit Recipient's current Spouse are required. Completion of a Dependent Coverage Eligibility Verification Statement is also required.

Adopted Children - A copy of the petition or court order is required. If the court order is from a foreign court, a copy of the translation must accompany the document.

Children for whom the Benefit Recipient has legal custody or permanent guardianship - A copy of the court order awarding custody or establishing permanent guardianship is required.

Dependent Beneficiaries Age 19 and Older

Student - Unmarried dependents, up to, but not including age 23, may be enrolled with proof of full-time student status in an accredited school. The following are examples of acceptable documentation: letter from the Office of the School Registrar, copy of enrollment from the university's website, an abbreviated transcript, copy of grant award or tuition waiver, itemized statement of account. Documentation must indicate **full-time enrollment**. Information must include the student's name and Social Security Number.

Handicapped - Unmarried dependents may be enrolled if they have been continuously disabled from a cause originating prior to age 19 (or prior to age 23 if enrolled as a full-time student). Initial enrollment in the Handicapped category requires a diagnosis from a physician with an ICD-9 diagnosis code, a letter from the doctor detailing the dependent's limitations, capabilities and onset of condition, and either a disability statement from the Social Security Administration or a court order adjudicating the disability and Medicare information if applicable. All initial enrollments into the handicapped category are subject to approval from the Department.

Parent - Verification the parent is dependent upon the Benefit Recipient for more than half of their support and that the parent is claimed by the Benefit Recipient as a Dependent for income tax purposes. A Dependent Coverage Certification Statement is required, as well as Medicare information, if applicable.

Documentation Requirements For Adding Dependent Coverage	
Type of Dependent	Supporting Documentation Required
Natural Newborn Child	Birth Certificate required, ~ OR ~ Court Order establishing a Benefit Recipient's financial responsibility for the child's medical, dental or other health care, ~ OR ~ Copy of Public Aid Order with the page of the document which has an 'X' indicating that the Member must provide health insurance through the employer.
Adoption or placement for adoption Birth up to, but not including, age 19	Adoption Decree/Order with judge's signature and circuit clerk's file stamp, ~ OR ~ Petition for Adoption with the circuit clerk's file stamp.
Handicapped Child Child age 19 or over	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 ~ Dependent Coverage Certification Statement, ~ AND ~ Medicare Card when applicable.
Stepchild Birth up to, but not including, age 19	Birth Certificate required, ~ AND ~ Marriage Certificate indicating the Member is married to the child's parent, ~ AND ~ Proof of the child's primary residence, such as school records or other documentation verifying the child's address is the same as the Benefit Recipient's address, ~ AND ~ Dependent Coverage Eligibility Verification Statement.
Student Child age 19 up to, but not including, age 23	Documentation indicating the student is enrolled full time at an accredited school, ~ AND ~ Dependent Coverage Certification Statement.
Parent Dependent who is financially dependent on the Benefit Recipient for at least 1/2 of their support	Benefit Recipient's tax return or other documentation proving financial dependency, ~ AND ~ Dependent Coverage Certification Statement, ~ AND ~ Medicare Card when applicable.
Note: Birth Certificate from either the State or admitting hospital which indicates the Member is the parent is acceptable.	

Penalty for Fraud

Falsifying information/documentation in order to obtain/continue coverage under TRS is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums TRIP made on behalf of the Benefit Recipient and/or Dependent Beneficiary, as well as expenses incurred by TRIP.

This section describes the events and timing of the termination of benefits. In most cases, health coverage can be continued at the Benefit Recipient's expense for a limited period of time under federal law referred to as COBRA (Consolidated Omnibus Budget Reconciliation Act). If interested in continuing coverage under COBRA, review the requirements and deadlines for filing in the next section entitled COBRA Continuation of Coverage. TRS can help with any questions regarding termination of benefits and how to apply for continuation of benefits under COBRA.

Termination of Benefit Recipient's Coverage

A Benefit Recipient's coverage terminates at midnight on the last day of the month when:

- Eligibility requirements are no longer met.
- A written request to terminate coverage is received by TRS.
- The Benefit Recipient becomes eligible for and enrolls in the State Employees Group Insurance Program.
- The TRIP Program is terminated.

Exception: A Benefit Recipient's coverage terminates at midnight on the date of death.

Contact TRS immediately upon becoming a Survivor in order to have eligibility determined and begin the application process.

Termination of Dependent Beneficiary Coverage

An enrolled Dependent Beneficiary's coverage terminates:

- Simultaneously with termination of a Benefit Recipient's coverage.

- At the end of the month in which the enrolled Dependent Beneficiary no longer meets eligibility requirements.
- At midnight on the date of death.
- At the end of the month the Dependent Beneficiary becomes 19 years of age and is ineligible to continue participation.
- The first day of the month following receipt of the written request to terminate Dependent Beneficiary coverage. Re-enrollment opportunities are limited.

Notes

COBRA - Continuation of Coverage

Overview

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides eligible covered Plan Participants 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, and the election to continue coverage must be made within a specified election period. If COBRA continuation coverage is elected, the coverage will be reinstated retroactive to 12:01 A.M. the date following termination of coverage.

An initial notice is provided to all new Annuitants and Survivors upon enrollment in Teachers' Retirement Insurance Program (TRIP). 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, contact TRS.

COBRA Eligibility

Plan Participants who lose coverage due to certain qualifying events (see chart at end of this section) are considered Qualified Beneficiaries and may be able to continue coverage under the provisions of COBRA. Continuation of coverage under COBRA for Qualified Beneficiaries is identical to the health coverage provided to Plan Participants.

Covered Dependent Beneficiaries retain COBRA eligibility rights even if the Benefit Recipients chooses not to enroll. Qualified Beneficiaries electing continuation of coverage under COBRA are enrolled as a Benefit Recipient. If the spouse or dependent children live at another address notify TRS immediately so that notification can be sent to the proper address.

Notification of COBRA Eligibility

The Benefit Recipients or Qualified Beneficiary must notify TRS within 60 days of the date of the event or the date on which coverage would end, whichever is earlier. Failure to notify TRS within 60 days will result in disqualification of COBRA continuation coverage.

TRS will send a letter to the Qualified Beneficiary regarding COBRA rights within 14 days of receiving notification 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 TRS within the 60-day period, contact TRS 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

If a Plan Participant's Medicare entitlement occurs **before** a COBRA qualifying event, the affected Qualified Beneficiary may elect COBRA coverage for the maximum continuation period. See the COBRA Qualifying Events chart for maximum continuation periods.

If a Plan Participant's Medicare entitlement or eligibility (see the COBRA Qualifying Events chart at the end of this section) occurs **after** a COBRA

qualifying event, affected Qualified Beneficiaries are not eligible to continue COBRA coverage.

COBRA Benefit Recipients who obtain coverage under another group health plan (which does not impose Pre-existing Condition Limitations or Exclusions) are ineligible to continue COBRA. TRS reserves the right to retroactively terminate COBRA coverage if an individual is deemed ineligible.

NOTE: Premiums will not be refunded for coverage terminated retroactively due to ineligibility.

COBRA Extensions

Disability Extension

Individuals 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. Enrolled Dependents are also entitled to COBRA and are eligible for the extension.

To be eligible for the extension, an individual must have become disabled during the first 60 days of COBRA continuation coverage and **MUST** submit a copy of the SSA determination to the Department **within 60 days** of the date of the SSA determination letter and before the end of the original 18-month COBRA coverage period. Coverage will not be extended to 29 months if the required documentation is not submitted to TRS within the appropriate timeframe.

The affected individual must also notify TRS 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 qualifying event resulting in an 18-month maximum continuation period is followed by a second qualifying event, the Spouse and/or Dependent child may extend coverage an additional 18 months for a maximum of 36 months. However, this 18-month extension does not apply to newly acquired Dependents added to existing COBRA coverage.

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 Benefit Recipients and charged the Benefit Recipient rate. A divorced or widowed Spouse who has Dependent coverage would be considered the Benefit Recipient and charged the Benefit Recipient rate, with the child covered as a Dependent Beneficiary and charged the applicable Dependent Beneficiary rate. If only a dependent child elects COBRA, then each child would be considered a Benefit Recipient and charged the Benefit Recipient rate.

Once the COBRA enrollment form is received and the premium is paid, coverage will be reinstated retroactive to the date coverage was terminated. TRS will mail monthly billing statements to the Benefit Recipient'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 date of the month in which premiums were paid.

It is the Benefit Recipient's responsibility to promptly notify TRS in writing of any address change or billing problem.

TRS does not contribute to the premium for COBRA coverage. Most COBRA Benefit Recipients must pay the applicable premium plus a 2% administrative fee for participation. COBRA Benefit Recipients 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.

Adding Newly-Acquired Dependents While Enrolled in COBRA

Newborns, a newly-adopted child or a newly-acquired spouse may be added to existing COBRA coverage. Documentation requirements must be met. See the Documentation Requirements chart in this chapter for details.

Termination of Coverage under COBRA

Termination of COBRA coverage occurs when the earliest of the following occurs:

- Maximum continuation period ends.
- Covered Plan Participant fails to make timely payment of premium.
- Covered Plan Participant becomes a participant in another group health plan which does not impose a Pre-existing Condition exclusion or limitation (for example, through employment or marriage).

- Covered Plan Participant becomes entitled to Medicare. Special rules apply for End Stage Renal Disease. Contact TRS for more information.
- Covered Plan Participant reaches the qualifying age for Medicare.

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 without providing evidence of insurability. This conversion privilege applies to health coverage only. Members are eligible for this conversion unless group health coverage ended because of:

- Failure to pay the required premium, or
- Coverage is replaced by another group health plan, or
- Member enrolls in Medicare, or
- Voluntary termination during COBRA coverage.

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 on COBRA conversion. Neither the Department, nor TRS, is not involved in the administration or premium rate structure of insurance benefits obtained through conversion.

