Navigating through the Online Group Insurance Manual

There are three methods of navigating through the online Group Insurance Manual:

- Bookmarks – the main sections of the manual are indicated with bookmarks. When you click on a specific bookmark, that section of the manual will appear on the screen. *See below for instructions.*
- Search feature on toolbar – The binoculars on the toolbar can be used when searching for a specific topic. The entire document will be scanned for the specified word.
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3. Click on the '+' sign to the left of the desired sort type (either Table of Contents or Recent Updates).
4. Click on a topic. The bookmark will display the page of the manual which corresponds to the topic.

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1.0 General Information

Employees who work a schedule that is 50% or greater have the option of either participating in the Group Insurance Program, or opting out of the Program. Employees electing to participate are enrolled with health, dental, vision and Basic Life coverage. (***Note:*** Employees who are eligible for state-paid Basic Life coverage are not allowed to waive this coverage). Dependents must be enrolled in the same health/dental plan as the member. Under certain circumstances, members may elect not to participate in the dental plan. See 1.2.C, 'No Dental Option' for details.

Employees electing to opt out (i.e., full-time employees) or waive (i.e., part-time employees) the health, dental and vision coverage are still eligible to participate in certain benefit programs, such as the Flexible Spending Account Program (FSA) and the Commuter Savings Program (CSP). For more information, refer to Section 3.2.A, 'Opting Out of Health, Dental and Vision Coverage.' Additionally, these members may elect any optional life coverage, including member Optional Life, Child Life, Spouse Life and/or AD&D.

1.1 Health Plans

Health plan options that are offered to members and eligible dependents include an indemnity plan (Quality Care Health Plan), several managed care plans and an Open Access Plan. Under each plan, a monthly contribution is made by all employees based upon what the employee's annual salary was on the preceding April 1st (or employment start date, if after April 1st). All dependent premiums are the responsibility of the employee and are payroll deducted from the employee's salary.

Important things to remember about health plans are:

- if a member is changing health plans effective July 1st and they are hospitalized in June, it is recommended that the member contact both the current plan/PCP and future plan/PCP well in advance of June 30/July 1.

- if a member knows they will be switching plans and are involved in an ongoing course of treatment, or have entered the third trimester of pregnancy, it is imperative that they contact the new plan to coordinate the transition of services of care.

A. State Quality Care Health Plan (QCHP)

The Quality Care Health Plan (QCHP) is a medical plan which offers a comprehensive range of benefits. Under QCHP, plan participants choose any physician or hospital for general or specialty medical services. Plan participants receive enhanced benefits by using a QCHP hospital, a physician who is enrolled in the QCHP Physician Network, pharmacy networks for prescription drugs and behavioral health network providers.

1. **QCHP Physician Network:** Plan participants choosing to utilize a physician in the QCHP Physician Network will only pay a percentage of the negotiated rate. An additional advantage to this option is that Usual and Customary (U&C) limits do not apply.

An **example** of the savings provided by this option is outlined in the following chart:		
	Outside Physician Network	**QCHP Physician Network**
Billed Charges for Office Visit	$50	$40
U&C Cut	$10	$ 0
Charges After U&C	$40	$40
Percentage QCHP Pays	$32 (80%)	$36 (90%)
Member Portion of Charges	$ 8 (20%)	$ 4 (10%)
U&C Portion	$10	$ 0
Member Pays	**$18**	**$ 4**

* This example is for illustration purposes only. Figures in this table are **not** based on actual rates.

2. **QCHP Hospital Network:** Whenever possible, plan participants are encouraged to use a QCHP network hospital at a savings for themselves and the state. If a person covered under this plan is admitted to a QCHP network hospital, the hospital deductible is waived and the coinsurance is reduced. For a list of network hospitals, call the plan administrator for the Quality Care Health Plan.

3. **Notification:**

   a. ***Medical Notification:*** Notification is the telephone call to the health plan administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility or for an outpatient procedure/therapy/service/supply.

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

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

   Failure to contact the Notification Administrator prior to having a service performed may result in a **financial penalty** and risk incurring non-covered charges deemed not medically necessary. **Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare.**

Notification is required for the following:

- Outpatient surgery and procedures including items such as imaging (MRI, PET, SPECT and CAT Scan)
- Physical, occupational or speech therapy
- Foot orthotics
- Durable Medical Equipment (DME) supplies
- Infertility treatment
- Cardiac or pulmonary rehabilitation
- Skin removal or enhancement (lipectomy, breast reduction/enlargement, select injectable drugs, treatment for varicose veins, etc.)

Services must be authorized before being services performed. Members should contact the Notification Administrator for the most up-to-date list of procedures requiring Notification.

b. ***Behavioral Health Notification:*** Notification to the Behavioral Health Plan Administrator is required prior to services at all levels of care to avoid penalties or non-authorization of benefits. All behavioral health services are subject to medical necessity. Services that are determined not medically necessary will not be reimbursed.

4. **Medicare Crossover (applies to QCHP members only)**

Medicare Crossover applies to Part B claims only. Part A claims must continue to be submitted with the Medicare Explanation of Benefits to the Medical Plan Administrator.

Medicare will automatically and electronically forward processed Part B claim(s) to the Medical Plan Administrator (refer to the current Benefit Choice Booklet) for all Quality Care members who are Medicare primary and have Part B coverage. The member must provide the Medicare Health Insurance Claim Number (HICN) to the Medical Plan Administrator to initiate future cross-over payments. Once the HICN is received, the Medical Plan Administrator will receive claim(s) determination information directly from Medicare, and will process Medicare Part B claims according to plan provisions.

A member's first claim may take up to 60 days from the time the Medical Plan Administrator is notified of the Medicare HICN number before Medicare begins to submit claims electronically to the Medical Plan Administrator. If the member has not received notification of the claim being processed within 60 days, he/she should be directed to call the Medical Plan Administrator of the QCHP.

If the GIR/P is notified by a member that Crossover does not appear to be in force after the 60 days, the member and/or dependent should be directed to contact the Medical Plan Administrator to verify enrollment in the Crossover service.

- Questions regarding Medicare Crossover should be directed to the Medical Plan Administrator.
- Questions regarding eligibility and enrollment for Medicare should be directed to the Social Security Administration.
- Questions regarding coordination of benefits between Medicare and the Medical Plan Administrator should be directed to the Group Insurance Division's Medicare COB Unit.

5. **Out-of-Pocket Maximums:** The amount a plan participant pays toward deductibles and coinsurance accumulates toward satisfying the annual maximum out-of-pocket (refer to the current Benefit Choice booklet for specific amounts). After the maximum has been met, the plan participant no longer pays coinsurance and the plan pays 100% of eligible charges for the remainder of the plan year.

   There are two out-of-pocket maximums under the QCHP which limit out-of-pocket medical expenses per plan year: a general maximum and a special maximum for non-QCHP charges. Coinsurance and deductibles count toward either the general "bucket" or the non-QCHP hospital "bucket," but not both. The chart below indicates which coinsurance and deductibles count toward which "bucket."

General	Non-QCHP
Plan year deductible Professional and Physician Coinsurance QCHP Physician Network Transplant deductible Transplant inpatient and outpatient coinsurance Standard hospital coinsurance* Standard hospital admission deductible* All emergency room deductibles Emergency room coinsurance *When the Notification Administrator grants an exception for a non-QCHP hospital admission, or when the plan participant does not reside within 25 miles of a QCHP hospital.	Non-QCHP hospital deductible Non-QCHP inpatient coinsurance Non-QCHP outpatient facility coinsurance
The following do not apply toward out-of-pocket maximums: • Prescription Drug benefits or co-payments. • Behavioral Health benefits, coinsurance or co-payments. • Notification penalties. • Ineligible charges (amounts over U & C and charges for non-covered services). • The portion of the Medicare Part A deductible which the plan participant is responsible to pay.	

6. **QCHP Prescription Drug Plan:** Prescription Drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. The Prescription Drug Plan includes both in-network and out-of-network benefits.

   There are three in-network prescription options, the Pharmacy Network, the Mail Order Pharmacy and the Maintenance Medication Program (MMP). A brief description of each is below. Refer to the Benefits Handbook for more specific information.

   Pharmacy Network: The Pharmacy Network consists of retail pharmacies that accept the co-payment and electronically transmit the Prescription Drug Claim for processing. Co-payment amounts are subject to change each plan year. Members should be referred to the Benefits Website for a listing of participating pharmacies.

   Mail Order Pharmacy: The Mail Order Pharmacy provides up to a 90-day supply of medication for two co-payments.

   Maintenance Medication Program (MMP): The Maintenance Medication Program consists of contracted retail pharmacies that have chosen to participate in the network. Pharmacies participating in the network allow the plan participant to obtain a 61 to 90-day supply of maintenance medication for two, 30-day retail co-payments. Members should be referred to the Benefits Website for a listing of participating pharmacies.

B. Managed Care Plans

Managed care plans negotiate rates with participating network physicians, hospitals and pharmacies. In turn, the plans offer cost-effective medical care with lower out-of-pocket costs. Individuals receiving medical care under a managed care plan are encouraged to have annual preventive physicals and seek early treatment if they become ill.

The two types of managed care plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive benefit coverage, although premium amounts may vary. The minimum levels of coverage managed care plans are required to provide are described in the current Benefit Choice Options Booklet. Beyond the minimum level of coverage requirements, the various managed care plans may have different covered services.

1. **Health Maintenance Organizations (HMOs):** HMOs operate on an “in-network” structure only. Members must select a Primary Care Physician (PCP) from the HMO’s network of participating providers. In conjunction with the health plan, the PCP directs all healthcare services for the member, including visits to specialists and hospitalizations. When care is coordinated through the PCP, the member pays only a predetermined co-payment. There are no annual plan deductibles for HMO plans.

2. **Open Access Plan (OAP):** The Open Access Plan (OAP) has three benefit levels which consist of two managed care networks (Tier I and Tier II) and an out-of-network benefit option (Tier III). The level of benefits the member receives is determined by the provider's category (i.e., Tier I, Tier II and Tier III, out-of-network) which the member selects. The benefit level for hospitals, physicians and other services will be the highest when a member selects a Tier I provider.

   Members who choose the Open Access Plan can mix and match providers. The plan provider directory contains separate listings of providers in the Tier I and Tier II networks. For example, a member can utilize a Tier II physician and receive care in a Tier I hospital.

3. **Important Reminders About Managed Care**

   - **Dependents**: Eligible dependents who live apart from the member's residence for any part of a plan year may be subject to limited service coverage (e.g., college student). If a member has such a dependent, it is critical that the member contact the managed care plan they are enrolled in, or are considering enrolling in, to determine the plan's guidelines on this type of coverage.

   - **Psychiatric/Substance Abuse Treatment**: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment.

   - **Transplant Services**: Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. The member should contact the respective managed care plan for specific information.

   - **Plan Year Limitations**: Certain managed care plans may provide benefit limitations based on a **calendar year**. In certain situations, the state's plan year may not coincide with the managed care plan's year.

   - **To change PCP**, members should be directed to contact their Medical Plan Administrator.

C. Appeals and Final Reviews

Under the State Employees Group Insurance Program, there is a formal claim review process available to plan participants and their dependents when they are dissatisfied with a claim determination. This appeal process may be applied to any of the plans the state offers, which include all health, dental, vision and life plans. **The plan participant must understand that the Plan Administrator's internal review process must be used to the fullest extent (usually two to three levels of appeal) prior to contacting the Group Insurance Division at CMS regarding a final determination.** Refer to the Benefits Handbook for more information regarding the appeal process.