COBRA QUALIFYING EVENTS	
<p>To be eligible for COBRA an individual must be enrolled in the group health plan on the day before the qualifying event takes place. A qualifying event is defined as any of the events shown below that cause a loss of coverage.</p>	
Duration of COBRA Coverage	
Qualifying Events	Continuation Period
Benefit Recipient	
Suspension of annuity benefits for any reason, including termination of disability benefits, except for gross misconduct	18 months
Loss of eligibility	18 months
Disability determination by the Social Security Administration (SSA) of a disability that existed at the time of the qualifying event	29 months
Dependent Beneficiary	
Suspension of Benefit Recipient's annuity benefits as stated above	18 months
Failure to satisfy the plan's eligibility requirements for Dependent Beneficiary status	36 months
Benefit Recipient's death, divorce or legal separation: Spouse or ex-spouse, under age 55	36 months
Benefit Recipient's death, divorce or legal separation: Spouse or ex-spouse, age 55 or older	36 months (if Medicare entitled), or obtains Medicare, or reaches the qualifying age for Medicare
Benefit Recipient's Medicare entitlement	Up to 36 months
Disability determination by the Social Security Administration (SSA) of a disability that existed at the time of the qualifying event. The dependent must have been covered by the Benefit Recipient's insurance at the time of the qualifying event.	36 months

Chapter 2

Health Plan Options and Information

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Notes

Overview

Depending on residence, there may be several health plans from which to choose. The plans offered may change annually. Refer to the annual Benefit Choice Options booklet for the health plans available.

Each plan provides medical and behavioral health benefits as well as prescription drugs. However, the Covered Services, benefit levels and exclusions and limitations differ. In making choices, consider the following: health status, coverage needs and service preferences.

Dependent Beneficiaries must have the same health plan as the Benefit Recipient under whom they are enrolled.

Types of Health Plans

There are three types of health plans available:

- Health Maintenance Organizations (HMOs).
- Open Access Plan (OAP).
- Indemnity Plan – Teachers' Choice Health Plan (TCHP).

Managed Care Health Plans

Managed care is a method of delivering health care through a system of network Providers. There are differences in the Co-payment amounts among the managed care health plans offered. However, these plans provide comprehensive medical benefits at lower Out-of-Pocket cost by utilizing network Providers. Managed care health plans coordinate all aspects of a Plan Participant's health care including medical, Prescription Drugs and behavioral health services.

Benefit Recipients who enroll in a managed care health plan must select a Primary Care Physician

or Provider (PCP) from the managed care health plan Provider directory or website. Always contact the Physician's office or managed care health Plan Administrator to find out if the PCP is accepting new patients. Special attention should be given to these participating Physicians and Hospitals, which Benefit Recipients are required to use for enhanced benefits. Refer to the annual Benefit Choice Options booklet for Plan Administrators and website information.

If the designated PCP leaves the managed care health plan network, there are three options:

- Choose another PCP with that plan,
- Change managed care health plans, or
- Enroll in the TCHP indemnity plan.

This opportunity to change health plans applies only to the PCP leaving the network. It does not apply to Hospitals, specialists or womens' healthcare Providers who are not the designated PCP.

Benefit Recipients are notified in writing by the managed care health Plan Administrator when a PCP network change occurs. Benefit Recipients have 60 days to select a new PCP or make a health plan change.

There may be managed care health plans that are self insured and administered by the State of Illinois, meaning all claims are paid by the Teachers' Retirement Insurance Program even though managed care health plan benefits apply. These plans are not regulated by the Illinois Department of Financial and Professional Regulation, Division 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, you may ask to receive a plan's Summary Plan Description (SPD) which describes the Covered Services, benefits levels and exclusions and limitations of the plan's coverage. The SPD may also be referred to as the Certificate of Coverage or the Summary Plan Document.

Pay particular attention to the health plan's exclusions and limitations. It is important that you understand what services are not covered under the plan. If you decide to enroll in a managed care health plan, it is essential that you read your SPD before you need medical attention. It is your responsibility to become familiar with all of the specific requirements of your health plan.

In most cases a referral for specialty care will be restricted to those services and Providers authorized by the designated PCP. In some cases, referrals may also require pre-approval from the managed care health plan. To receive the maximum Hospital benefit, your PCP or specialist must have admitting privileges to a network Hospital.

For complete information on specific plan coverage or Provider network, contact the managed care health plan and review the SPD.

NOTE: Managed care health plan provider networks are subject to change. Always call the respective Plan Administrator for the most up-to-date information.

Health Maintenance Organization (HMO)

HMO Plan Participants must choose a Primary Care Physician or Provider (PCP) who coordinates the medical care, hospitalizations and referrals for specialty care.

HMOs are restricted to operating only in certain counties and zip codes called service areas. There is no coverage outside these service areas unless pre-approved 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 benefit levels for out-of-area services or emergencies, call the HMO.

Like any health plan, HMOs have plan limitations including geographic availability and limited Provider networks. Most managed care health plans impose benefit limitations on a Plan Year basis (July 1-June 30). However, some managed care health plans impose benefit limitations on a calendar year basis (January 1 through December 31). Contact the managed care health plan for additional information.

NOTE: When a managed care health plan is the secondary plan and the Plan Participant does not utilize the managed care health plan network of Providers or does not obtain the required referral, the managed care health plan is not required to pay for services. Refer to the plan's SPD for additional information.

Open Access Plan (OAP)

The Open Access Plan combines similar benefits of HMOs and traditional health coverage. The Plan offers two managed care networks, Tier I and Tier II. Enhanced benefits are available by utilizing providers in Tier I and II. In addition, Tier III benefits (out-of-network) are available, so Plan Participants can have flexibility in selecting health care Providers. The Provider and tier selected for each service determines the level of benefits available.

The OAP allows Plan Participants to mix and match Providers. For example, the Plan Participant can utilize a Tier II Physician and receive care at a Tier I hospital. The OAP Plan Administrator can provide a directory that contains listings of the Tier I and Tier II networks. The benefit level for services rendered will be the highest if selecting Tier I Providers.

- Tier I is often a 100% benefit after a Co-payment.
- Tier II is generally a 90% benefit with a 10% Coinsurance after the annual Plan Deductible is met.
- Tier III (out-of-network) is generally paid at 80% of the **Usual and Customary (U&C) charges** after the annual Plan Deductible is met.

The Indemnity Plan - Teachers' Choice Health Plan (TCHP)

The Teachers' Choice Health Plan (TCHP) is the self-insured indemnity health plan that offers a comprehensive range of benefits. Under the TCHP, Plan Participants are free to utilize any Provider (physician, specialist or hospital) of their choice, with the exception of transplant services. Benefit enhancements are available by utilizing:

- Preferred Provider Organization (PPO) Hospitals, physicians and other medical providers.
- Pharmacy network.
- Behavioral health benefits through the Behavioral Health Plan Administrator.
- Transplant PPO (TPPO) network (plan participants are required to use a network hospital).

Notes

If a Plan Participant enrolled under one of the TRIP medical plans is entitled to primary benefits under another group plan, the amount of benefits payable under TRIP 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 the TRIP Plan or one of the plans identified below.

Under Coordination of Benefits (COB) rules, the TRIP Plan first calculates what the benefit would have been for the Claim if there was no other plan involved. The TRIP 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 Certificate of Coverage for additional information.

For purposes of COB, the term "plan" is defined as any plan that provides medical care coverage including the following:

- Any group insurance plan.
- Any governmental plan (including Medicare), except the Illinois Medical Assistance Program (Medicaid).
- 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.

- TRIP does not coordinate benefits with private individual insurance plans, elementary, high school and college accident insurance policies, Medicaid and individuals covered under TRICARE. The TRIP Plan is primary.

It is the Benefit Recipient's responsibility to provide other insurance information (including Medicare) to the Teachers' Retirement System (TRS). Any changes to other insurance coverage must be reported to TRS promptly.

Order of Benefit Determination

TRIP medical plans follow the National Association of Insurance Commissioners (NAIC) model regulations. These regulations dictate the order of benefit determination. The rules are applied in sequence. If the first rule does not apply, the sequence is followed until the appropriate rule that applies is found.

The order is as follows:

- **Benefit Recipient**
 - The plan that covers the Plan Participant as an active Employee or Member is primary over the plan that covers the Plan Participant as a Dependent.
 - The plan that covers the Plan Participant as an active Employee (not as a laid-off Employee or Retiree) is primary over the plan that covers the Plan Participant as a laid-off Employee or Retiree.
 - If the Plan Participant is covered as an active Employee or Member under more than one plan, but is covered under COBRA (state or federal) under one of the plans, then the plan covering the Plan

Participant as an active Employee or Member is primary over the plan covering the Plan Participant under COBRA.

- If the Plan Participant is covered as an active Employee or Member under more than one plan, and none of the above rules apply, then the plan that has been in effect the longest is primary, 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**

If a child is covered by more than one group plan, the plans must pay in the following order:

- The plan covering the parent whose birthday* falls earlier in the calendar year is the primary plan (Birthday Rule).
- 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.

- **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:

- The plan of the parent with custody of the child;
- The plan of the Spouse of the parent with custody of the child;
- 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 health care 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 plan covering the parent whose birthday* falls earlier in the calendar year is the primary plan (Birthday Rule).

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

Overview

Medicare is a federal health insurance program for individuals:

- Age 65 or older, or;
- Receiving Social Security Administration (SSA) benefits or Railroad Retirement Board disability benefits for over 24 months, or;
- With End Stage Renal Disease (ESRD).

The Medicare program is administered by the federal Centers for Medicare and Medicaid Services (federal CMS), formerly known as the Health Care Financing Administration (HCFA). Medicare Part A provides coverage for hospital care, skilled nursing facility care, home health and hospice care. Medicare Part B provides coverage for physician/professional care, outpatient hospital care and other medical services.

Qualifying for Medicare

An individual can qualify for Medicare Part A based on their own work history or the work history of a former or current Spouse. If the Plan Participant is already receiving retirement benefits from SSA or the Railroad Retirement Board, Medicare will automatically enroll the Plan Participant in Medicare Parts A and B and send a Medicare card before the first day of the month they turn age 65. If the Plan Participant is not receiving retirement benefits from SSA or the Railroad Retirement Board, the individual should contact the local SSA office three months prior to turning age 65 to prevent a break in coverage.

Medicare Eligible Due to Age (65 and Over)

Eligibility for Medicare benefits due to age begins when the Plan Participant turns age 65. All

retired Plan Participants eligible for premium free Medicare Part A, as well as Plan Participants actively employed without other group health coverage, must enroll in Medicare Part A when first eligible. The purchase of Medicare Part B is not required. However, all Plan Participants that are enrolled in Medicare Part A and Medicare Part B qualify for the substantially lower Medicare primary premium. Once a Plan Participant enrolls in Medicare Part A and chooses to enroll in Part B, failure to remain enrolled in Medicare Part B will result in the collection of the higher premium. Also Plan Participants that terminate Part B coverage will be subject to claim adjustments by the claims administrator for any claims paid at the incorrect benefit level. If Medicare Part B is not purchased at age 65 and the Plan Participant chooses to enroll in Medicare Part B at a later date, the SSA will impose a 10% penalty for each year it was not purchased.

Medicare Eligible Due to Disability (Under Age 65)

Plan Participants under the age of 65 and receiving SSA benefits or Railroad Retirement Board disability benefits will automatically be enrolled in Medicare Parts A and B after 24 months. If the Plan Participant does not remain enrolled in Medicare Part B, the Plan Participant will pay the higher premium. Also Plan Participants that terminate their Part B coverage will be subject to claim adjustments by the claims administrator for any claims paid at the incorrect benefit level. The lower Medicare primary premium is only available when the Plan Participant is enrolled in Medicare Parts A and B.

Medicare Eligible Due to End Stage Renal Disease (ESRD)

Plan Participants of any age may qualify for premium-free Medicare Part A due to ESRD. Application for premium-free Medicare Part A is

required when a Plan Participant is receiving dialysis treatment for ESRD or placed on a transplant waiting list. To make application for Medicare benefits due to ESRD, the Plan Participant must contact their local SSA office. If it is determined by SSA that a Plan Participant qualifies for premium-free Medicare Part A, the Plan Participant must enroll.

Medicare Ineligible (Any Age)

If the Plan Participant is ineligible for premium-free Medicare Part A, they must provide written certification from the SSA that they are ineligible based on their work history or the work history of any current or former Spouse. The certification for the Plan Participant must be submitted to TRS.

Medicare Coordination with the Teacher's Choice Health Plan (TCHP)

When Medicare is primary, TCHP will coordinate benefits with Medicare as follows:

Part A - Hospital Insurance

After Medicare Part A pays, TCHP pays:

- All but \$50.00 of the Medicare Part A Deductible.
- Skilled nursing in a skilled nursing facility, extended care facility or nursing home are limited to 100 days each plan year.
- Hospital and Skilled Extended Care Facility stays beyond the maximum days allowed under Medicare, provided that the care satisfies the TCHP criteria of Medical Necessity and skilled care.
- All Medicare reserve days must be used before TCHP will pay as primary.

Part B - Medical Insurance

After Medicare Part B pays, TCHP pays:

- All of the Medicare Part B Deductible.
- Medicare Part B Coinsurance.

If services and supplies are not covered by Medicare:

- TCHP pays standard benefits for services and supplies (if they meet Medical Necessity and benefit criteria and would normally be covered) as if the Plan Participant does not have Medicare. The annual TCHP deductible applies. A denial of Medicare benefits must accompany the claim.

NOTE: If the Provider accepts Medicare assignment, TCHP pays the 20% of the approved charges which Medicare does not cover. If the Provider does not accept Medicare assignment and/or no private contract has been signed, TCHP pays all amounts Medicare does not cover, up to the maximum limiting charges set forth by Medicare.

Medicare Crossover

Medicare will automatically and electronically forward only processed Part B claim(s) to the Plan Administrator. This is known as "Medicare Crossover." In order to set up Medicare Crossover, the Plan Participant must contact the Health Plan Administrator and provide the Medicare Health Insurance Number (HICN). This is the number on the Medicare card. Once Medicare Crossover has begun, the Plan Administrator will receive claim determination information directly from Medicare and process only Medicare Part B Claims according to Plan provisions. Medicare Crossover applies to Plan Participants that have Medicare Part B coverage.

Medicare Part A claims must continue to be submitted with the Remittance Notice to the Plan Administrator.

NOTE: Questions regarding Medicare Crossover should be directed to the Health Plan Administrator. Questions regarding eligibility or enrollment in Medicare should be directed to the Plan Participant's local SSA office.

Medicare Part D

Medicare Part D is part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Any updates to Medicare Part D, as it specifically applies to pharmacy coverage for Plan Participants, will be communicated in the Benefit Choice Options booklet and on the Benefits website.

Qualifications for Medicare Part D

All individuals eligible for Medicare Part A and/or Part B due to age, disability or End Stage Renal Disease (ESRD) are eligible for the Medicare Part D benefit.

Notice of Creditable Coverage

The Notice of Creditable Coverage is a document that is intended to advise Medicare beneficiaries whether Prescription Drug coverage through the Program is creditable, meaning that coverage is the same or better than the Medicare Part D benefit. This Notice of Creditable Coverage prevents Plan Participants from being penalized if enrolling in Medicare Part D at a later date. The Notice of Creditable Coverage will be provided in the Benefit Choice Options booklet.

COBRA & Medicare

Refer to the COBRA section in this Chapter.

Notes

Subrogation and Reimbursement

Overview

The Program will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. The Program also does not provide benefits to the extent that there is other coverage under non-group medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

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

- In the event of any payment, the Program 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 Program and/or any representatives of the Program in completing such documents and in providing such information relating to any accident as the Program by its representatives may deem necessary to fully investigate the incident. The Program 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 Program 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 Program.
- The Program, 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 Program 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 tort-feasor or any insurance company on behalf of a third party tort-feasor or any other payments on behalf of a third party tort-feasor.
 - 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 Dependent Beneficiary understand and agree that the Program 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 Dependent Beneficiary are conditional upon the Program'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 tort-feasor or other person or entity to any minor Dependent Beneficiary of the adult covered person without the express prior written consent of the Program. In the event any minor Dependent Beneficiary is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the Program of the existence of any claim on behalf of the minor Dependent Beneficiary against the third party tort-feasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any Claim against the third party tort-feasors responsible for the injuries to the minor Dependent Beneficiary, to either assign any right to collect medical expenses from any tort-feasor or other person or entity to the Program, or at their election, to prosecute a Claim for medical expenses on behalf of the Program.

- In default of any obligation hereunder by the adult covered persons/parents, the Program 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 Program.
- The Program'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 Program's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No covered person under the Program shall incur any expenses on behalf of the Program in pursuit of the Program's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the Program's recovery without the prior express written consent of the Program. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- The Program 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 Program 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 Program 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.

Overview

Under TRIP there are formal procedures to follow in order to file an appeal of a Claim determination. The Plan Administrator's internal appeal process must be followed through all available levels. **A Plan Participant who believes an error has been made in the benefit amount allowed or disallowed must follow appeal procedures outlined below.**

Appeal Process for Managed Care Health Plans

The Department of Central Management Services (Department) does not have the authority to review or process managed care health plan appeals.

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.

Appeal Process for Teachers' Choice Health Plan (TCHP) and Self-funded Managed Care Plans

There are two separate categories of appeals: medical and administrative. **Medical appeals** pertain to denials determined by the Plan Administrator to be based on lack of Medical Necessity. **Administrative appeals** pertain to denials based on Plan design and/or Plan Exclusions and Limitations. The Plan Administrator determines the category of appeal.

The Plan Administrator's internal review

process must be used to the fullest extent prior to filing an appeal with the Department. The Plan Participant will receive written notification regarding their appeal rights from the Plan Administrator.

1. Initial Appeal to the Plan Administrator

Appeals must be initiated with the appropriate Plan Administrator within 180 days of the denial of the initial claim determination. The Plan Administrator will be able to provide more information regarding the denial. In some cases, additional information such as an operative report or x-ray may be required to determine if additional benefits are available. In some cases, a special review by a Physician or dentist may be warranted. Each case will be reviewed and considered on its own merits.

2. Appeal of the Plan Administrator's Decision to DCMS Group Insurance Division

If, after exhausting every available level of review by the Plan Administrator, the Plan Participant still feels that the denial by the Plan Administrator is not in accordance with the published benefit coverage, the Plan Participant may exercise the following procedures for both **Medical Necessity** and **Administrative appeals**.

For an appeal to be considered by DCMS Group Insurance Division, the Plan Participant must appeal the Plan Administrator's denial in writing within 60 days of the Plan Administrator's written notification.

Submit Appeal Documentation to:

**DCMS Group Insurance Division
201 E. Madison Street, Suite 1C
P.O. Box 19208
Springfield, IL 62794-9208**

The Group Insurance Division will determine if the Plan Administrator has appropriately followed the Medical Necessity and/or Plan guidelines.

- **Medical Necessity appeals** must be accompanied by all documentation supporting the reconsideration of the benefit determination.
- **Administrative appeals** are based on Plan Exclusions and Limitations and Plan design. For Administrative appeals, the DCMS Group Insurance Division's Final Determination is final and binding on all parties.

3. For Medical Necessity Appeals Only; Final Review by DCMS Appeal Committee

If the Plan Participant is not in agreement with the decision made by the Department, with respect to Medical Necessity, the Plan Participant may initiate one additional step of the appeal process. An appeal committee appointed by the Director will review whether the Plan Administrator has appropriately followed the Medical Necessity determination procedure and all Plan guidelines.

- The Plan Participant must submit a written request to the appeal committee within 60 days of the final determination by the Department.
- The appeal committee will review the documentation presented in the appeal to the Department.
- The appeal committee will consider the merits of each individual case. If new information is presented during the final determination, the appeal will be returned to the Department for further review and reconsideration.

- Plan Participants will be notified in writing of the outcome of the appeal committee's review. The decision of the appeal committee shall be final and binding on all parties.

Submit Appeal Documentation to:

**DCMS Benefits Deputy Director
Group Insurance Division
201 E. Madison Street, Suite 3A
P.O. Box 19208
Springfield, IL 62794-9208**

Chapter 3

Teachers' Choice Health Plan

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Teachers' Choice Health Plan (TCHP) Overview

The Teachers' Choice Health Plan (TCHP) is a traditional indemnity plan which offers a comprehensive range of benefits. Under TCHP, Plan Participants choose any Physician or Hospital for general or specialty medical services, and receive enhanced benefits by using Preferred Provider Organization (PPO) Hospitals, Physicians and Providers, network pharmacies for Prescription Drugs and behavioral health Providers.

Plan Components

- TCHP is comprised of three independent components:
 - Medical.
 - Prescription Drugs.
 - Behavioral Health Services.