D. Health Accessibility – Quality Care Health Plan Only (QCHP)

Employees enrolled in the QCHP who live in Illinois and reside in an area where a managed care provider is not accessible, may be eligible for a lower premium. Health accessibility applies to active employees only, and does not apply to retirees, annuitants or survivors.

1. **Determination of Accessibility:** During the annual Benefit Choice Period or upon initial enrollment, if an employee believes he/she resides in a non-accessible area, the GIR/P must direct the employee to contact the Group Insurance Division to review the case. The employee and the GIR/P will receive written notification from CMS of the determination. If approved, the employee will be placed in a special QCHP carrier code (D1) that indicates a lower premium would apply. The transaction to place a person in the special carrier code can only be processed by GID.

   There are two carrier codes for QCHP based upon determination of accessibility:

   - **D3** is the standard code for employees who choose the QCHP as their health carrier when they have access to both the QCHP as well as at least one managed care plan.

   - **D1** is a code for employees enrolled in the QCHP who reside in Illinois, <u>and</u> either 1) do not have a managed care plan available in their county of residence, or 2) the managed care plan(s) in their county has determined that the plan is not reasonably accessible to the member. Employees coded as D1 receive the same QCHP coverage as employees who are coded D3, however, will pay a lower premium. See the current rate table for the D1 premiums.

   a. **No Managed Care Plan Available**

      If an employee chooses QCHP during the Benefit Choice Period and their address on the Membership file indicates they reside in a county that does not have a managed care plan available they will be allowed to receive the lower rate for the QCHP coverage.

b. **Limited Managed Care Available**

Employees who believe they have limited access to managed care may submit a request for the QCHP lower premium to CMS Group Insurance. Upon receipt of the request, the managed care plan provider(s) will review the request. Once a decision has been reached, the Group Insurance Division will be notified if managed care is not accessible to the employee based on the respective plan's accessibility standards and procedures. Managed care plans will base the determination on the provider directory as of May 1st of each year. Requests submitted after the Benefit Choice Period will have the determination based on the current provider directory.

2. **Changes Affecting Health Accessibility**

New Hires Who Live in a Non-Accessible County: CMS will generate a weekly report listing all new hires who reside in an Illinois county that has been deemed non-accessible and who have signed up for the QCHP (D3). All members on this report will have their health code switched to the lower rate QCHP (D1) by CMS, effective their start date.

Employees Moving to a Non-Accessible County: CMS will generate a weekly report listing all current employees who have moved to a county that has been deemed non-accessible and who have signed up for the QCHP (D3). All members on this report will have their health code switched to the lower rate QCHP (D1) by CMS, effective the first day of the pay period following the date the address change is processed on the Membership System.

Employees Moving From a Non-Accessible County to an Accessible County: CMS will generate a weekly report listing all employees who have moved from a non-accessible county to a county with managed care. The Analysis and Resolution Unit will review this report and determine whether the employee has access to a managed care provider. If the employee is determined to have access to a managed care provider, the health carrier will be changed to D3, by CMS. The effective date will be the first day of the pay period following the date the address change is processed on the Membership System. These employees are considered to have experienced a qualifying change in status (changing county of residence) and would have 60 days to request a change of the health carrier.

1.2 Dental Plans

Members have the option of either (a) enrolling in the dental indemnity plan (Quality Care Dental Plan) or (b) not participating in the dental plan (see Section 1.2.B, 'No Dental Option' for details), regardless of the type of health plan they choose. Members choosing to opt out of the health program are not eligible for the dental program.

A. Quality Care Dental Plan (QCDP)

The Quality Care Dental Plan (QCDP) allows the member to go to the dentist of their choice. An individual plan deductible applies for all dental services other than diagnostic and preventive. Preventive services, such as cleanings, sealants and x-rays are not subject to the deductible. QCDP reimburses a predetermined or maximum benefit amount for each covered service. Dental procedure codes **not** listed in the Schedule of Benefits are considered non-covered services and are **not** eligible for payment. Members are responsible for any amount over the maximum benefit. A premium is required.

Please refer to the current Benefit Choice booklet for monthly premium amounts and a schedule of benefits.

B. No Dental Option

Members have the option of **not** participating in the Quality Care Dental Plan (QCDP). Proof of other coverage is not required for members electing this option not to participate. Members who elect this option may only re-enroll in the dental plan during the annual Benefit Choice Period.

Members may elect not to participate in the dental plan during the following periods/situation:

- **Initial Enrollment**: New members may elect not to participate in the Quality Care Dental Plan during their 10-day initial enrollment period. Members must check the 'I elect not to participate in dental' box on the Member Initial Enrollment form (CMS-310) to make this election.

- **Benefit Choice Period**: Members may elect not to participate in the Quality Care Dental Plan by checking the 'I choose not to participate in the dental plan' box on the Benefit Choice Election form (CMS-350) during the annual Benefit Choice Period.

- **Upon Opting Into the Group Insurance Program**: Members may elect not to participate in the Quality Care Dental Plan when they opt back into the Group Insurance Program. Members electing this option must check the 'I elect not to participate in dental' box on the Member Initial Enrollment form (CMS-310) to make this election.

1.3 Vision Plan

All members and dependents covered by any of the health plans offered by the State Employees Group Insurance Program are eligible for, and are automatically enrolled in, the Vision Plan. There are no monthly premiums charged for this plan. Members choosing to opt out of the health program are not eligible for the vision program.

The Vision Plan has both an in-network benefit level and an out-of-network benefit level. Each benefit component is independent and may be obtained at separate times from separate providers. Please refer to the current Benefits Handbook for a Schedule of Benefits.

For a list of in-network providers, contact the Vision Plan Administrator.

1.4 Life Plan

The state life plan provides term life insurance coverage through the State Employees Group Insurance Program. New members have ten days from their start date to complete the request for life insurance coverage.

The following are the effective dates and Statement of Health requirements for life coverage, if requested:

- **During the 10-Day Initial Enrollment Period** members are not required to complete a Statement of Health application for member Optional Life 1 – 4 times, Spouse Life and/or Child Life (AD&D never requires a Statement of Health application). Coverage is effective the date of employment with the state.

  Member Optional Life in excess of 4 times requested during the 10-day Initial Enrollment Period requires Statement of Health approval. Coverage is effective the first day of the pay period following Statement of Health approval.

- **After the Initial 10-Day Period** members are required to complete a Statement of Health application for adding/increasing member Optional Life in any amount, or adding Spouse Life and/or Child Life. Coverage is effective the first day of the pay period following Statement of Health approval. AD&D can be added at any time and does not require Statement of Health approval. Coverage is effective the first day of the pay period following the request. ***Note:*** In order to add or increase member Optional Life coverage outside the annual Benefit Choice Period or due to a qualifying change in status, the member must have at least $50,000 of member Optional Life and Basic Life coverage combined.

Members electing optional life coverage that requires Statement of Health approval (see chart below) must complete the medical underwriting process. This process is dependent upon written proof (based on medical information) that the person is insurable. The member must complete and return the Statement of Health application to the Life Plan Administrator (see 'Medical Underwriting Workflow' in Appendix F for step-by-step instructions on the application process).

The following is a chart listing whether or not a Statement of Health application and approval is required for the requested change:

Statement of Health Required	Statement of Health Not Required
Adding Spouse and/or Child Life	Adding AD&D coverage any time
Increasing member Optional Life (member must have at least $50,000 of member Optional Life and Basic Life combined to increase coverage at a time other than Benefit Choice or with a qualifying change in status)	Adding Child Life for newborn within 60 days of birth
	Adding Spouse or Child Life for newly-acquired dependents within 60 days of event (i.e., spouse, adopted child, stepchild)
Requesting 5 – 8 times member Optional Life coverage at any time	Adding 1 – 4 times member Optional Life during the 10-day Initial Enrollment Period

There are two types of life coverage available to the member: basic member coverage and optional coverage.

A. Basic Member Coverage (State-paid)

Term life coverage is provided automatically by the state at no cost to active employees through the State Employees Group Insurance Program. Basic coverage is provided as follows:

- *Full-time and Part-time Employees*: Each eligible active, non-retired employee is insured for an amount equal to their annual basic salary, rounded up to the next $100.

- *Annuitants*: The Basic Life benefit is equal to the basic annual salary as of the last day of active state employment until age 60, at which time the benefit amount reduces to $5000.

- *Survivors prior to September 22, 1979 of employees, immediate or deferred annuitants*: The benefit amount is $2000.

- *Survivors of employees and annuitants on or after September 22, 1979*: No Basic Life benefit available.

B. Optional Coverage (Member-paid)

Employees, immediate annuitants, New SERS, SURS and certain survivors may purchase optional coverage at low group rates. **All premiums for optional coverage are at the member's expense.** Optional coverage includes:

- Member Optional Life coverage equal to one thru eight times the basic member coverage, subject to a $3,000,000 maximum. Member Optional Life coverage for annuitants decreases to 4 times the Basic Life amount when they turn age 60.

- Member Accidental Death and Dismemberment (AD&D) coverage (basic or combined). Basic AD&D coverage is equal to one times the Basic Life member coverage amount. Combined AD&D coverage is equal to the Basic Life + member Optional Life amounts with a maximum of 5 times basic (Basic + 4 times) or $3 million, whichever is less.

- Spouse Life insurance of $10,000 for members and annuitants under age 60. Spouse Life reduces to $5,000 when <u>the annuitant</u> (not the spouse) turns age 60.

- Child Life insurance of $10,000.

C. Other Life Coverage Provisions

See the current State of Illinois Group Life Insurance Program Certificate for details.

1. **Changes to Life Coverage:** Certain changes to life coverage may be made any time during the plan year and are exceptions to the Irrevocability Rule (See "Group Insurance Policy - Irrevocability" for further details). These changes include:

   – Increasing member Optional Life coverage above $50,000. Member Optional Life plus Basic Life coverage must be at least $50,000 in order to increase coverage outside the Benefit Choice Period. Statement of Health is required to increase member Optional Life.

   – Decreasing member Optional Life coverage. Member Optional Life plus Basic Life coverage must not decrease below $50,000 in order to decrease coverage outside the Benefit Choice Period.

   – Adding/Dropping member AD&D coverage. Statement of Health approval is not required to add AD&D coverage.

   – Adding/Dropping Spouse Life or Child Life coverage. Statement of Health approval is required to add Spouse and/or Child Life coverage.

2. **Effective Dates of Life Coverage:** Effective dates vary depending on whether the change requires Statement of Health approval.

   – ***Statement of Health Required***: In situations where evidence of insurability is required (i.e., increasing member Optional Life, adding Spouse Life or Child Life), the effective date of additional coverage will be the first day of the pay period following Statement of Health approval.

   – ***Statement of Health Not Required***: In situations where evidence of insurability is not required (i.e., adding AD&D) the effective date of additional coverage will be the first day of the pay period following the written request.

3. **Accelerated Benefits:** Life insurance benefits may be paid to the member prior to death under certain circumstances. Accelerated Benefits offer access to a portion of the member's Basic and Optional Life Insurance benefits for members diagnosed with a terminal illness, in which the member's life expectancy is 12 months or less. The member may elect to receive ½ of their Basic and/or ½ of their member Optional Life coverage. Refer to the 'State of Illinois Group Life Insurance Program' booklet for details.