The coverage for Prescription Drugs and behavioral health services operates independently of medical benefits. It is not necessary to satisfy the Plan Year Deductible in order to start receiving benefits for Prescription Drugs or behavioral health services. The Prescription Drugs and behavioral health services are not subject to Out-of-Pocket Maximums; however, charges accumulated under these programs do apply toward the lifetime maximum. Each of these three components is discussed separately in this chapter. Each component has its own Plan Administrator.

Plan Features

Plan Participant Responsibilities

- **The Plan Participant is always responsible for:**
 - Any amount required to meet **Plan Year Deductibles, Special Deductibles** and **Coinsurance** amounts.
 - Any amount over the **Usual & Customary (U&C)** charge.

- 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.

Plan Year Deductible

The Plan Year Deductible must first be satisfied before benefits begin. This Deductible requirement applies to all services unless otherwise noted in this section. The Plan Year Deductible also applies toward satisfying the Out-of-Pocket Maximums.

To verify the Plan Year Deductible, review the current Benefit Choice Options booklet. Each Plan Year begins on July 1.

The annual Deductible in force at the time of termination of eligibility under TCHP remains in force for those who elect continuation of coverage under COBRA.

Special Deductibles

In addition to the Plan Year Deductible, Plan Participants must pay a Special Deductible for each emergency room visit that does not result in a Hospital Admission. A Special Deductible will also apply for each Admission to a non-PPO Hospital. Special Deductibles are waived for Admission to a PPO Hospital or for medically necessary transfers.

Special Deductibles accumulate toward the annual Out-of-Pocket Maximum, but do not apply to the Plan Year Deductible.

Coinsurance

After the annual Plan Year Deductible has been met, the Plan generally pays most of the cost of services or supplies; but Plan Participants must pay a percentage, called Coinsurance, of Eligible Charges.

Once the Out-of-Pocket Maximum expenses are met, the Plan pays 100% of all Eligible Charges. This protects Plan Participants from catastrophic medical expenses.

Annual Out-of-Pocket Maximum Expenses

The amounts paid toward Deductibles and eligible Coinsurance accumulate toward satisfying the annual Out-of-Pocket Maximum.

After the maximum has been met, Coinsurance amounts are no longer required and the Plan pays 100% of Eligible Charges for the remainder of the Plan Year.

There are two separate Out-of-Pocket Maximums: a general one and one for non-PPO charges. Coinsurance and Deductibles apply toward one or the other, but not both.

Lifetime Maximum

There is a \$2,000,000 lifetime maximum.

Eligible Charges

- **TCHP provides benefits for Eligible Charges for those Covered Services and supplies which are:**
 - Medically necessary.
 - Based on U&C charges.

Medical Necessity

- **TCHP covers charges for services and supplies that are medically necessary. Medically necessary services or 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.
- Unable to be safely provided in an outpatient setting due to the patient's medical symptoms, condition, diagnosis or treatment.
- Not redundant when combined with other treatment being rendered.

Pre-Determination of Benefits

Pre-determination is a method to ensure 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 pre-determination of benefits, contact the Plan Administrator.

Precise claim payment amounts can only be determined upon receipt of the itemized bill. Benefits are based on the Plan Participant's eligibility and Plan provisions in effect at the time services are rendered. Standard Claim Payment policies include, but are not limited to, multiple procedure reductions and U&C charges. Claim bundling/unbundling procedures will be applied to only services eligible for coverage under the Plan.

Usual and Customary (U&C) Charges

U&C is an amount determined by the Plan Administrator not to exceed the general level of amounts charged by Providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition.

The Plan Participant is responsible for the portion of the expense that is above U&C. Amounts in excess of U&C are not Eligible Charges and are not applicable to Plan Year Deductible or Out-of-Pocket Maximum.

IMPORTANT: The percentage of the claim that will be paid is always based on the U&C amount or the actual charge made by the Provider, whichever is less.

Preferred Provider Organization (PPO) Network

The TCHP PPO Network includes Hospitals and Physicians throughout Illinois as well as nationwide. The network is subject to change. PPOs provide quality inpatient and outpatient care at reduced rates, which result in savings to Plan Participants. Costs can be significantly reduced by using a PPO.

Exceptions to the PPO Hospital Network

If a Plan Participant resides within 25 miles of a PPO Hospital, but requires emergency or specialized care not available at the PPO facility, an exception to the non-PPO rate of 60% may be requested. Upon request, the Notification Administrator will evaluate the case, and when appropriate, authorize an exception to utilize a non-PPO Hospital. When an exception is granted, the benefit is 70% of U&C. If an exception is not granted, the non-PPO benefit level of 60% of U&C applies.

If a Plan Participant voluntarily chooses to travel more than 25 miles and a PPO Hospital is available within the same travel distance, a PPO Hospital must be used or the 60% benefit level will apply.

Any Hospital may be used for Inpatient or Outpatient Services, but enhanced benefits are only available if services are provided at a PPO network Hospital.

Medical Case Management

The Medical Case Management (MCM) Program is designed to assist the Plan Participant requiring complex care in times of serious or prolonged illness.

If a Plan Participant is confronted with such an illness, a case manager will help find appropriate treatment to ensure optimum benefits under the Plan. Participation in MCM has proven to enhance benefits based on an evaluation of the individual's needs. MCM is part of the benefits under TCHP. There is no cost to the Plan Participant for this service.

The referral to the MCM Program is made through either the MCM Administrator, the TCHP Plan Administrator or by request from a Plan Participant. The case manager serves as a liaison and facilitator between the patient, family, Physician and other healthcare Providers. This case manager is a Registered Nurse or other health care professional with extensive clinical background. The case manager can effectively minimize the fragmentation of care so often encountered within the health care delivery system in response to complex cases.

Upon completing the MCM review, the case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. **Refusal to**

participate in the MCM Program will result in a reduction of benefits available under the Plan for treatment of the illness for which the Plan Participant was referred to MCM.

To reach the MCM Administrator, call the toll-free number listed in the Plan Administrator section of the current Benefit Choice Options booklet.

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of upcoming behavioral health services, Surgery, outpatient procedure or Admission to a facility such as a Hospital or extended care facility. Notification is the Plan Participant's responsibility to avoid penalties and maximize benefits. Notification is required for all Plan Participants including those with Medicare or other insurance as primary payer. If the medical service is approved for benefits by the Notification Administrator, an authorization number will be assigned and a written communication sent to the provider of care and the Plan Participant.

- **If using a PPO provider**, the medical provider is responsible for contacting the Notification Administrator on behalf of the Plan Participant.
- **If using a non-PPO provider**, the Plan Participant is responsible for contacting the Notification Administrator prior to receiving services. Plan Participants who receive services from a non-PPO provider and fail to call the Notification Administrator prior to having the services performed, may have a financial penalty imposed and risk incurring non-covered charges for services not deemed to be medically necessary.

The Plan Participant must direct their medical Provider to contact the Notification Administrator to provide specific medical information, the setting and anticipated initial length of stay for medical appropriateness.

■ Notification is required for the following:

- **Outpatient Surgery & Procedures**
Outpatient surgery and procedures including items such as imaging (MRI, PET, SPECT and CAT Scan), physical occupational or speech therapy, foot orthotics, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, breast reduction/enlargement, select injectible drugs, treatment for varicose veins, etc.) services must be authorized before having any services performed. **The procedures requiring Notification are subject to change.** Contact the Notification Administrator for the most up-to-date list of procedures requiring Notification.
- **Any Elective Inpatient Surgery or Non-Emergency Admission**
The Hospital Admission and length of stay must be authorized before entering the facility for elective inpatient surgery or non-emergency admission.
- **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission**
A review of the care being rendered will be conducted by the Notification Administrator to determine if the services are skilled in nature.
- **Emergency or Urgent Admission**
The Notification Administrator must be contacted within 48 hours of an emergency or urgent Admission.
- **Hospice Admission**
The Notification Administrator must be contacted prior to the Hospice Admission.
- **High-Risk Pregnancy or inpatient maternity admission in excess of 48 hours for a vaginal delivery or 96 hours for a C-section delivery.**

The Notification Administrator must be contacted for high-risk pregnancies or maternity admissions that exceed 48 hours for a vaginal delivery or 96 hours for a C-section delivery.

– **Potential Transplants**

Potential transplant candidates should provide Notification at the first indication of their status to receive benefits under the Plan. Benefits are only available through the Transplant PPO (TPPO) network of Hospitals/facilities.

■ **Notification is Not:**

- **A final determination of Medical Necessity.** Health conditions and need for treatment can change quickly. 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 were ineligible.
- **Enrollment of a newborn for coverage.** The Plan Participant must contact TRS to enroll a newborn within 31 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.

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, 24 hours a day.

NOTE: For Notification procedures and time limits for Behavioral Health Services, see the Behavioral Health Services 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 generally accepted medically necessary services usually rendered within the United States.

All Plan benefits are subject to Plan provisions and Deductibles. The benefit for facilities is 70% of U&C and Professional charges are paid at 80% of U&C. Notification is not required for medically necessary services rendered outside of the United States.

Payment for the services will most likely be required from the Plan Participant at the time of services. 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 dollar amount 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.

In general, Medicare will not pay for health care obtained outside the United States and its territories. If Medicare is primary, include the Explanation of Medicare Benefits (EOMB) denying payment, along with the Claim form and send to the Plan Administrator.

TCHP - Plan Year Deductibles and Out-of-Pocket Maximums

TCHP Plan Year Deductibles and Maximums	
The benefits described in this summary represent the major areas of coverage under TCHP. The most current Plan information will appear each year in the current Benefit Choice Options booklet. The Plan Year is July 1 through June 30.	
Plan Year Deductible	Consult the most current Benefit Choice Options booklet for Plan Year Deductible information for all Plan Participants.
Special Deductibles	Each emergency room visit
Note: These deductibles are in addition to the Plan Year Deductible.	Non-PPO Hospital Admission Transplant Deductible Note: There is no additional Deductible for Admission to a PPO Hospital.
Lifetime Maximum	\$2,000,000

TCHP Out-Of-Pocket Maximums	
There are two separate Out-of-Pocket Maximums: a general one and one for non-PPO charges. Coinsurance and Deductibles listed below count toward one or the other, but not both.	
General Out-of-Pocket Maximum: Per Plan Year, Per Individual	Non-PPO Out-of-Pocket Maximum: Per Plan Year, Per Individual
Plan Year Deductible	Non-PPO Hospital Deductible
Professional & Physician Coinsurance	Non-PPO Inpatient Coinsurance
PPO Inpatient and Outpatient Facility Coinsurance	Non-PPO Outpatient Facility Coinsurance
Ambulatory Surgical Facility	
Transplant Deductible	
Transplant Inpatient and Outpatient Coinsurance	
Standard* Hospital Coinsurance	
Standard* Hospital Admission Deductible	
All Emergency Room Deductibles	
* Applies when the Notification Administrator grants an exception for a non-PPO Admission, or when the Plan Participant does not reside within 25 miles of a PPO Hospital.	
The following do NOT apply toward Out-of-Pocket Maximums:	
<ul style="list-style-type: none"> ı Prescription Drug benefits; Coinsurance or Co-payments. ı Behavioral Health Coinsurance or Co-payments. ı Ineligible charges (amounts over U&C and charges for non-covered services). ı The portion (\$50) of the Medicare Part A Deductible the Plan Participant is responsible to pay. 	

Notes

TCHP - Medical Benefits Summary

This section contains a brief overview of some of the benefits available under the Teachers' Choice Health Plan (TCHP). Contact the Plan Administrator for more information or coverage requirements and/or limitations.

Allergy Injections

- Allergy testing is paid at 80% PPO or 60% of U&C non-PPO.
- 80% PPO or 60% of U&C non-PPO for injections and serum, provided the person has had recognized allergy testing to determine hypersensitivity and the need to be desensitized.

Ambulance

- 80% PPO or 80% of U&C non-PPO for 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.
- 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.

- Transportation exclusions include, but are not limited to:
 - Transportation that is not medically necessary.
 - Transportation between health care facilities for preference or convenience.
 - Transportation of patient for office or other outpatient visit.

Blood/Blood Plasma

- 80% PPO or 60% of U&C non-PPO for blood and blood plasma in excess of the first 3 pints in a Plan Year.

Breast Implant Removal and Reimplantation

- Coverage for removal or implantation only when medically necessary and not cosmetic in nature.
- Coverage for reimplantation only when initial implant was medically necessary.

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.

- Two mastectomy bras are covered at 80% PPO or 60% of U&C non-PPO following surgery or a change in prosthesis.

Cardiac Rehabilitation

- 80% PPO or 80% of U&C non-PPO for Phase I and Phase II, when ordered by a Physician.
- Medical Necessity must be determined if cardiac rehabilitation is to be considered a Covered Service and services must be provided in a medical facility approved by the Plan Administrator.

Chiropractic Services

- 80% PPO or 60% of U&C non-PPO.
- No coverage for chiropractic services considered to be maintenance in nature. Medical information must document progress in the improvement of the condition.
- The Plan will cover a maximum of \$1000 per plan year for care rendered by a chiropractic provider.

Christian Science Practitioner

- 80% PPO or 60% of U&C non-PPO of charges for the services of:
 - Christian Science Practitioner. See Glossary.
 - Christian Science Nurse. See Glossary.
 - Plan Participant must exhibit sign of illness or injury.

Circumcision

- 80% PPO or 60% of U&C non-PPO for professional services.
- Charges for circumcision are considered to be Covered Services, when billed as a separate

Claim for the newborn, if performed within the first thirty (30) days following birth and if the newborn is enrolled in the Plan.

- Charges for circumcision performed beyond the 30-day time frame are considered to be Covered Services only when Medical Necessity is documented.

Colonoscopy and Sigmoidoscopy

- 80% PPO or 60% of U&C non-PPO and subject to Plan Deductible.

Dental Services

- **Accidental Injury:**
 - 80% PPO or 60% of U&C non-PPO 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 3 months of original accidental injury. The appropriate facility benefit applies.
- **Non-Accidental:**
 - 80% PPO or 60% of U&C non-PPO for 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 indemnity plan.**
 - Chronic Disability
- Dental exclusions include, but are not limited to:
 - Services and appliances related to the diagnosis or treatment of

Temporomandibular Joint Disorder or Syndrome (TMJ) and other myofunctional disorders.

- Internal accidental injury to the mouth caused by biting on a foreign object.
- Outpatient Services for routine dental care.

Diabetic Coverage

- For Dietitian Services and Consultation:
 - 80% PPO or 60% of U&C non-PPO when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.
- For routine foot care by a Physician:
 - 80% PPO or 60% of U&C non-PPO when diagnosed with diabetes.
- For insulin pumps and related supplies:
 - 80% PPO or 60% of U&C non-PPO when deemed medically necessary.

Dialysis

- Hemodialysis and Peritoneal Dialysis.
- 80% PPO or 60% of U&C non-PPO.

Durable Medical Equipment (DME)

- **Short-term Rental:**
 - 80% PPO or 60% of U&C non-PPO 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:**
 - 80% PPO or 60% of U&C non-PPO 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.
 - Items viewed as convenience items such as exercise equipment and non-Hospital type adjustable beds.
 - Similar or redundant equipment purchased for patient's convenience.
 - Environmental items such as air conditioners, humidifiers, dehumidifiers or purifiers.
- 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

Emergency Services are those services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries that, in the opinion of a prudent layperson, might result in permanent disability or death if not treated immediately. **The facility in which emergency treatment is rendered and the level of care determines the benefit level (Hospital, urgent care center, Physician office).**

- **Emergency Room:**
 - 80% PPO or 80% of U&C non-PPO after the special emergency room Deductible. The Deductible applies to each visit to an emergency room which does not result in an inpatient Admission.

■ Physician's Office:

- 100% PPO or 100% of U&C non-PPO; 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. Non-emergency medically necessary care is considered at 80% PPO or 60% of U&C non-PPO.

■ Urgent Care or Similar Facility:

- 100% PPO or 80% of U&C at non-PPO; 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 are not covered when services are performed in a Physician's office or urgent care centers. Non-emergency medically necessary care is considered at 80% PPO or 60% of U&C non-PPO.

Eye Care

- 80% PPO or 60% of U&C non-PPO for treatment of injury or illness to eye.
 - First pair of eye glasses covered after cataract Surgery.
 - One refractive exam, pre- and post-cataract Surgery.

Foot Orthotics

- 80% PPO or 60% of U&C non-PPO.
- Subject to Medical Necessity and ordered by a Physician or podiatrist.
- Must be custom molded or fitted to the foot.

Hearing Services

- 80% PPO or 60% of U&C non-PPO for Professional Services for the hearing exam associated with the care and treatment of an injury or an illness.
- Hearing aids and associated costs, including the exam and evaluation for the purpose of screening and obtaining a hearing aid, are not covered.

Home Health Care Services

See Skilled Nursing Service - Home Setting

Hospice

- 80% PPO or 80% of U&C non-PPO. Written Notification of terminal condition (i.e., life expectancy of one year or less) is required from the attending Physician.
- Must be approved by the Plan Administrator as meeting established standards including any legal licensing requirements.
- Inpatient Hospice requires Notification. See Notification requirements in this section.

Infertility Treatment

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

- Pre-determination of Benefits:
 - A written pre-determination of benefits must be obtained from the Medical 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, In Vitro 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: In Vitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.
 - 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.
- Benefit Level:
 - The appropriate benefit level will apply (i.e., Physician charges are covered at 80% PPO or 60% of U&C at non-PPO; lab and x-ray are covered at 80% PPO or 80% of U&C non-PPO).
- Infertility treatment exclusions include, but are not limited to:
 - Medical or non-medical costs of anyone NOT covered under the Plan.
 - Non-medical 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, cryo-preservation 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.

Infusion Therapies

- 80% PPO or 60% of U&C non-PPO.
- Coverage includes chemotherapy and other intravenous drugs/agents in a home or Physician office setting.

- Medical Necessity must be determined by the MCM Administrator in order for therapy to be considered a covered expense.
 - Infusion therapy must be under the supervision of a Physician.
- Covered expenses include, but are not limited to:
 - Medication and intravenous solution.
 - Equipment rental and supplies such as infusion sets, syringes and heparin.

Inpatient Hospital/Facility Services, including Surgery

- 80% at PPO Hospital/facility.
- 70% of U&C if residence is not within 25 miles of a PPO Hospital/facility, when approved by the Notification Administrator.
- 60% of U&C if residence is within 25 miles of a PPO Hospital but Plan Participant elects to use a non-PPO Hospital.
 - If residence is within 25 miles of a PPO Hospital, but emergency or specialized care is required which is not available at the PPO Hospital, an exception to the non-PPO rate of 60% may be requested. The Notification Administrator will evaluate the case and, when appropriate, may authorize an 70% of U&C benefit at a non-PPO Hospital.
 - 60% of U&C will apply if the Plan Participant voluntarily chooses to travel more than 25 miles and a PPO Hospital is available within the same travel distance.

- Inpatient hospitalization exclusions include, but are not limited to:
 - Holding charges (charges for days when the bed is not occupied by the patient).
 - Private room differential when private room is not medically necessary.
 - Nursing charges if billed separately.
 - Personal convenience items such as guest meals, television rental, admission kits and telephone charges.
 - Services not related to or necessary for the care and treatment of an illness or injury.

NOTE: Failure to provide Notification of an upcoming Admission or Surgery will result in a financial penalty and no coverage for services not deemed to be medically necessary. See the current Benefit Choice Options booklet for penalty amount. Also, see Notification Requirements in this section.

Lab and X-ray

- Outpatient:
 - 80% PPO or 80% of U&C non-PPO at a Physician's office, Hospital, clinic or urgent care center.
- Inpatient:
 - If billed by a Hospital as part a Hospital confinement, paid at the appropriate Hospital benefit level.
- Professional charges:
 - 80% of PPO or 60% of U&C non-PPO for professional charges associated with the interpretation of the lab or x-ray.

Medical Supplies

- 80% PPO or 60% of U&C non-PPO.
- Medical supplies include, but are not limited to ostomy supplies, surgical dressings and surgical stockings.

NOTE: This covers a wide range of supplies for all types of medical conditions. However, the requirement for any supply must be determined to be medically necessary for the diagnosed condition.

- Medical supply exclusions include, but are not limited to:
 - Personal convenience items, such as diapers.
 - Supplies that are not medically necessary for the diagnosed illness or injury.
 - Appliances for temporomandibular joint disorder or syndrome (TMJ), myofunctional disorders or other orthodontic therapy.