4. **Beneficiary Form:** GIR/Ps are responsible for giving new employees a Life Insurance Beneficiary Designation form (CMS-617; see Appendix D) at the time of employment. The member must complete the form and return to either the GIR/P, or directly to the Life Plan Administrator. Forms returned to the GIR/P should be checked for completeness. Incomplete/illegible forms must be returned to the employee for proper completion. Members who send incomplete/illegible forms to the Life Plan Administrator will be contacted directly by the Life Plan Administrator. There is no need to keep a copy of the form in the member's insurance file, as the Life Plan Administrator will enter the beneficiary designees in a database created for the retention of this information.

   Members may contact the Life Plan Administrator directly to receive a copy of the latest Beneficiary Designation form on file, or request the GIR/P to print their beneficiary designations from the Life Plan Administrator's Extranet database. This free service (provided through the Life Plan Administrator) also allows GIR/Ps to check the status of Statement of Health applications, as well as that status of life claims. ***Note:*** Agencies must have Internet capability in order to utilize the database. If interested in gaining access to this database, the agency must simply call the Life Plan Administrator, Minnesota Life, at 1-888-202-5525.

   The GIR/P should periodically ask members to review their beneficiary designations and beneficiary addresses. Marriage, divorce, the birth of a child, relocation or a name change are typical reasons to update the Beneficiary Designation form. Once member beneficiary designations are stored on the secure electronic database, agencies are not required to maintain file copies; nor are they required to forward a copy of the existing paper Beneficiary Designation form to other agencies when members transfer.

5. **Continuing Life Coverage After Terminating Employment or Retiring – Conversion and Portability:** Members terminating state employment or retiring may continue life coverage at their own expense. **It is the GIR/P's responsibility to give the member** information regarding conversion and portability of life insurance coverage **within 31 days of the member's termination**. If the GIR/P does not give the member notice in writing of this right to continue their group life insurance within 31 days after the date the life insurance would otherwise end, an additional 15 days will be granted to the member to complete the form. The Life Insurance Plan Administrator will NOT accept forms that are received more than 46 days after the date of retirement or employment termination!

   a. **Conversion:** When a member terminates state service they may convert Basic Life and/or Optional Life Insurance to an individual life insurance policy offered by the Life Insurance Plan Administrator. Members electing to convert their coverage may <u>not</u> also elect to port their life coverage. The amount of coverage the member is eligible for may not exceed the amount insured under the Group Life Insurance Program (both Basic and Optional Life Insurance, if elected). No Statement of Health will be required. Dependent coverage may also be converted, however AD&D cannot be converted.

b. **Portability:** When a member terminates state service they may port Optional Life Insurance in lieu of converting to an individual life insurance policy. The amount of coverage that can be ported is limited to 4 times the member's basic amount subject to a $500,000 maximum. Continuing coverage through portable insurance does not apply to Basic Life, Spouse Life, Child Life or AD&D life insurance coverage. No Statement of Health will be required.

6. **Continuing Life Coverage upon Retirement:** Immediate annuitants are allowed to continue Optional Life coverage. Deferred annuitants are not eligible for Optional Life coverage.

   Immediate annuitants under age 60 may retain the coverage they enjoyed as an employee. Those age 60 or older will have their coverage (both Optional and Basic) reduced to increments of $5000 with an Optional Life maximum of 4 times; however, the amount of the life coverage that is lost may be ported (see Section 1.4.C.5).

   Spouse Life coverage will reduce to $5000 once the annuitant turns age 60. Child Life coverage remains $10,000 regardless of the annuitant's age.

   Annuitants electing to become a dependent of their spouse upon receiving their retirement annuity (i.e., Public Act 93-553) continue to have life coverage as a member under the Group Insurance Program even though they are a dependent.

7. **Continuing Life Coverage After Member's Death:** If an insured *dependent* wishes to convert their insurance to an individual life insurance policy, the insured dependent may do so **within 60 days of the member's death.**

8. **Opt Out:** Members electing to opt out of the group health insurance coverage must maintain Basic Life coverage. These members are given the same life election choices as employees active in the health plan.

Please refer to the *'State of Illinois Group Life Insurance Program'* booklet for more details on the Life Insurance Program. Step-by-step instructions for performing the various life insurance related transactions are described in Appendix F.

2.0 General Information

Eligibility for the State Group Insurance Program is determined by the State Employees Group Insurance Act of 1971. To determine the appropriate eligibility type enrollee code to be used for the employment status of the member, please refer to Appendix J, 'Type/Subtype Chart'.

All employees must meet the following criteria in order to be eligible for the State Group Insurance Program:

- Eligible to participate in any of the state retirement systems.
    - State Employees Retirement System (SERS)
    - General Assembly Retirement System (GARS)
    - State Universities Retirement System (SURS)
    - Teachers' Retirement System (TRS)
    - Judges Retirement System (JRS)

    ~ and ~

- Paid a salary through the Comptroller's Office or a local university payroll.

If a GIR/P has a question regarding the eligibility and cannot find the answer in the Member Handbook, the GIR/P should contact the Membership Unit to assist with the determination.

Individuals eligible for participation in the state's health plans are classified in the following groups:

A. Eligible As Members

1. **Full-Time Employees** – Full-time employees are automatically enrolled in the health, dental, vision and Basic Life coverage in the Group Insurance Program. Full-time employees may:
   - elect not to participate in the dental coverage, or
   - elect to opt out of all coverage (except life coverage).

   Employees choosing to opt out of the health/dental/vision coverage must maintain Basic Life coverage and meet certain criteria (please refer to Section 3.2, 'Enrollment – Opting Out/Waiving/Transferring/Retiring').

   a. *Employees of the State and/or University "Non-Academic Year" Non-faculty Employees (type enrollee code 1001)*: Full-time employees working 1950 hours per 12-month period. *(These could be university groundskeepers, carpenters, administrative staff, etc.)*

   b. *Employees of the State and/or University "Non-Academic Year" Non-faculty Employees Hired Prior to January 1, 1980 (type enrollee code 1001)*: Employees working 50% - 99%, hired prior to January 1, 1980, that have been continuously employed. These employees may participate as full-time members. *(These could be university groundskeepers, carpenters, administrative staff, etc.)*

   c. *University Faculty Employees (type enrollee code 1001)*: Employees working greater than or equal to the 9 month "academic year" (generally mid-August through mid-May). These employees maintain coverage during the annual summer break period (type enrollee code 6023 when on seasonal leave). *(These are full-time faculty employees only.)*

   d. *University "Academic-Year" Non-Faculty (type enrollee code 1001)*: Employees hired to work an average of 37.5 hours per week on a permanent basis during the 9 month "academic year" (generally mid-August through mid-May). These employees maintain coverage during the annual summer break period (type enrollee code 6023 when on seasonal leave). *(These could be food service, health service, residence hall clerks, etc.)*

   e. *Employees of two State Agencies/Universities (type enrollee code 1001):* Occasionally an employee works for two state entities simultaneously. To determine whether the employee is considered full-time, the percentages worked for each agency/university must be added together. If the combined percentage is 100% or greater, the employee is considered full-time and must be coded on the Membership System as 100%. (See Section 10, 'Premium Calculation and Coding – Basic Life Units' for specific information regarding basic life units, reporting agency, etc.)

Note: Although an employee's employment status may be classified as full-time, for Group Insurance purposes, the employee could be classified as part-time based upon hours worked.

2. **Part-Time Employees** – Part-time employees working 50% - 99%, measured on a yearly basis, are automatically enrolled in the health, dental, vision and Basic Life coverage in the Group Insurance Program. These employees ***must be given the option*** to waive health and dental coverage.
   Part-time employees may:
   - elect not to participate in the dental coverage, or
   - elect to waive all coverage (except life coverage).

   It is recommended the part-time percentage be recalculated once per year. The GIR/P should use the employee's work hours from the previous 12 months to calculate the upcoming year's part-time percentage. *(Exception: Part-time faculty's insurance percentage is calculated using the formula in 2.c below.)*

   Example (does not apply to part-time faculty – see the Part-time Faculty section for an example): Employee worked a full-time schedule from March 1st – November 30th, and was on seasonal leave December 1st – April 30th. The calculation would be 39 work weeks x 37.5 hours/week = 1462.50 hours in the 12-month period. Since full-time employees work 1950 hours in a 12-month period, the GIR/P would divide the hours worked by 1950: Therefore, 1462.50 / 1950 = .75 or 75%.

   Employees choosing to participate in the health and dental program must pay a portion of the state's cost in relation to the percentage of hours worked, in addition to the member portion.

   a. *Permanent Part-time Employees of the State and/or University "Non-Academic Year" Non-faculty Employees (type enrollee code 1016)*: Persons employed <u>on or after January 1, 1980</u> and working 50% - 99% of weekly hours based upon the full-time hours of 1950 hours per 12-month period. These employees **are not eligible** for seasonal leave. (Note: See the 'Full-Time Employees' section if the employee was hired prior to January 1, 1980.) *(These could be administrative, groundskeepers, carpenters, etc.)*

   b. *University Part-time "Academic-Year" Non-faculty (type enrollee code 1020)*: Permanent employees working 50% - 99% of weekly hours based upon the full-time hours of 1460 per the 9 month "academic year" (generally mid-August through mid-May). These employees **maintain coverage** during the annual summer break period (type enrollee code 6037 when on seasonal leave). *(These could be food service, health service, residence hall clerks, etc.)*

c. *University Part-time Faculty Employees (type enrollee code 1018/1019)*:
For insurance purposes, faculty employees with less than 100% contracts are considered part-time employees. These employees must have their part-time percentage re-evaluated each fall semester for the upcoming 9-month academic year (generally mid-August through mid-May). **Summer contracts are not included when calculating part-time percentage.**

Employees who work ≥ 6 months and ≤ 9 months must be coded 1019. These employees maintain coverage during the annual summer break period (type enrollee code 6036 when on summer break).

Faculty employees hired to work only one contract period of 4.5 continuous months (e.g., filling in for faculty on maternity leave) are eligible for insurance benefits only if their contract is 100%. Since the employee is only working half of a full academic year, the percentage that must be assigned to these employees for insurance purposes is 50%. If the employee is rehired for the following academic year with a 100% contract, the employee would become a full-time university faculty employee. If the faculty member is hired back the following academic year less than 100%, the part-time percentage for these employees must be evaluated for the upcoming 12-month period.

Employees who work ≥ 4.5, but < 6 months must be coded 1018. These employees are not eligible for seasonal leave benefits during the annual summer break period (type enrollee code '8008 - term employment' when on summer break).

Use the following formula to derive a **faculty** employee's part-time percentage, ***for insurance purposes***:

(1) ***Is the employee working the full academic year (fall and spring semesters)?*** If so, average the fall and spring contract percentages together. If the average is less than 50%, the employee is not eligible for insurance. If the average is 50% or greater, use this percentage when assigning the member a part-time insurance percentage for the upcoming 12-month period. Code these members 1019.

Example: An employee is scheduled to work a 30% contract in the fall semester and a 100% contract in the spring semester. The average percentage is 65% (30 + 100 = 130 ÷ 2 = 65). The member must be coded with the 1019 type enrollee code at 65% until the following fall semester, at which time the percentage will need to be recalculated for the upcoming year.

(2) ***Is the employee working full-time (100%) for only one 4.5 month contract, or is he/she hired full-time mid-academic year?*** If not working a 100% contract, the employee is not eligible for coverage. If working full-time (100%) for one semester, the member should be coded as 50% part-time.