Morbid Obesity Treatment

- 80% PPO or 60% of U&C non-PPO for Professional Services.
- Obesity Surgery is eligible for coverage dependent on Medical Necessity and pre-determination of benefits.

Newborn Care

- 80% PPO or 60% of U&C non-PPO for Professional Services in an office or Hospital setting. Refer to benefit levels listed under 'Inpatient Hospital Facility/Services Including Surgery'.

- Benefits are available for newborn care only if the Dependent is enrolled no later than 31 days following the birth.
 - See Preventive Services in this section for well-baby/child care benefits and immunization schedule.

Nurse Practitioner

- 80% PPO or 60% of U&C non-PPO for Professional Services provided under the supervision of a Physician and billed by a Physician, Hospital, clinic or home health care agency.

Occupational Therapy/Physical Therapy

- 80% PPO or 60% of U&C non-PPO if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or Physician.
 - Must be medically necessary for the treatment of an illness or injury.
- Occupational therapy/physical therapy exclusions include, but are not limited to:
 - Therapy considered educational.
 - Therapy when improvement is no longer documented.

Outpatient Hospital/Facility Services, including Surgery

- 80% at a PPO Hospital/facility.
- 70% of U&C at a non-PPO Hospital/facility, if an exception to non-PPO benefits is granted by the Notification Administrator.
- 60% of U&C at a non-PPO Hospital/facility.
- 80% if performed at a PPO ambulatory surgical treatment center which is licensed by the Department of Public Health, or the

equivalent agency in other states, to perform outpatient Surgery.

- Surgical facility exclusions include, but are not limited to:
 - Facility charges for a Surgery performed in or billed by a Physician’s office or clinic.
 - Facility charges for a Surgery or procedure which is NOT covered.

Physician Services

- 80% PPO or 60% of U&C non-PPO for medical treatment of an injury or illness.
 - Physician charges associated with services not eligible for coverage are excluded.

Physician Services – Surgical

- Inpatient Surgery:
 - 80% PPO or 60% of U&C non-PPO for Physician services.
Follow-up care by the surgeon is considered part of the cost of the surgical procedure. It is NOT covered as a separate charge.
- Outpatient Surgery:
 - 80% PPO or 60% of U&C non-PPO for Physician services. 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 Surgery is 80% or 60% of U&C non-PPO and is limited to the following:
 - An accidental injury.
 - Congenital deformities that are evident in infancy.
 - Reconstructive mammoplasty following a mastectomy when medically indicated.
- Assistant surgeon:
 - A payable assistant surgeon is a Physician who assists the surgeon, subject to Medical Necessity.
 - Up to 20% of U&C of Eligible Charges billed by the surgeon.
- Multiple surgical procedures:
 - Standard guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
 - 80% PPO or 60% of U&C non-PPO for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the Plan Administrator for a pre-determination of benefits.
- Surgical exclusions include, but are not limited to:
 - Abortion, induced miscarriage or induced premature birth, unless it is a Physician’s opinion that such procedures are necessary to preserve the life of the woman, or an induced premature birth is intended to produce a live, viable child and is necessary for the health of the woman or her unborn child.
 - Keratotomy or other refractive Surgeries.
 - Obesity Surgery unless medically necessary to treat morbid obesity (2 times normal body weight).

- Surgery not recommended, approved and performed by a Physician.

Podiatry Services

- 80% PPO or 60% of U&C non-PPO.
- Routine foot care is covered only with the diagnosis of diabetes.

Prescription Drugs

- 80% PPO or 60% non-PPO of the drug charges administered by a Physician and not obtained at a pharmacy.
- If purchased at a pharmacy or through the Prescription Drug Plan Administrator’s mail order pharmacy, the Prescription Drug Plan benefits apply. See Prescription Drug Coverage later in this Chapter.
- Prescription Drugs obtained as part of a Hospital stay are payable at the appropriate facility benefit level.

Prosthetic Appliances

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

- 80% PPO or 60% of U&C non-PPO 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 to be cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
- Experimental or investigational appliances.

Radiation Therapy

- 80% PPO or 60% of U&C non-PPO for radiation therapy ordered by a Physician in an outpatient setting.
- Appropriate facility benefit for inpatient stays.

Second Surgical Opinion

The Notification Administrator will determine the necessity of obtaining a Second Opinion for both inpatient and outpatient procedures.

- 80% PPO or 60% of U&C non-PPO if required by Notification Administrator. No Plan Year Deductible applies.
 - Contact the Notification Administrator who will determine if a second opinion for a procedure is required.
 - Failure to obtain a second opinion when required and proceeding with the procedure will result in a financial penalty.
- 80% PPO or 60% of U&C non-PPO (if not required by the Notification Administrator). Plan Year Deductible applies.

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

- 80% PPO or 80% of U&C non-PPO. 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 Notification/Medical Case Management Administrator.
- Limit of 100 days per plan year.
- Must be a licensed healthcare facility primarily engaged in providing skilled care.
- Notification is required at least 7 days prior to Admission or at time of transfer from an inpatient Hospital stay.
- 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 service must be medically necessary and ordered by a Physician.
- The continued coverage for Skilled Nursing Service will be determined by the review of medical records and nursing notes.
- Holding charges (charges for days when the bed is not occupied by the patient) are not covered.
- Prescription Drugs billed by a skilled nursing facility, extended care facility or nursing home will be submitted to the Medical 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.

Skilled Nursing Service – Home Setting

- 80% PPO or 60% of U&C non-PPO for eligible charges.
- Contact the Notification/Medical Case Management 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.

Speech Therapy

- 80% PPO or 60% of U&C non-PPO 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.

Sterilization

- **Tubal Ligation**
 - This is a Covered Service. See the Physician Services-Surgical section for appropriate benefit levels.
- **Vasectomy:**
 - This is a Covered Service. See the Physician Services-Surgical section for appropriate benefit levels.
- **Family planning exclusions include, but are not limited to:**
 - Charges for services relating to the reversal of sterilization.

Transplant – Organ and Tissue (Notification Required)

TCHP includes a Transplant Preferred Provider Organization (TPPO) Hospital network. **In order for any organ or bone marrow transplant to be covered under the Plan, one of the designated organ-specific TPPO Hospitals must be utilized.** The transplant candidate must contact the Notification/Medical Case Management 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 illness.

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 TPPO Hospital are covered at 80% of the contracted rate.

In some cases, transplants may be considered non-viable for some candidates, as determined by

the MCM 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 TPPO 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 Plan Participants from the same family and are both covered by the Plan, no Deductible or Coinsurance shall apply.

The TPPO Hospital network is subject to change throughout the year. Call the Notification/Medical Case Management Administrator for current TPPO Hospitals. Transplants are not covered by non-TPPO 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
201 E. Madison Street, Suite 1C
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

- 80% PPO or 60% of U&C non-PPO.

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. Facility charges are not covered when services are performed in a Physician's office or urgent care centers.

NOTE: See Emergency Services for medically necessary emergency care.

Overview

Routine services which do NOT require a diagnosis or treatment are often referred to as Preventive Services. There are limitations on the frequency and coverage for some Preventive Services.

Unless otherwise noted, Claims for Preventive Services are NOT subject to the Plan Year Deductible. Claims which indicate a diagnosis are not considered preventive and are subject to the Plan Year Deductible.

Only the Preventive Services listed below are covered under TCHP.

Covered Benefits – Adults

- **Colorectal Cancer Screening:**
 - 80% PPO or 60% of U&C non-PPO for sigmoidoscopy or colonoscopy once every 3 Plan Years for persons who are at least 50 years old.
 - 80% PPO or 60% of U&C non-PPO for sigmoidoscopy or colonoscopy once every 3 Plan Years for persons who are at least 30 years old and have a family history of colorectal cancer.
 - 100% of U&C for fecal occult blood testing once every 3 Plan Years for persons who are at least 50 years old or for persons at least 30 years old who have a family history of colorectal cancer.
 - 80% PPO or 60% of U&C non-PPO for professional charges associated with the interpretation of the screening.
- **Mammography:**
 - 100% PPO or 100% of U&C non-PPO.
 - One baseline mammogram for women age 30-39.
 - One mammogram per Plan Year for women age 40 and over.
 - 80% PPO or 60% of U&C non-PPO for professional charges associated with the interpretation of the test.
- **Pap/Cervical Smears:**
 - 100% PPO or 100% of U&C non-PPO for pap/cervical smear once per Plan Year.
 - 80% PPO or 60% of U&C non-PPO for office visit.
 - 80% PPO or 60% of U&C non-PPO for professional charges associated with the interpretation of the test.
- **Prostate Screening:**
 - 100% PPO or 100% of U&C non-PPO for prostate-specific antigen test for men age 40 and over once per Plan Year.
 - 80% PPO or 60% of U&C non-PPO for office visit for prostate exam.
 - 80% PPO or 60% of U&C non-PPO for professional charges associated with the interpretation of the screening.

Notes

Overview

Prescription Drug benefits are independent of other medical services and are not subject to the Plan Year Deductible; however, plan benefits are subject to the lifetime maximum amount. The Prescription Drug Plan includes both in-network and out-of-network benefits.

Most drugs purchased with a prescription from a Physician or Dentist are covered. Drugs that can be lawfully purchased without a prescription are not covered, except insulin. No over-the-counter drugs will be covered even if purchased with a prescription.

The Annual Prescription Out-of-Pocket

Maximum applies for In-Network Benefits and the Mail Service Program. Out-of-Network claims do not count towards this annual Out-of-Pocket Maximum. Ineligible expenses do not count toward the annual prescription Out-of-Pocket Maximum. Once the annual prescription Out-of-Pocket Maximum is reached the plan participant will have no responsibility for eligible prescription charges. The amount of this Out-of-Pocket Maximum may change. See the annual Benefit Choice Options booklet for the current amount of the annual prescription Out-of-Pocket Maximum.

A Preferred Drug List, also known as a Formulary, is a list of prescription medications that have been chosen because they are both clinically and cost effective to you and the Plan. The drugs selected for the Preferred Drug List have been carefully reviewed by a team of medical professionals and meet high standards for quality and effectiveness. Utilizing the Preferred Drug List helps control overall Plan costs and ensure a quality drug plan for all Plan Participants. For specific information regarding the Formulary program and the Formulary exception process, contact the Prescription Drug Plan Administrator.

After a review of the Preferred Drug List, you may wish to contact your Physician to determine if a change in your prescription is appropriate.

The Prior Authorization Program is designed to manage the use of a select list of medications that may have the potential for being prescribed for unapproved uses, improper dosage or exceeding the recommended drug therapy guidelines. 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 acceptable medical documentation to the Prescription Drug Plan Administrator for review. Once a prior authorization is in place, the prescription may be filled until the authorization expires.

Plan Coverage Information

Diabetic supplies and insulin are covered through the Prescription Drug Plan. In order for insulin and diabetic supplies to be a covered benefit under this Plan, they must be purchased with a prescription. Diabetic supplies are subject to the appropriate Co-payment.

Some diabetic supplies are also covered under Medicare Part B. If the Plan Participant is not Medicare Part B primary, the appropriate Co-payment must be paid at the time of purchase at network pharmacies. If Medicare Part B is primary, the Plan Participant is responsible for the Coinsurance payment at the time of purchase. The claim must first be submitted to Medicare for reimbursement. Upon receipt of the Explanation of Medicare Benefits (EOMB), a Claim may be filed with the Prescription Drug Plan Administrator for any secondary benefit due.

Insulin pumps and their related supplies are not covered under the Prescription Drug Plan. In order to receive coverage for these items, contact the Medical Case Management Administrator listed in the Plan Administrators section of the current Benefit Choice Options booklet.

Compound drugs are covered under the Prescription Drug Plan. Compound drugs purchased from a network pharmacy are subject to the applicable Co-payment. As these are unique medications, contact the Prescription Drug Plan Administrator immediately if the network pharmacy attempts to charge more than the appropriate Co-payment.

Injectables and intravenous medications may be obtained through a retail network pharmacy or through the Prescription Drug Plan Administrator 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.

Pre-packaged Prescriptions – A Co-payment or 20% Coinsurance with minimum and maximum amounts are based on a 1 to 30-day supply as prescribed by the Physician. Since manufacturers sometimes pre-package products in amounts that may be more or less than a 30-day supply as prescribed, more than one Co-payment may be required.

- **Example A** (more than a 30-day supply): Manufacturers commonly pre-package lancets in units of 100. If the 30-day prescription is for 90 units, two Co-payments are required, since the pre-packaged amount exceeds the 30-day supply as required by the prescription.

- **Example B** (less than a 30-day supply) Manufacturers commonly pre-package inhalers or tubes of ointment. Since the packaged medication may be less than a 30-day supply, more than one package unit may be required; therefore, more than one Co-payment will be required.

Prescribed medical supplies are supplies necessary for the administration of Prescription Drugs such as covered hypodermic needles and syringes. Co-payments/Coinsurance apply.

In-Network Benefits

The Pharmacy Network consists of retail pharmacies which accept the Co-payment/Coinsurance amount and electronically transmit the Prescription Drug Claim for processing. Refer to the current Benefit Choice Options booklet for information regarding Co-payment of Coinsurance minimum and maximum amounts.

When medication is purchased at an in-network pharmacy without presentation of the Prescription Drug Identification Card, you may be charged the full retail cost of the medication. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

There are thousands of pharmacies in the network nationwide, including independent community pharmacies. For the most up-to-date information on network pharmacies, call or go online to the Prescription Drug Plan Administrator. Contact information is available in the current Plan Administrators section of the Benefit Choice Options booklet. A link to the Prescription Drug Plan Administrator's website can be found by accessing the Benefits website located at www.benefitschoice.il.gov.

In-Network Benefit Summary:

- No Plan Year deductibles; no claim forms to file.
- Co-payments or 20% Coinsurance with minimum and maximum amounts apply. See current Benefit Choice Options booklet for applicable amounts.
- The maximum day supply available at one fill is a 60-day supply. The Co-payment/Coinsurance amount will double for a 31 - 60 day supply.
- Co-payment/Coinsurance for Prescription Drugs is separated into three different categories: generic, preferred brand, or non-preferred brand. Minimum and maximum Co-payment/Coinsurance amounts for each category are subject to change each Plan Year.
- When the pharmacy dispenses a brand drug for any reason and a generic is available, the Plan Participant must pay the cost difference between the brand product and the generic product, plus the generic Co-payment/Coinsurance amount.
- If no generic is available, the appropriate preferred brand or non-preferred brand Co-payment or minimum and maximum Coinsurance will apply.

Mail Order Pharmacy

The mail order pharmacy provides up to a 90-day supply of medication only. The Co-payment and/or minimum and maximum Coinsurance amounts double for a 90-day supply of medication at mail order. There is a savings by utilizing mail order; the Plan Participant will receive a three-month supply at two Co-payment/Coinsurance amounts. See the current Benefit Choice Options booklet for Co-payments and minimum and maximum Coinsurance amounts for each category. To

receive a discounted 61 to 90-day supply of medication, obtain an original prescription from the attending physician written for a 61 to 90-day supply, plus up to three 90-day refills, totaling one year of medication. Complete the mail order form; attach the original prescription and mail to the Prescription Drug Plan Administrator’s mail order pharmacy. The mail order form can be found on the plan administrator’s website listed in the annual Benefit Choice booklet.

Out-of-Network Benefit

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand and generic in-network rate minus the appropriate **in-network** Co-payment/Coinsurance amount. In most cases, the cost of the Prescription Drugs will be higher when not using in-network pharmacies; therefore reimbursement will be lower. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from the Prescription Drug Plan Administrator) and the original prescription receipt. Out-of-network claims do not count toward the annual prescription Out-of-Pocket Maximum.

Coordination of Benefits

This Plan coordinates with Medicare Part B and other group plans.

Exclusions

The Plan reserves the right to exclude or limit coverage of specific Prescription Drugs or supplies.

Notes

TCHP - Behavioral Health Services

Overview

Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are administered through the Behavioral Health Plan Administrator. See the current Benefit Choice Options booklet for Behavioral Health Plan Administrator information.

Pre-existing Conditions do not apply and it is not necessary to satisfy the Plan Year Deductible in order to start receiving benefits for behavioral health services; however, plan benefits are subject to the lifetime maximum amount. Coinsurance or Co-payments do not apply toward the medical Out-of-Pocket Maximums. Eligible Charges are for those services deemed medically necessary by the Behavioral Health Plan Administrator.

Contact the Behavioral Health Plan Administrator for a listing of in-network Hospital facilities and participating Providers.

Authorization for Services

Calling the Behavioral Health Plan Administrator begins the Authorization process for services with all levels of care to avoid penalties or non-authorization of benefits. In an emergency or a life threatening situation, call 911, or go to the nearest Hospital emergency room. Call the Behavioral Health Plan Administrator as soon as possible (must be within 48 hours) to avoid a financial penalty.

A licensed behavioral health professional will conduct a review to determine if treatment meets Medical Necessity criteria and appropriateness of care. If treatment is Authorized, services are eligible for benefit coverage. Services determined not medically necessary will not be eligible for coverage.

- **Inpatient Services** must be Authorized prior to Admission or within 48 hours of an emergency Admission. 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.
- **Partial Hospitalization and Intensive Outpatient Treatment** must be Authorized prior to Admission. 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.
- **Outpatient Services** are authorized by calling for a referral and Authorization to an in-network Provider. Medically necessary Outpatient Services received without an Authorization will be subject to the out-of-network benefit.
- **Psychological testing** must be authorized to receive an in-network or out-of-network benefit.
- **Coordination of Benefits (COB)** general provisions are described in the section entitled COB. Medicare COB for behavioral health services is described below. Under all circumstances, notify the Behavioral Health Plan Administrator so that Medical Necessity can be determined and benefits applied accordingly.

Medicare COB for Behavioral Health Services

Medicare Part A

After Medicare Part A pays, the TCHP pays all but \$50 of the Medicare Part A Deductible.

Medicare Part B

Medicare Part B primary Plan Participants should always contact Medicare for a list of Medicare-approved Providers.

If the Provider is Medicare approved and accepts assignment, Medicare pays 50% of the Medicare-approved amount and the Plan pays:

- Any part of the annual Medicare Part B Deductible for which the Plan Participant is responsible at that time.
- The Plan Participant's Coinsurance.

If the Provider is Medicare approved, but does not accept assignment, Medicare pays 50% of the approved amount and the Plan pays:

- Any part of the annual Medicare Part B Deductible for which the Plan Participant is responsible at that time.
- The Plan Participant's Coinsurance and all amounts Medicare does not cover, up to the maximum limiting charges set by Medicare.

If the Provider is not Medicare approved, Medicare pays 0% and the Plan pays:

- 50% up to \$35 for Outpatient visits with a maximum of 50 visits per Plan Year for visits not Authorized by the Behavioral Health Plan Administrator, or
- 100% after a \$15 Co-payment for visits authorized.

Plan Participants who receive services from a Provider who is not Medicare approved must notify the Behavioral Health Plan Administrator to receive Authorization for in-network benefits.

Out-of-Area Benefits

If Plan Participants do not live within 25 miles of a PPO facility for Inpatient, Intensive Outpatient or Partial Hospitalization Treatment, the following benefits apply:

- Outpatient
 - Applicable in-network or out-of-network benefits are listed in the Benefit Summary Chart in this section.
- Inpatient
 - Plan Participant responsibility: 20% Coinsurance and \$50 Co-payment per day up to \$250 per Admission.
 - Plan coverage at non-PPO facilities is 60%.
 - Professional charges are reimbursed at the applicable in-network or out-of-network benefit level.
 - Plan Participant's Maximum Out-of-Pocket expense is \$1,500 per Plan Year.
- Partial Hospitalization and Intensive Outpatient Treatment
 - Plan Participant responsibility: 20% Coinsurance and \$25 Co-payment per day up to \$125 per Admission.
 - Plan coverage at non-PPO facilities is 80%.
 - Professional charges are reimbursed at the applicable in-network or out-of-network benefit level.
 - Plan Participant's Maximum Out-of-Pocket expense is \$1,500 per Plan Year.

Behavioral Health Services Benefit Summary

All behavioral health services are subject to Medical Necessity. Eligible Charges are for services that are deemed Medically Necessary by the Behavioral Health Plan Administrator.