> ***Example:*** Employee is hired to fill in for a faculty member on maternity leave for the fall semester only. The contract is 100%. This employee would be coded 50% with a type enrollee code of 1018 (i.e., working < 6 months of the academic year) and not eligible for the seasonal leave. The employee must be coded with the type enrollee code 8008 (terminate employment) at the end of the semester.

d. *Agency and/or University Seasonal Employees (type enrollee code 1021)*: Employees working greater than, or equal to, a total of 6 months but not less than 975 hours per 12-month work period on an as-needed basis. These employees **are eligible** for unemployment and maintain coverage (type enrollee code 6029 when on seasonal leave). *(These could be painters, groundskeepers, carpenters, IDES, DNR, SOS.)*

These employees must be coded the percentage of hours worked. To calculate, the GIR/P should divide the number of hours worked in a 12-month period by the number of hours a full-time 12-month employee works.

> ***Example:*** For purposes of this example, a normal work week is 37.5 hours; therefore, total work hours in a year are 37.5 x 52 = 1950. An employee working 1150 hours in 12-month period would be coded as a 59% employee. To calculate: 1150 ÷ 1950 = .5897 or 59%.

e. *Employees of two State Agencies/Universities (type enrollee code 1016):* Occasionally an employee works for two state entities simultaneously. To determine the member's part-time percentage, the percentages employed at each agency/university must be added together. If the combined percentage is 50% to 99%, the member is considered a part-time employee and the combined percentage must be coded on the Membership System for insurance purposes. (See Section 10, 'Premium Calculation and Coding – Basic Life Units' for specific information regarding basic life units, reporting agency, etc.)

3. **Annuitants** – Annuitants become eligible as members effective the date of the commencement of their retirement or annuity benefits, or the first of the month of their application for retirement – *whichever is later*. Annuitants must satisfy the minimum vesting requirements of the appropriate retirement system based solely on prior state employment.

   Annuitants with less than 20 years of creditable service must pay a percentage of the state's portion of the cost for the coverage. Annuitants may:
   - elect to participate in the health, dental and vision coverage in the Group Insurance Program,
   - elect not to participate in the dental coverage, or
   - elect to opt out of all coverage (except life coverage).

   Opt Out Option (Public Act 92-0600): **Effective September 1, 2002**, annuitants may elect to opt out of the health, dental and vision coverage of the Group Insurance Program. Members choosing this option must meet certain criteria (please refer to Section 3.2, 'Opting (Opt Out/In)/Waiving/ Transferring/ Retiring'). Opting out of health benefits has no impact on Basic Life coverage (see Section 1.4.C.8, 'Other Life Coverage Provisions' for more information regarding life coverage options for members opting out).

   Opt Out Financial Incentive (Public Act 94-0109): **Effective January 1, 2006,** non-Medicare members receiving a retirement annuity from the State Employees' Retirement System (SERS) who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to Opt Out of the Health Insurance Program and receive a financial incentive of $150 per month. Members interested in this option should be referred to the State Employees' Retirement System.

   Waiver Option (Public Act 93-553): **Effective August 20, 2003**, annuitants who are married to a member of the state group health plan can continue/begin coverage as a dependent of their spouse. This election can be made 1) when initially applying for an annuity; 2) during the annual Benefit Choice Period; or 3) within 60 days of an eligible qualifying change in status. To waive health benefits as a member and elect coverage as a dependent, annuitants must complete the 'Waiving Annuitant Health Insurance Coverage Notification and Election' form (CMS-565, found in Appendix D). Electing to waive health benefits has no impact on the annuitant's Basic Life coverage (see Section 1.4.C.6, 'Other Life Coverage Provisions' for more information regarding life coverage options of annuitants electing to waive health coverage).

a. Employees who retired **on or after January 1, 1966 and prior to January 1, 1998** under one of the state's retirement systems are an:

- *Immediate Annuitant*: A person who begins to receive retirement benefits within one year from being removed from an active payroll, or *
- *Deferred Annuitant*: A person who begins to receive retirement benefits after being off active payroll for more than one year. *

  ***** Employees who retire after being on a leave of absence or are receiving disability benefits should have the one year period calculated from the date they cease to accrue creditable service time.

b. Employees who retired **on or after January 1, 1998** under one of the state's retirement systems are a:

- *New SERS Annuitant*: A person who receives a retirement annuity under Article 14 of the Illinois Pension Code, or
- *New SURS Annuitant*: A person who receives a retirement annuity under Article 15 of the Illinois Pension Code.

c. Employees who retired **on or after July 1, 1999** under the *Teachers' Retirement System* are a:

- *New TRS Annuitant*: person who receives a retirement annuity under Article 16 of the Illinois Pension Code.

d. Deferred annuitants who were employed under a SURS employer on July 7, 1997 who retire under the State University Retirement System **on or after July 30, 1999** are eligible to elect a lower pension benefit with fully state-paid insurance.

4. **Retirees** – Individuals who began receiving pension benefits from one of the state's retirement systems prior to January 1, 1966.
   Retirees may:
   - elect to participate in the health, dental and vision coverage in the Group Insurance Program,
   - elect not to participate in the dental coverage, or
   - elect to opt out of all coverage (except life coverage).

   Retirees choosing to opt out of the Program must maintain Basic Life coverage and meet certain criteria (please refer to Section 3.2, 'Opting (Out/In)/ Waiving/Transferring/Retiring').

5. **Survivors** – A spouse, child or dependent parent of a deceased member who is certified as eligible to receive an annuity from one of the five state retirement systems as a result of the death of a member in one of the above categories. Survivors may:
   - elect to participate in the health, dental and vision coverage in the Group Insurance Program,
   - elect not to participate in the dental coverage, or
   - elect to opt out of all coverage (except life coverage, if applicable)

   Survivors choosing to opt out of the Program must meet certain criteria (please refer to Section 3.2, "Opting (Out/In)/ Waiving/Transferring/Retiring').

   a. Prior to September 22, 1979: A survivor whose annuity is paid based upon the death of an employee occurring prior to September 22, 1979, or the death of a SERS, SURS, TRS, GARS or JRS Annuitant.

   b. On or After September 22, 1979: A survivor whose annuity is paid based upon the death of an employee occurring on or after September 22, 1979, or the death of a SERS, SURS, TRS, GARS or JRS Annuitant.

   c. On or After January 1, 1998:

   - *New SERS Survivor*: A survivor whose annuity is paid based upon the death of an employee occurring on or after January 1, 1998, or the death of a New SERS Annuitant.

   - *New SURS Survivor*: A survivor whose annuity is paid based upon the death of an employee occurring on or after January 1, 1998, a New SURS Annuitant or the death of a SURS retired employee.

   d. On or After July 1, 1999

   - *New TRS Survivor*: A survivor whose annuity is paid based upon the death of an employee occurring on or after July 1, 1999, or the death of a New TRS Annuitant.

   e. Non-Certified Survivors: Non-certified survivors are those dependents covered for health insurance by the member at the time of the member's death who are not certified as eligible to receive an annuity from one of the five retirement systems. These dependents are eligible to participate at their own expense.

6. **Others Considered as Covered Employees**

   a. Elected state officials and the employees under their jurisdiction who meet the standards as employees.

   b. Persons on approved leaves of absence.

   c. Emergency appointments may participate in the Group Insurance Program entirely at their own expense.

   d. Individuals receiving ordinary or accidental disability benefits or total permanent or total temporary disability under the Workers' Compensation Act or Occupational Disease Act for injuries or illnesses contracted in the course of employment with the State of Illinois.

   e. Former members of the General Assembly who have vested and allowed their contributions to remain with the General Assembly Retirement System, but are not receiving an annuity, may participate at their own expense.

B. Ineligible As Members

The following individuals are not eligible to participate in the Group Insurance Program.

- Employees who work less than 50% of the average hours required of a full-time employee measured on a yearly basis. This eligibility requirement applies regardless of the personnel employment status classification (i.e., full-time or part-time).

- Contractual employees.

- Temporary employees.

- Employees who are ineligible to participate in any of the state retirement systems.

- Individuals whose Visa has expired.

C. Eligible As Dependents

Eligible dependents of a member are:

1. **Spouse** (does not include ex-spouses, common-law spouses or same sex partners).

2. **Certain unrelated, same-sex Domestic Partners** – Refer to Section 15, 'Domestic Partner Coverage' for complete details of this benefit.

3. **Unmarried child from birth to age 19, including:**

   - Natural child.
   - Adopted child.
   - Stepchild living with member in a parent-child relationship at least 50% time.
   - Child for whom the member has permanent legal guardianship or custody.
   - Adjudicated child for whom a U.S. court decree has established a **member's** financial responsibility for the child's medical, dental or other health care.

4. **Unmarried child age 19 to 23 who meets ALL of the following conditions (student dependent category):**

   - Enrolled as a full-time student in an accredited school.
   - Financially dependent upon the member.
   - Eligible to be claimed as a dependent for income tax purposes by the member.

   Note: Military students between the ages of 23 and 25 are classified as "other" dependents.

5. **Unmarried child age 19 and older who is mentally or physically handicapped and meets ALL of the following conditions (handicapped dependent category):**

   - Continuously disabled as determined by the Social Security Administration from a cause originating prior to age 19 (or a cause originating prior to age 23 if enrolled as a full-time student).
   - Financially dependent upon the member.
   - Eligible to be claimed as a dependent for income tax purposes by the member.

6. **Unmarried child age 19 and older who meets ALL of the following conditions ("other" dependent category):**

   - Financially dependent upon the member.
   - Eligible to be claimed as a dependent for income tax purposes by the member.
   - Has been **continuously** enrolled as a dependent prior to February 11, 1983,

     ~ or ~

   - Has received an organ transplant after June 30, 2000.

     ~ or ~

   - Was a member of the U.S. Armed Services, including National Guard, on or after January 1, 2002 and is now a full-time student (up to age 25).

7. **A member's mother, father, grandmother, grandfather, grandchild, niece or nephew who meets ALL of the following conditions ("other" dependent category):**

   - Financially dependent upon the member.
   - Eligible to be claimed as a dependent for income tax purposes by the member.

- Has been **continuously** enrolled as a dependent prior to February 11, 1983,

  ~ or ~

- Has received an organ transplant after June 30, 2000.

D. Ineligible As Dependents

Dependents who would be considered ineligible dependents of a member include, but are not limited to:

- Stepchildren not living with the member in a parent-child relationship at least 50% of the time.

- Handicapped children who became handicapped due to a cause originating on or after they turned 19 years of age, or due to a cause originating on or after age 23 if enrolled as a full-time student.

- Students who graduate, cease to take classes or turn 23 years of age.

- Family members that do not qualify for the "Other" category, such as dependents covered under Golden Rule for any amount of time. ***Note:*** Golden Rule was a private policy offered to cover the dependents of a member. Golden Rule policies were not part of the State Employees Group Insurance Program; therefore, coverage under a Golden Rule policy, or any other private policy, does not apply toward one's continuous enrollment in the Group Insurance Program.

- Grandchildren for whom the member does not have a court order awarding permanent guardianship.

- Military students who reaches the age of 25.

2.1 Dependent Recertification

A. Recertification Periods

Once a dependent age 19 or older has initially been added to the Membership System, they must be recertified periodically to verify eligibility in the Program. The recertification periods are briefly described in the chart below:

Recertification Type	Applicable Ages	Processed By	Criteria
"Birth Date" recertification	Dependents turning age 19 or 23	CMS Group Insurance Division	Dependents may qualify to remain in the Program in either the Student, Handicapped or "Other" category upon turning age 19. Upon age 23, if the dependent qualifies for the Handicapped or "Other" category, coverage may continue with supporting documentation; however, the dependent is no longer eligible as a student.
"Semi-Annual" recertification	Dependents age 19, and up to, but not including, age 23	GIR/GIP	Dependents may remain in the Student category up to, but not including, the age of 23, or until they cease taking classes, whichever comes first, provided eligibility requirements continue to be met. Upon age 23, if the dependent qualifies for the Handicapped or "Other" category, coverage may continue with supporting documentation.
"Annual" recertification	Dependents age 19 and above	GIR/GIP	Dependents may remain in the Handicapped and "Other" categories, provided eligibility requirements continue to be met.