	In-Network	Out-of-Network
Outpatient	100% coverage after \$15 Co-payment per visit.	50% coverage up to \$35 per visit; 50 visit maximum per Plan Year.*
Inpatient	<p>Plan coverage is 100% after Co-payment.</p> <p>Plan Participant responsibility: \$50 Co-payment per day up to \$275 per Admission.</p> <p>Professional charges: 100% coverage after \$15 Co-payment.**</p>	<p>Plan coverage at non-PPO facilities is 60%.</p> <p>Plan Participant responsibility: 40% Coinsurance plus \$50 Co-payment per day up to \$250 per Admission.</p> <p>Professional charges: 50% coverage up to \$35 per visit; 50 visits maximum per Plan Year.*</p>
Partial Hospitalization and Intensive Outpatient	<p>Plan coverage is 100% after Member Co-payment.</p> <p>Plan Participant responsibility: \$25 Co-payment per day up to \$125 per Admission.</p> <p>Professional charges: 100% coverage after \$15 Co-payment.**</p>	<p>Plan coverage at non-PPO facility is 60%.</p> <p>Plan Participant responsibility: 40% Coinsurance and \$25 Co-payment per day up to \$125 per Admission.</p> <p>Professional charges: 50% coverage up to \$35 per visit; 50 visits maximum per Plan Year.*</p>

*All Outpatient Services received at the out-of-network benefit level must be provided by a licensed professional including Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), Licensed Marriage and Family Therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.

**Out-of-network professional charges are covered at 50% up to \$35 per visit; 50 visit maximum per Plan Year.

Notes

TCHP - Exclusions and Limitations

Teachers' Choice Health Plan 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 Handbook 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 check-ups, employer-required check-ups, 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. When the charges for the services, Room and Board or supplies exceed U&C.
5. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, non-Hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps 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 (two times normal body weight), 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 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.

Participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.
16. 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.
17. For services rendered by a health care Provider specializing in behavioral health services who is a candidate in training.
18. For services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.
19. 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.
20. For the purchase of the first three pints of blood or blood plasma.
21. For services due to bodily injury or illness arising out of or in the course of a Plan
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 contacts) 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 (formerly HCFA).
30. For services rendered prior to the effective date of coverage under the Plan or subsequent to

the date coverage is terminated.

31. For hearing aids and associated costs including the exam and evaluation for the purpose of screening and obtaining a hearing aid, regardless of diagnosis.
32. For private duty nursing, skilled or unskilled, in a Hospital or facility where nursing services are normally provided by staff.
33. For services or care provided by an employer-sponsored health clinic or program.
34. Travel time and related expenses required by a Provider.
35. Facility charges when services are performed in a Physician's office or urgent care centers.
36. For residential treatment for behavioral health services.
37. Treatment for educational disorders relating to learning, motor skills, communication and pervasive developmental conditions.
38. Non-medical 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 non-medical ancillary services for learning disabilities or developmental delays.
39. For routine physical exams, immunizations, flu shots, acupuncture and smoking cessation programs.
40. For treatment of teeth or periodontium unless such expenses are incurred for:
 - a) charges made for a continuous course of dental treatment started within 3 months of an injury to sound natural teeth caused by an external force;
 - b) charges for inpatient room and board determined to be medically necessary by the Notification Administrator.
41. Expenses associated with legal fees.

Notes

TCHP - Claim Filing Deadlines and Procedures

The following procedures and deadlines pertain to the TCHP, Prescription Drug Plan and Behavioral Health Services. Utilization of network Providers usually eliminates the need to file paper claims; however, if an out-of-network Provider is utilized the procedures and deadlines must be followed. Contact the appropriate Plan Administrator with any questions about Covered Services, benefit levels or Claim Payments.

Claim Filing Deadlines

All Claims should be filed promptly. The Plans require that all Claims be filed no later than one year from the ending date of the Plan Year in which the charge was incurred.

Claims with Service Dates of:	Final Filing Date
Prior to July 1, 2005	No longer eligible
July 1, 2005 thru June 30, 2006	June 30, 2007
July 1, 2006 thru June 30, 2007	June 30, 2008
July 1, 2007 thru June 30, 2008	June 30, 2009
July 1, 2008 thru June 30, 2009	June 30, 2010

Claim Filing Procedures

All communication to the Plan Administrators must include the Member's Social Security Number (SSN) or Alternate Member Identifier (AMI) 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) from the other plan must also be attached to the Claim.

- The Plan Administrators 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 Benefit Recipient (not to any Dependent Beneficiaries), unless benefits have been assigned directly to the Provider of service.
- If benefits are assigned, the benefit check is 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.
- Claims are adjudicated using industry standard Claim processing software and criteria. Claims are reviewed for possible bundling and unbundling of services and charges. Providers may occasionally bill for services that are not allowed by the Claim review process.

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Chapter 4

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Notes

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 Program or Partial Hospitalization Program.

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

Authorization (as applies to Behavioral Health Services): 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 Benefit Recipients may change benefit coverage elections.

Benefit Recipient: An Annuitant or Survivor enrolled in the Program.

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.

Christian Science Nurse: 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.

Christian Science Practitioner: 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.

Chronic Pain: Pain that persists longer than the amount of time normally expected for healing.

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. All Claim Payments will be calculated on the basis of the Provider's Charge for Covered Services rendered.

Coinsurance: The percentage of the charges for eligible services for which the Plan Participant is responsible.

Contract (Plan) Year: July 1 through the following June 30 for the TCHP and most other plans.

Coordination of Benefit: A method of integrating benefits payable under more than one group insurance Plan.

Co-payment: A specific dollar amount the Plan Participant is required to pay for certain services covered by a Plan.

Covered Services: Services 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 Plan Participant 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 which Plan Participants must pay before benefits begin.

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

Dependent Beneficiary/Dependent: A person eligible for coverage as a Dependent of a Benefit Recipient.

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.

Eligible Charges: Charges for Covered Services and supplies which are medically necessary and based on Usual and Customary 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 a prudent layperson might result in permanent disability or death if not treated immediately.

Exclusions and Limitations: Services not covered under the Teachers' Retirement Insurance Program (TRIP) or services that are provided only with certain qualifications, conditions or limits.

Explanation of Benefits (EOB): A statement from a Plan Administrator explaining benefit determination.

Explanation of Medicare Benefits (EOMB): A statement from Medicare explaining benefit determination.

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

Formulary (Prescription Drugs): See Preferred Drug List.

Generic Drug: The official non-proprietary name of a drug, under which it is licensed and identified by the manufacturer. Generic drugs are therapeutically equivalent to a brand name drug and must be approved by the U.S. Food and Drug Administration for safety and effectiveness.

Group Number: A number used by a Plan Administrator to identify the group in which a Plan Participant is enrolled.

Home Health Care: See Skilled Nursing Service.

Home Infusion Therapy: Self administration or administration by a home health agency, of intravenous medication when medically necessary for the treatment of disease or injury.

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.

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 Case Management (MCM): A program for Plan Participants designed to assist in times of very serious or prolonged illness.

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.

Medical Necessity: The need for an item or service to be reasonable and necessary for the diagnosis or treatment of disease, illness, injury or defect. The need for the item or service must be clearly documented in the patient's medical record. Medically necessary services or items are:

- appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury; and
- provided for the diagnosis or the direct care of the patient's condition, illness, disease or injury; and
- in accordance with current standards of good medical practice; and
- not primarily for the convenience of the patient or provider; and
- and the most appropriate supply or level of service that can be safely provided to the patient.

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

Non-preferred Brand Drug: Prescription Drugs available at a higher co-payment. Many high cost specialty drugs fall under the non-preferred drug category.

Notification: Notification is the telephone call to the Notification Administrator informing them of upcoming mental health services, Surgery, outpatient procedure or Admission to a facility such as a Hospital extended care facility. Notification is the Plan Participant's responsibility and is a method to avoid penalties and maximize benefits.

Out-of-Pocket Maximum: The maximum dollar amount paid out of pocket for covered expenses in any given contract year. After the out-of-pocket maximum, the plan design begins paying at the 100% of U&C for eligible covered expenses.

Outpatient Services (behavioral health services): Care rendered for the treatment of mental health or substance abuse. This type of care is limited to individual, group and/or family psychotherapy 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 Program (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 properly enrolled and participating in the Program.

Plan Year: July 1 through the following June 30.

PPO: See Preferred Provider Organization Hospital.

Pre-certification: See Notification.

Preferred Drug List: A list of drugs and ancillary supplies approved by the Prescription Drug Plan Administrators for inclusion in the prescription drug plan. These drugs are proven to be both clinically and cost effective. The preferred list is subject to change.

Preferred Provider Organization (PPO) Hospital: A Hospital or facility with which the Plan has negotiated favorable rates.

Prescription Drugs: Medications which are lawfully obtained with a prescription from a Physician/Doctor or Dentist.

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 health care needs.

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

Program: Teachers' Retirement Insurance Program (TRIP) 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.

Qualified Beneficiary: An individual who is entitled to receive continuation of coverage under COBRA as a result of a loss of employer-provided group health coverage.

Room and Board: Charges for room and meals for an inpatient stay.

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

Skilled Nursing Service: Non-custodial 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.

Special Deductible: Emergency Room Deductible and Non-PPO admission Deductibles. These Deductibles are not part of the annual Plan Deductible.

Spouse: A person who is legally married to the Benefit Recipient as defined under Illinois law.

State Employees Group Insurance Act: The statutory authority for benefits offered to TRIP Benefit Recipients (5 ILCS 375/1 et seq.).

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

Survivor: Spouse, Dependent child(ren) or Dependent parent(s) of a deceased Benefit Recipient who is receiving a monthly annuity from TRS.

TDD/TTY: A communication device used by people who are deaf, hard of hearing or have a severe-speech impairment.

Transplant Preferred Provider Organization (TPPO) Hospital: A Hospital with negotiated rates to perform certain transplants.

TRS: Teachers' Retirement System.

Usual and Customary (U&C): U&C is an amount determined by the Plan Administrator not to exceed the general level of charges by Providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition. This comparison takes into account all factors specific to a given claim including:

- Complexity of the services.
- Range of services provided.
- 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.

U&C applies to professional fees and some other services.

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**Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208**

**Printed by the authority of the State of Illinois
(CMS-BEN2002-02-70M-01/07)
Printed on recycled paper.**