1. **Birth Date Recertification Policy and Procedures**
   POLICY

   The Birth Date Recertification process is used to determine an enrolled dependent's eligibility and category status upon turning 19 or 23 (i.e., Student, Handicapped or "Other").

   Several weeks prior to the enrolled dependent's 19th or 23rd birth month, the member will receive notification from CMS indicating that the dependent must be recertified in order to continue coverage. At this time, GIR/Ps will receive an informational report ('Dependents Turning 19 or 23') from CMS of all members receiving Birth Date recertification letters.

   The Group Insurance Division (GID) is responsible for processing the 19th and 23rd birth date recertifications; therefore, system edits have been put in place to prevent the GIR/P from processing birth date recertifications. Members are instructed to send the ***Dependent Coverage Certification Statement (CMS-138)*** and supporting documentation to the Membership Unit.

PROCEDURE

a. Members must complete the ***Dependent Coverage Certification Statement (CMS-138)*** indicating for which category (Student, Handicapped or "Other") the dependent qualifies upon turning 19 or 23. The member must sign and date the form.

   Note: If the dependent's birth date is in June, July or August and they will be a full-time student in the fall, the member must check the box indicating the dependent's "intent" to enroll as a full-time student in the fall. These dependents will remain active on the Membership System throughout the summer. Members will be asked to verify full-time enrollment of their dependent during the fall recertification period. Dependents with summer birthdays (June, July or August) who are not recertified during the fall recertification period will have coverage automatically terminated by the Membership System. *

b. In addition to the ***Dependent Coverage Certification Statement (CMS-138),*** the member must provide either proof of full-time student status (if turning 19), or proof of Handicapped status (see Appendix B - 'Documentation and Recordkeeping Requirements'). The Membership Unit will verify proof of "Other" status.

c. The member must send the ***Dependent Coverage Certification Statement (CMS-138)*** and supporting documentation to the Membership Unit for processing. The effective date of recertification will be the dependent's 19th or 23rd birth date.

*** Do not terminate dependent coverage!!**
Let the Membership System automatically terminate dependent coverage to assure the correct termination reason and dates are entered.

2. **Semi-Annual Recertification Policy and Procedures**

POLICY
The state requires members to verify continued eligibility for dependent students age 19 through 23. Members will receive notification from CMS after the start of the spring and fall semesters to verify the dependent's eligibility. At this time, GIR/Ps will receive an informational report ('Notice for Semi-Annual Recertification') from CMS of all members whose dependents are receiving recertification letters.

PROCEDURE

a. Each spring and fall, dependents on the Membership System will be cross-matched with the National Student Clearinghouse (NSC) database to verify student enrollment. ***Note:*** NSC is a clearinghouse which maintains enrollment information for many universities in the nation.

   - *Dependent Enrollment Verified by NSC*: Members whose student's full-time enrollment is verified by NSC will be sent a ***Dependent Coverage Certification Statement (CMS-138)*** to complete, sign and date.

   - *Dependent Enrollment Not Verified by NSC*: Members whose student's full-time enrollment is not verified by NSC will be sent the ***Dependent Coverage Certification Statement (CMS-138)*** to complete, sign and date. In addition to completing the ***CMS-138*** form, the member will be required to provide proof of the dependent's full-time student status. (See Appendix B - 'Documentation and Recordkeeping Requirements' for acceptable documentation.)

b. The member must return the ***Dependent Coverage Certification Statement (CMS-138) and required documentation, if applicable,*** to the GIR/P by the due date indicated on the recertification letter to avoid termination of the dependent's coverage.

c. The GIR/P must sign and date the ***Dependent Coverage Certification Statement (CMS-138)***.

GIR/Ps with online access must process the recertification on the Membership System. Recertifications may be processed through the recertification period deadline.

GIR/Ps without online access must send the ***Dependent Coverage Certification Statement (CMS-138)*** and supporting documentation to the Membership Unit for processing.

Do not terminate dependent coverage!!
Let the Membership System automatically terminate dependent coverage to assure the correct termination reason and dates are entered.

3. **Annual Recertification Policy and Procedures**

POLICY
The state requires members to annually verify continued eligibility for dependents age 19 and over who are in the Handicapped and "Other" categories. Members will receive notification from CMS in the fall semesters to verify these dependent's eligibility. At this time, GIR/Ps will receive an informational report ('Notice for Annual Recertification') from CMS of all members whose dependents are receiving recertification letters.

PROCEDURE

a. Each fall, members with dependents in the Handicapped or "Other" categories will be sent a ***Dependent Coverage Certification Statement (CMS-138)*** to complete on behalf of the dependent. The form must be signed and dated by the member.

b. The member must return the ***Dependent Coverage Certification Statement (CMS-138)*** to the GIR/P by the due date indicated on the recertification letter to avoid termination of the dependent's coverage.

   Failure to verify dependent eligibility will result in termination of the dependent's coverage.

c. The GIR/P must sign and date the ***Dependent Coverage Certification Statement (CMS-138)***.

GIR/Ps with online access must process the recertification on the Membership System. Recertifications may be processed through the recertification period deadline.

GIR/Ps without online access must send the documentation to the Membership Unit for processing.

Do not terminate dependent coverage!!
Let the Membership System automatically terminate dependent coverage to assure the correct termination reason and dates are entered.

B. Failure to Recertify

Failure to verify dependent eligibility for **"Birth Date Recertifications"** will result in automatic termination of dependent coverage effective the first day of the month following the birth date.

All members failing to recertify dependent eligibility for the **"Annual and Semi-Annual Recertifications"** by the due date indicated on the recertification letter will have the dependent's coverage terminated. The terminations will be processed on the Membership System. The date of the mass termination will be communicated to the GIR/P via a GI Notice (email).

The GIR/P must allow the Membership System to automatically terminate ineligible dependents. Do not manually terminate dependent coverage.

C. Reinstatement Policy of Terminated Dependent Coverage

Dependent coverage terminated due to a member failing to recertify their dependent's eligibility by the due date, may be reinstated retroactively if the member provides the required documentation to the GIR/P **within 30 days** of the Membership System's termination process date. The coverage will be reinstated retroactively to the date of termination.

Documentation provided any time **after the 30-day period** will permit coverage to be reinstated effective the date the required documentation was provided, but not retroactive to the date of termination. There is no time limit for reinstating the coverage; however, the dependent must continue to meet the dependent eligibility criteria in order to be reinstated (e.g., student dependents must either be currently enrolled in classes full-time or, if requesting the reinstatement during the summer months of May, June or July, the student must have attended classes full-time during the previous semester).

Note: Reinstatement may cause a break in coverage which would prevent a dependent from qualifying for the "Other" category. Additionally, pre-existing condition limitations may apply if the break in coverage is greater than 63 days.

2.2 Eligibility Disputes

The GIR/P should advise members of the eligibility policy. Disputes that cannot be resolved by the GIR/P should be submitted in writing and directed to:

CMS Group Insurance Division
Agency Services Manager
201 E. Madison, Suite 2B
P.O. Box 19208
Springfield, Illinois 62794-9208

3.0 Benefit Enrollment/Change Periods

Members may enroll, opt out or change benefit selections with supporting documentation during the following periods:

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

NOTE: **GIR/Ps should make every effort to process Membership transactions immediately upon receipt.**

A. Initial Enrollment

New state employees, or state employees who experience a break in state coverage of more than 10 days*, are considered "new" members. Members with a break in coverage of less than 10 days must continue the same coverage they had prior to terminating employment.

Example: A person who is employed by the state who terminates employment for a 15-day period and subsequently becomes re-employed by the state would be considered a "new" member. "New" members are eligible to choose any available health or dental plan, and life coverage options.

*** *Note:*** *Termination for non-payment of premium does not apply under the initial enrollment provisions.*

Employees, either full-time or part-time, enrolling in the Group Insurance Program have 10 calendar days from the date they physically begin work, or begin receiving an annuity, to elect health, dental and optional life coverage. **Full-time employees, annuitants/retirees and survivors** may elect to opt out of health, dental and vision coverage. **Part-time employees** (working 50%-99%) have the option of either participating in the Program at a percentage of the state cost, or "waiving" coverage. See Section 3.2, 'Opting Out/In, Waiving/Transferring/Retiring' for details.

The GIR/P must give the member a copy of the Benefit Choice Options Booklet and Member Handbook *that is currently in effect* to aid the member with their coverage decisions. During this 10-day period, the member may change their initial coverage elections. If the member does not elect coverage during the 10-day enrollment period, the GIR/P must default the employee into the Quality Care Health Plan and Quality Care Dental plans with member-only coverage (no dependent coverage).

Dependent documentation must be provided to the GIR/P within 15 days of the initial enrollment period. If the documentation is not provided within the 15 days, the GIR/P should not add the dependents. **Documentation requirements must be met for dependents being added during the Initial Enrollment of a member** (See Appendix B – 'Documentation Requirements' and 'Documentation Requirements Time Limits' for specific documentation requirements and time limits, and Section 3.A.1, 'Default Elections' for additional information)**.**

1. **Default Elections**
   Full-time or part-time employees, who do not complete and submit the ***Group Insurance Initial Enrollment*** form to the GIR/P within the initial 10-day period must be defaulted by the GIR/P to member-only coverage in the Quality Care Health, Quality Care Dental and Basic Life coverage. The GIR/P does not need the member's signature to enroll the member in the Quality Care health and dental plans when an election is not made. The GIR/P may simply file the enrollment paperwork indicating the member was defaulted to the Quality Care plans for failure to return the required paperwork in the specified time frame. The 'Pre-existing Conditions' field in the Membership System must be set to '6' months. The member will not be allowed to elect dependent coverage until the annual Benefit Choice Period or until an eligible qualifying change in status occurs.

2. **New Members Enrolling 'Student' Dependents During June, July or August**
   New state employees hired during the months of June, July or August, or new annuitants who begin receiving an annuity during June, July or August, may enroll dependents into the 'Student' category if the dependent was enrolled as a full-time student in the most recent spring semester (or quarter) or if the dependent is currently a full-time student. Coverage for these dependents is effective the member's start date.

   The member must provide proof of full-time student status (see Section 3.1.B.1, 'Documentation Requirements') for the spring or current semester to the GIR/P, along with a completed Dependent Coverage Certification Statement (CMS-138).

   Dependents not currently enrolled or who were **not** enrolled as a full-time student in the preceding spring semester, are not eligible for state group insurance coverage until either the first day of the month in which the student begins fall semester classes, or the date the coverage was requested, *whichever is later.*

3. **New Members Enrolling in May or June**
   New members enrolling in the Group Insurance Program in May or June should be given *both the current plan year's Benefit Choice Options booklet and the new plan year's booklet*.

   The new member should make their coverage elections ***for May and June's coverage*** based upon the current plan years' Benefit Choice Options booklet to ensure the options given to them are currently available.

These members should also be advised to review the new Benefit Choice Options booklet to make themselves aware of any health carrier changes in their area ***for the upcoming plan year*** (i.e., a certain health carrier may have dropped out or may have been added to a Managed Care Network, effective the upcoming July 1st).

- New members who begin state employment **during the month of May**, or begin receiving an annuity following a break in coverage **during the month of May,** have the option to change any of their coverage elections during the Benefit Choice Period. Changes will be effective July 1st.

- New members who begin state employment **during the month of June**, or begin receiving an annuity following a break in coverage **during the month of June**, have the option to enroll in a health plan/carrier just for the month of June if another plan/carrier in which they wish to enroll is not available until the start of the new plan year (effective July 1st). Members choosing to change to a newly available health plan/carrier effective July 1st shall be given the opportunity to do so and must request the change within 10 days of their start date.

Example: A new employee has a start date of June 6th. The employee enrolls in HMO 'A' based on the **current** plan year's Benefit Choice Options booklet; however, the member notices there is a new plan (HMO 'B') available in his area beginning July 1st. Therefore, in order to enroll in HMO 'B' effective July 1st the member must submit his request to change to the new health plan by June 16th (i.e., within 10 days of his start date). The GIR/P must process the change as a Benefit Choice election (10).

4. **Effective Date of Initial Enrollment**

Criteria	Effective Date
Employees scheduled to begin state employment on a day in which they are scheduled to work every available day in the pay period have an effective date of the first day of the pay period. Deductions should be taken on payroll for that pay period. ***Weekend Example:*** An employee is scheduled to begin state employment, October 3rd, which is a Monday. Even though the first day of the payroll period is a Saturday (October 1st), the member is scheduled to work every available day in that pay period. Therefore, the effective date for **insurance purposes** would be October 1st. Deductions for the first pay period in October should be taken on payroll by the agency. ***Holiday Example:*** An employee is scheduled to begin state employment, Tuesday, September 3rd, which is the day after a state holiday. Even though the first day of the payroll period is a Sunday (September 1st), the member is scheduled to work every available day in that pay period. Therefore, the effective date for **insurance purposes** would be September 1st. Deductions for the first pay period in September should be taken on payroll by the agency.	First day of the pay period

Criteria	Effective Date
Employees scheduled to begin state employment on a day in which they are not scheduled to work every available day in the pay period have an effective date of the first day they physically begin work. Deductions should not be taken on payroll for that pay period. Payroll must be directed to code the member 'C' (i.e., no insurance) on payroll for the first pay period the member is active.	First day physically at work

5. **General Information:** Eligible employees and their dependents may be enrolled in the Group Insurance Program during the Initial Enrollment period, the Benefit Choice Period or when an eligible qualifying change in status occurs.

Enrolling Member or Dependent-

The GIR/P should follow the steps below when processing a member's initial enrollment. If the GIR/P is unfamiliar with the specific processes involved with an enrollment step, they should refer to Section 3.3, 'Supplemental Enrollment Information' for further details. Refer to Appendix D – 'Forms Requiring Member's Signature' for sample forms.

1. Provide the member the current Benefit Choice Options booklet, the Benefits Handbook and any benefit-related pamphlets.

2. Determine whether the member wants to participate in the State of Illinois Group Insurance Program's health, dental and vision coverage (or health and vision coverage, electing not to participate in the dental plan) or if they would like to "Opt Out" of the health, dental, and vision coverage (refer to Section 3.2, 'Opting (In/Out)/Waiving/Transferring/Retiring' for more information). Once enrolled, the member will receive ID cards from the plans they selected.

3. Determine whether the pre-existing conditions exclusion applies. If so, the "Pre-existing Months" field on the Initial Enrollment form must be completed (refer to Section 3.3.E, 'Certificate of Creditable Coverage' for more information).

4. Complete a Coordination of Benefits worksheet for member and all dependents (refer to Appendix D for a sample of the form).

5. Determine whether Medicare coverage exists for the member or any dependents. If so, obtain a copy of the Medicare card and complete the Medicare Status section of the Initial Enrollment form. If the member or their dependent is Medicare ineligible, the Initial Enrollment form must be sent to the Group Insurance Division's Medicare COB Unit for processing, along with a copy of the ineligibility letter.

6. Give the member a Life Beneficiary Designation Statement (CMS-617) to complete and return to Life Plan Administrator. Forms returned to you must be

checked for completeness and legibility and forwarded to the Life Plan Administrator. See Section 1.4.C.4, 'Life Plan – Beneficiary Form' for further details regarding the Life Beneficiary Designation Form.

7. Have all part-time employees complete the 'Part-time Employee Election/Waiver of Group Insurance Participation' (refer to Appendix D for a sample of the form).

8. Complete the member and/or dependent information on the proper Membership forms. Members should be strongly encouraged to provide a valid social security number for each dependent entered on the Membership System. When a dependent's Social Security number (SSN) is not available, the temporary SSN '808-00-0000' may be entered on the Membership System. Ideally, temporary social security numbers (described above) should only be used in the case of newborn dependents. Note: Foreign members should apply for a social security number as soon as possible upon seeking employment in the United States. The Social Security office can take as long as 90+ days to issue a social security number to foreign members.

9. Collect the required documentation from the member, including Certificate of Creditable Coverage, birth certificate, marriage license, court decree, Medicare card, etc. (See Appendix B - 'Documentation Requirements' for specific documentation requirements).

   Online GIR/Ps – Enter the information captured on the enrollment forms into the Membership System, using the 'Membership Enrollment Procedures,' if necessary. Refer to Section 12 for enrollment procedures.

   Non-Online GIR/Ps – Forward a **copy** of the required documentation and enrollment forms into the Membership Unit for processing.

10. Forward a copy of the Membership form(s) to the agency payroll personnel for entry on the payroll system. If the part-time member chooses to waive health and dental coverage, or if a full-time member chooses to opt out of the health and dental coverage, the GIR/P must ensure the eligibility code on payroll is 'R' – "Life Only" (or the code the agency uses for life only – see "GIFCS Eligibility Codes" in Appendix H, 'System Codes.')

11. Create an insurance folder for the new member. Separate medical information from insurance information.

12. Provide the member with optional pre-tax program information/booklets for the:

    - Flexible Spending Account (FSA) Program. Assist the member with completing the information on the MCAP and/or DCAP Enrollment form(s), if necessary.
    - Commuter Savings Program (CSP) for pre-tax parking and transit benefits. The member may enroll by calling the plan administrator or by accessing the plan administrator's website available in the most current Benefit Choice Options booklet.
    - State of Illinois Deferred Compensation Program.

6. **Initial Enrollment Checklist**

GIR Duties
♦ Obtain required documentation for enrolling dependents ♦ Enter Initial Enrollment information on Membership System *(online GIR)* ♦ Send Initial Enrollment form and supporting documentation to Membership Unit for processing *(GIR not online)* ♦ Create insurance folder for member – separate medical information from general insurance forms ♦ Send a copy of completed enrollment forms to the Payroll Office

Booklets and Pamphlets
♦ State of Illinois Benefits Handbook ♦ State of Illinois Benefit Choice Options booklet ♦ State of Illinois Group Life Insurance Program booklet ♦ State of Illinois Flexible Spending Account Program Booklet *(enrollment forms are in booklet)*

Forms
♦ Member Initial Enrollment Form (CMS-310) ♦ Dependent Initial Enrollment Form (CMS-311) ♦ Dependent Recertification Statement (CMS-138) *(when member is adding dependent age 19 – 23)* ♦ Beneficiary Designation Form (CMS-617) ♦ Part-time Employee Election/Waiver of Group Insurance Participation *(all part-time employees must complete whether participating in the Program or waiving coverage)* ♦ Opt Out & Opt In Election Certificate (CMS-500) and proof of comprehensive major medical coverage provided by an entity other than the Department of Central Management Services ♦ Coordination of Benefits Statement for member and all dependents

B. Annual Benefit Choice Period

The Benefit Choice Enrollment Period is the annual election period normally held from May 1st to May 31st each year. All members may make changes to their coverage during this period. **Back-up documentation is required when adding dependent coverage or when opting out during the Benefit Choice Period. *Note:* Documentation (concerning loss of other coverage) is not required for the member to opt back into the Program during the Benefit Choice period.**

When opting out of the coverage, proof of comprehensive major medical coverage (copy of the front and back of ID card) provided by an entity other than the Department of Central Management Services must be supplied. The member must check the 'Opt Out' box on the Benefit Choice Election form (CMS-350), as well as complete and sign an 'Opt Out/ Opt In Election Certificate' (CMS-500). When opting into the state's insurance coverage, the employee may be subject to pre-existing condition limitations if a break in health insurance coverage of more than 63 days occurs.

Coverage elections made during the Benefit Choice Period, including opting out of the Program or opting into the Program, have an effective date of July 1st.

1. **Override Capability**
   During the Benefit Choice Period, agencies with online access are given override capabilities on the Membership System. This override function allows Benefit Choice election changes (effective July 1) to be changed as many times as necessary without the GIR/P needing to send a correction form to the Membership Unit.

   Note: Once a July 1st transaction has been processed, the system will not allow transactions with an effective date **prior** to July 1st to be processed for the same member. Changes with an earlier effective date must be sent to the Membership Unit as a correction.

2. **Changes Allowed During Benefit Choice**
   Members may make the following changes during the annual Benefit Choice Period:

   - Change health plans
   - Elect to participate, or not participate, in the dental plan
   - Add or drop dependent coverage for health or dental
   - Add or drop an un-related same-sex Domestic Partner
   - Increase or decrease member Optional Life Insurance and member AD&D coverage (Statement of Health approval is required to increase member Optional Life coverage, but is not required to add AD&D coverage)

- Add or drop Spouse Life/Child Life coverage (Statement of Health approval is required to add dependent life coverage)

- **Full-time active employees, annuitants/retirees and survivors** may elect to opt out of health/dental/vision coverage (non-Medicare SERS members may, upon request, receive a financial incentive of $150 per month for opting out)

- **Full-time active employees, annuitants/retirees and survivors** may elect to opt into health/dental/vision coverage – proof of the loss of other coverage is not required when opting in during the Benefit Choice Period

- **Full-time active employees, annuitants/retirees and survivors** may elect to opt into health/vision coverage, electing not to participate in the dental plan

- **Annuitants** can waive health, dental and vision coverage and become a dependent of another member (see 'Waiver Option' in Section 2.0.A.3, 'Annuitants' for details)

- **Participating part-time members** may elect to waive health, dental and vision coverage

- **Non-participating part-time members** may elect to enter the Program

- Enroll or re-enroll in one or both of the Flexible Spending Accounts (FSA) plans – the Medical Care Assistance Plan (MCAP) or the Dependent Care Assistance Plan (DCAP)

3. **Effective Date of Benefit Choice Elected Life Coverage**
   Life coverage changes initiated during the annual Benefit Choice Period requiring Statement of Health approval are effective either a) July 1st if approval is received from the Life Plan Administrator **prior to July 1st** or b) the first day of the pay period following the Statement of Health approval date, if the approval is received **after July 1st.**

4. **Changing Benefit Elections**
   Members may change their benefit elections during the Benefit Choice Period by completing the Benefit Choice Election Form (CMS-350) and submitting it, along with any required documentation, to their agency GIR/P. The member must sign, date and return the form to the GIR/P by the last day of the enrollment period, which is normally May 31st. Forms postmarked by the last day of the enrollment period are also acceptable. The GIR/P must also sign and date the form(s).

5. **Benefit Choice Checklist**

♦ Benefit Choice Election Form (CMS-350)
♦ Coordination of Benefits Worksheet for newly enrolled members and dependents
♦ Opt Out & Opt In Election Certificate (CMS-500) and proof of comprehensive major medical coverage provided by an entity other than the Department of Central Management Services, if opting out
♦ Member and/or Dependent Address Change Form (CMS-314)
♦ Certificate of Creditable Coverage *(when adding a dependent to plan which has the pre-existing exclusion)*
♦ Dependent Certification Statement (CMS-138) form *(when member is adding dependent age 19 – 23)*
♦ Documentation verifying student's full-time enrollment during the spring semester *(when member is adding dependent student age 19 – 23)*
♦ MCAP/DCAP Enrollment Form(s)
♦ Notify payroll of Benefit Choice enrollment election changes
♦ Statement of Health Application (when member is applying to add or increase member Optional Life coverage, Spouse or Child Life) ♦ Domestic Partner Enrollment Form along with supporting documentation (refer to Section 15, 'Domestic Partner Coverage' for more information)

* GIR/Ps must take every opportunity to ensure members have a current address on file. A current address must be maintained on the Membership System for active members and members terminating coverage. The GIR/P must update the Membership System to reflect the new address.

C. Qualifying Changes in Status

Members experiencing a qualifying change in status have certain options, including opting out of/into health, dental and vision coverage if requested within 60 days. Any mid-year election change must be consistent with the qualifying change in status the member has experienced. See Appendix A, 'Consistency Matrix' to determine which changes are allowed for the qualifying change in status the member experienced.

Members must submit proper documentation to the GIR/P **within 60 days** from the date of the qualifying change in status. (See Appendix B, 'Documentation Requirements Time Limits' for details.)

1. **Consistency**
   The most common qualifying changes in status are listed in the Consistency Matrix located in Appendix A. If a GIR/P is uncertain that a specific change is a qualifying change in status, the Group Insurance Division should be contacted for a determination.

2. **Effective Dates of Qualifying Changes in Status**

Requested Change	Effective Date
Health/Dental/Vision	The 1) date the request for change was signed by the member, or 2) date the event occurred, *whichever is later.* ***Newborn Exception*** *to the rule above:* *If the request for coverage (for newborns and adopted newborns) was made within 60 days of birth, coverage may be retroactive to the date of birth.*
Life *(for changes requiring Statement of Health approval)*	The first day of the pay period following the health certificate approval date.
Life *(for changes Not requiring Statement of Health)*	The first day of the pay period on or after the date the request for change was signed by the member.
FSA Enrollment Change	The first day of the first full pay period **after** the date the request for change was signed by the member.
Opt Out upon Initial Enrollment	"Opt out" requests received during the 10-day initial enrollment period are effective the date of employment.
Opt Out due to a Qualifying Change in Status	"Opt out" requests received prior to, or during the 60-day period immediately following a qualifying change in status are effective *the later of:* • the date of the event (if requested prior to the event), **or** • the date the request was signed (must be within 60 days of the event).
Opt In	"Opt in" requests received by the Group Insurance Division due to a qualifying change in status are effective *the later of:* • the date of the event (if requested prior to the event), **or** • the date the request was signed (must be within 60 days of the event).

3. **Qualifying Change in Status Checklist**

- Calculate Months of Pre-Existing Condition Exclusion using the Certificate of Creditable Coverage *(when adding dependent to plan requiring pre-existing exclusion)*
- Part-time Employee Election/Waiver of Group Insurance Participation *(when member is changing to part-time status)*
- Statement of Health Application *(when member is applying to add or increase optional life)*
- Coordination of Benefits Worksheet for newly added dependents
- Dependent Certification Statement (CMS-138) form *(when member is adding dependent age 19 – 23)*
- Required documentation for the specific qualifying change in status *(see Appendix B, 'Documentation Requirements')*
- MCAP/DCAP Enrollment form(s)
- Member Change Form (CMS-312) *(when member is changing carrier election)*
- Dependent Change Form (CMS-313) *(when member is adding/dropping a dependent)*
- Member and/or Dependent Address Change Form (CMS-314) *
- Opt Out & Opt In Election Certificate (CMS-500) and proof of comprehensive major medical coverage provided by an entity other than the Department of Central Management Services

* GIR/Ps must take every opportunity to ensure members have a current address on file. A current address must be maintained on the Membership System for active members and members terminating coverage. The GIR/P must update the Membership System to reflect the new address.

3.1 Dependent Enrollment

Members and their dependents must be enrolled in the same health and dental plans. Members electing to opt out of health, dental and vision coverage may only elect Child Life and/or Spouse Life coverage for their dependents.

A. Unmarried Children 18 and Under

1. **Newborn dependents** may be added within 60 days of birth. The effective date of coverage may be retroactive to the date of birth. Birth certificates are required. ***Note:*** Hospital birth certificates are acceptable.

2. **Adopted newborns** may be added within 60 days of birth. The effective date of coverage may be retroactive to the date of birth. Birth certificates are recommended, however, a copy of the petition for adoption or court order granting legal custody is required to add the newborn. If the request is not received by the agency within the 60-day period, the dependent may not be added until the next Benefit Choice Period or until an eligible qualifying change in status occurs. If the court order is from a foreign court, a copy of the translation must accompany the document.

3. **Adopted children, *other than newborns***, may be added if requested within 60 days of a) finalizing the court order for the petition of the adoption or b) custody of the child being awarded. Once a petition for adoption has been filed, or custody of the child has been granted, the child may be enrolled as a dependent. If the request for change is made within 60 days, coverage may be retroactive to the date of placement.

   Birth certificates are recommended, however, a copy of the petition of the adoption or the court order granting legal custody is required to add the adopted child. If the request is not received by the agency within the 60-day period, the dependent will not be added until the next Benefit Choice Period or until an eligible qualifying change in status occurs. If the court order is from a foreign court, a copy of the translation must accompany the document.

4. **Children for whom the member has legal custody or permanent guardianship** must live with the member in a parent-child relationship. The member may add the dependent if the GIR/P is notified within 60 days of the judge's signature date on the United States Court Order awarding custody or establishing permanent guardianship. If received within the 60-day period, coverage is effective the date the member's request to add the dependent was signed. If the request is not received by the agency within the 60-day period, the dependent may not be added until the next Benefit Choice Period or until an eligible qualifying change in status occurs. A copy of the United States Court Order establishing custody or permanent guardianship is required.

5. **Adjudicated children** are natural children for which a member has been deemed by a United States court to be financially responsible for the child's health, dental or other healthcare (e.g., a court makes a determination of a member's paternity). A copy of the National Medical Support Notice signed by a Healthcare and Family Services (HFS) Representative is sent directly to the agency. The member's signature on documentation requesting the dependent be added to coverage is **not** required for the National Medical Support Notice.

   If the Judicial Support Order or National Medical Support Notice is received **within 60 days** of the circuit clerk's file stamp, or of the HFS Representative's signature and date, coverage is effective the date of the order. If the order is received **after 60 days**, the effective date is six months retroactive from the date received, but not prior to the date of the circuit clerk's file stamp.

6. **Stepchildren** may be added if the GIR/P is notified within 60 days of the child becoming eligible for coverage (such as the stepchild coming to live with the member in a parent-child relationship). The stepchild must live with the member in a parent-child relationship at least 50% of the time in order to be eligible as a dependent.

   Coverage is effective the date the member signed the request to add the stepchild, or the date of the event in which the child became eligible, *whichever is later*. If the request and supporting documentation are not received by the agency within the 60-day period, the dependent may not be added until the next Benefit Choice Period or until an eligible qualifying change in status occurs. Documentation required to add the stepchild is (a) proof/evidence the child resides with the member (i.e., copies of records, such as school, child care, social services or medical, etc.), ***and*** (b) a birth certificate indicating that the member's spouse is the child's natural parent ***and*** (c) a marriage certificate indicating the child's parent is the member's current spouse.

7. **Natural Children** are not required to live with the member to be eligible as a dependent. A copy of the birth certificate is required to add the dependent.

B. Unmarried Children Age 19 and Above

Children age 19 and above may be eligible for coverage provided they meet the qualifications of the category for which they qualify (Student, Handicapped or "Other"). In order to qualify for the Group Insurance Program, these dependents must 1) be eligible to be claimed for income tax purposes by the member, 2) be financially dependent upon the member and 3) provide the appropriate documentation (as listed below).

1. **Documentation Requirements**
   The member must provide a completed ***Dependent Coverage Certification Statement (CMS-138)***, as well as the appropriate documentation (as listed below) to enroll a dependent age 19 or above:

   a. **Students**: Proof of full-time student status in an accredited school for dependents age 19 and up to, but not including, age 23. The following are examples of acceptable documentation, provided *full-time enrollment* is indicated: letter from the Office of the School Registrar, tuition bill marked paid, copy of enrollment from the university's website, an abbreviated transcript, copy of grant award or tuition waiver, itemized statement of account.

      Note: Military students between the ages of 23 and 25 are classified as "Other" dependents.

   b. **Handicapped**: Proof that the dependent became handicapped from a cause originating prior to age 19 (or a cause originating prior to age 23 if enrolled as a full-time student). Initial enrollment in the Handicapped category requires 1) a diagnosis from a physician with an ICD-9 diagnosis code, 2) a letter from the doctor detailing the dependent's limitations, capabilities and onset of condition and 3) a statement from the Social Security Administration with the Social Security disability determination or a court order adjudicating the disability.

      Note: The final determination of the dependent's Handicapped status will be made by CMS. If eligible, the dependent's recertification will be processed by the Group Insurance Division.

   c. **"Other"**: Proof that the dependent age 19 or older has <u>either</u> (1) received an organ transplant after June 30, 2000, **or** (2) been **continuously** enrolled in the State Group Insurance Program (or CNA for universities) under a member since 2/11/83 or (3) was a member of the U.S. Armed Services, including National Guard, on or after January 1, 2002 and is now a full-time student (up to age 25). (***Note:*** Enrollment in Golden Rule does **not** count toward being continuously enrolled.)

Notes Regarding "Other":

- *Golden Rule was a private policy offered in 1980's to cover the dependents of a member. Golden Rule policies were not part of the State Employees Group Insurance Program; therefore, coverage under a Golden Rule policy, or any other private policy, does not apply toward one's continuous enrollment in the Group Insurance Program.*
- *Dependents enrolled in the "Other" category are **not** eligible for life insurance coverage.*
- *Proof of continuous enrollment in the state health program, or in CNA, if applicable, must be provided. The Membership System may not have the correct employee start date due to the system's conversion; therefore, the GIR/P should have the Membership Unit verify the dependent's continuous enrollment.*

2. Effective Dates of Dependents age 19 and Above

ENROLLEE		CRITERIA	EFFECTIVE DATE
STUDENT	Dependent of New Employee	***If the member is adding the dependent during the period of September through April***, the dependent must currently be attending classes in a full-time capacity.	Same as new employee
	Dependent of New Employee	***If the member is adding the dependent during May, June, July or August***, the dependent must have attended school in a full-time capacity during the most recent Spring semester.	Same as new employee
	Dependent Enrolled Due to Qualifying Change in Status	***If the member is adding the dependent during the period of September through April***, the dependent must currently be attending classes in a full-time capacity.	Date request is signed
	Dependent Enrolled Due to Qualifying Change in Status	***If the member is adding the dependent during May, June, July or August***, the dependent must have attended school in a full-time capacity during the most recent Spring semester.	Date request is signed
	Dependent Enrolled During Benefit Choice Period	***If the member is adding the dependent during May,*** the dependent must have attended school in a full-time capacity during the most recent Spring semester.	July 1st
Note: Dependents who do not meet the 'Student' criteria (above) are not eligible to be enrolled in the Group Insurance Program until either the first day of the month in which classes begin or the date coverage is requested, *whichever is later.*			
HANDICAPPED & OTHER	Dependent of New Employee	***If the member is adding the dependent upon initial enrollment,*** the dependent must satisfy the Handicapped or "Other" requirements.	Same as new employee
	Dependent Enrolled Due to Qualifying Change in Status	***If the member is adding the dependent due to a Qualifying Change in Status,*** the dependent must satisfy the Handicapped or "Other" requirements.	Date request is signed
	Dependent Enrolled During Benefit Choice Period	***If the member is adding the dependent during the Benefit Choice Period,*** the dependent must satisfy the Handicapped or "Other" requirements.	July 1st
	Dependent Enrolled Due to No Longer Being a Student	***If the member is adding the dependent due to the dependent no longer qualifying as a Student,*** the member should wait until the next recertification period to enroll the dependent in the Handicapped or "Other" category.	Recertification Date

C. State-Employed Spouses

- Spouses who are both actively working full-time for the state and are eligible for insurance coverage must each be enrolled as a member in their own right.

- Full-time employees on a leave of absence in which the state continues to contribute to the cost of their coverage **may not** elect to be a dependent of their state-employed spouse.

- Full-time employees and survivors may not elect to opt out of health, dental and vision and enroll as a dependent on another plan administered by the Department of Central Management Services (i.e., LGHP, CIP, TRIP).

- Effective August 20, 2003, annuitants may elect to become a dependent of their state-employed spouse. These annuitants are covered as a dependent for health, dental and vision, and as a member for life coverage (see 'Waiver Option' in Section 2.0.A.3, 'Annuitants' for details).

- Members who are ineligible to receive the state's contribution to the cost of their insurance coverage may be covered as a dependent of their state-employed spouse. The following are the two situations in which an ineligible member may be covered as a dependent of their state-employed spouse:

    1. Employees in certain non-pay status (such as personal/general leave of absence, dock/suspension over 30 days and those employees who have exhausted the maximum coverage period allowed under the leave classification) have the option of electing coverage as a dependent of their state-employed spouse.

    2. If a spouse terminates eligibility as an employee, that spouse may be enrolled as a dependent of the other member (does not apply for termination due to non-payment of premium). If requested within 10 days of termination, no break in coverage occurs.

- Either spouse may elect health coverage for dependents; however, the same dependent cannot be enrolled under both members for the same type of coverage (health, dental, life, vision). For example, eligible dependents may be enrolled under one spouse for health and dental and enrolled in life coverage under the other spouse. Furthermore, all dependents are not required to be enrolled under the same member.

- Effective July 1, 2003, a part-time employee **may not** be enrolled as a dependent of their state-employed spouse.

- A part-time employee may only be carried as a dependent on a spouse's coverage if they waived *all coverage* as a member prior to July 1, 2003.

- New SERS/SURS/TRS Annuitants who waived health/dental/life coverage prior to July 1, 2003 while in active status as a part-time employee and became a dependent of a spouse may continue as a dependent while receiving an annuity.

3.2 Opting (Out/In)/Waiving/Transferring/Retiring

A. Opting Out of Health, Dental and Vision Coverage

Full-time active employees, annuitants/retirees and survivors are allowed to opt out of the State Group Insurance Program's health, dental and vision coverage as long as they provide proof of comprehensive major medical health coverage (indemnity or managed care) provided by an entity other than the Department of Central Management Services. Proof of coverage may be a Certificate of Creditable Coverage or a copy of the front and back of the member's health ID card. Medicare and Medicaid are considered acceptable forms of other coverage. ***Note***: A member's application for other health coverage is not acceptable proof of other coverage.

Members electing to opt out of the health/dental/vision coverage must be enrolled with Basic Life coverage and may elect optional life coverage.

Members opting out of the Program **are not** eligible for the:

- Free influenza shot offered to state employees
- COBRA continuation of coverage
- Smoking Cessation Program

Members opting out of the Program **are** eligible for the:

- Paid maternity/paternity benefit
- Flexible Spending Accounts (FSA) Program
- Commuter Savings Program (CSP)
- Either of the two separate Employee Assistance Programs
- Long-Term Care Program
- Adoption Benefit Program

New employees: All new full-time employees electing to opt out must be entered on the Membership System with state-paid Basic Life coverage. These employees must complete an Initial Enrollment form (CMS-310) in addition to completing Section A of the "Opt Out & Opt In Election Certificate" (CMS-500).

Members currently enrolled in the Group Insurance Program may elect to opt out of the coverage only during the annual Benefit Choice Election Period or when an eligible qualifying change in status occurs. These members must complete and sign an "Opt Out & Opt In Election Certificate" (CMS-500).

The election to opt out of coverage, either by a current full-time member, new full-time employee, annuitant/retiree or survivor remains in effect until the next annual Benefit Choice Period or until an eligible qualifying change in status occurs. See Section 3.2.B, 'Opting Back Into Health, Dental and Vision Coverage' for details on opting back into health, dental and vision coverage.

Opt Out Documentation

- **Opt Out Documentation Approved**
  Once documentation has been provided and approved, the GIR/P must complete the "GIR/P Use Only" portion of Section A on the "Opt Out & Opt In Election Certificate" (CMS-500). Once completed, the GIR/P may process the opt out election on the Membership and payroll systems. The Membership transaction must be processed on the Membership file by placing the member in a special 'Opt Out' type/subtype code with life only coverage (i.e., 1051, 1053 or 1056). ***Note:*** For assistance in determining whether documentation is acceptable, the GIR/P should call the Membership Unit. See Section 10.4, 'Opt Out Coding,' for Membership and payroll coding instructions.

  Once the transaction has been processed, the member and the agency GIR/P will receive a copy of the Verification form denoting the type code change. A Notice letter (see a copy of the 'Notice' in Appendix I – "Sample Letters") will be included with the member's copy of the Verification form and includes information regarding the "opt in" process.

- **Opt Out Documentation Denied**
  Documentation which does not meet the proof requirement of comprehensive major medical health coverage must be denied by the GIR/P. Members whose opt out request was denied will not be allowed to request to opt out again until the next Benefit Choice Period or until an eligible qualifying change in status occurs.

B. Opting Back Into Health, Dental and Vision Coverage

Employees, annuitants/retirees and survivors are allowed to opt back into health, dental and vision coverage during the annual Benefit Choice Period or when an eligible qualifying change in status occurs (see the Consistency Matrix in Appendix A). Employees electing to opt back into the coverage are subject to pre-existing condition limitations.

Members who elect to opt back in during the Benefit Choice Period do not need to provide proof of the loss of other coverage; however, they do need to provide a Certificate of Creditable Coverage from the previous insurer if they are enrolling in a health plan which applies pre-existing condition limitations.

Members who elect to opt back in due to a Qualifying Change in Status must provide proof of the loss of other coverage in the form of a Certificate of Creditable Coverage from the previous insurer.

Members opting back into the Program must:

- Complete the appropriate form:
  - Benefit Choice Election form (CMS-350) (if enrolling during the Benefit Choice Period),
    OR
  - Initial Enrollment form (CMS-310) (if enrolling due to a qualifying change in status)
- Complete Section B of the "Opt Out & Opt In Election Certificate" (CMS-500)
- Provide a Certificate of Creditable Coverage from the previous insurer, if applicable
- Provide qualifying change in status back-up documentation

The GIR/P must complete the 'GIR/P Use Only' portion of the "Opt Out & Opt In Election Certificate", Section B. Once completed, the GIR/P must send all forms and documentation to CMS for approval. If approved, the Membership Unit will activate the member and eligible dependent's health, dental, and vision coverage effective *the later of:*

- the date of the event (if requested prior to the event), **or**
- the date the request was signed (must be within 60 days of the event).

Dental Option: Effective July 1, 2004, members who elect to opt back into the Program may choose not to participate in the dental plan at that time. Members electing this option must check the 'I elect not to participate in the Dental Plan' box on the Initial Enrollment form (CMS-310). Members electing not to participate in the dental plan will not be given the option to re-enter the plan until the next Benefit Choice Period.

C. Waiving Coverage (Part-time Employees)

Part-time employees may elect to waive coverage in which they are required to pay a portion of the state-paid premium. Part-time employees who elect not to participate in health, dental and vision coverage are considered to have waived – not to have "opted out" of coverage. (*Opt out* is a term used for full-time employees, annuitants/retirees and survivors.) **Part-time new hires who do not submit a "Part-time Employee Election/Waiver of Group Insurance Participation" form to waive coverage must be defaulted to the Quality Care health and dental plans.**

The effective date of the part-time waiver is the later of the signature date of the request or the date of the qualifying change in status event.

Part-time employees may not waive coverage and become a dependent of their state-employed spouse. Only those part-time employees who waived coverage and became a dependent of their state-employed spouse prior to July 1, 2003 may continue to waive coverage. Part-time employees who waived coverage prior to July 1, 2003 are not eligible for life coverage as a member.

Part-time employees eligible for the Group Insurance Program may:

(a) elect health/dental/vision/optional life coverage
(b) elect health/dental/vision
(c) elect optional life coverage only

Note: Part-time employees waiving health, dental and vision coverage must be coded on payroll with an eligibility code of 'U' indicating 'Life Part-time.' The carrier codes on payroll should be coded 'NH' for "no health" and 'ND' for "no dental."

Eligible part-time employees (working 50% - 99%) may only waive health, dental and vision coverage during the Initial Enrollment Period, the Benefit Choice Period or when an eligible qualifying change in status occurs.

D. Employee Transferring to Another Agency

Employees leaving a state agency or university and starting employment within 10 days with another state agency or university are considered "transfers." No break in coverage occurs in the interim period between agencies. The employee's existing coverage elections will remain the same unless the health carrier is not available in the area the employee is transferring. In this situation, the employee may choose a new carrier which is valid for the new area.

When an employee transfers to a different agency, the GIR/P of the 'losing' agency must change the organizational processing code (org proc code) on the Membership System. If the org proc code is not changed, the 'receiving' agency will not have access to the employee's online information. The effective date of the transfer to the 'receiving' agency must be the day following the last day worked at the 'losing' agency. Once the change is processed, the 'receiving' agency will have access to the employee's online file.

The GIR/P must forward a **copy** of the employee's entire insurance file to the receiving agency's Benefit Office. The State Records Commission requires the 'losing' agency to maintain all original documents signed by the employee, as well as any verifications obtained for eligibility. (See Appendix B, 'Recordkeeping Requirements.')

DO NOT TERMINATE THE EMPLOYEE'S INSURANCE IF THEY ARE TRANSFERRING TO ANOTHER AGENCY.

E. Employee Retiring

Most Benefit Choice elections are available to employees who are retiring if requested within 60 days of filing the application for the annuity, or of the effective date of the annuity, w*hichever is later*. Annuitants/retirees electing to opt out of health, dental and vision coverage must remain on the Membership System with Basic Life coverage. Eligible annuitants/retirees may elect optional life coverage (see Section 1.4.C.6, 'Continuing Life Coverage upon Retirement' for eligibility). Retirees cannot participate in the FSA Program.

If an employee works any portion of the last pay period prior to the date of retirement, the retirement system will change the organizational processing code (org proc code). The GIR/P should not terminate the coverage**,** change the org proc code or process any other transaction for these members. However, in the event that a semi-monthly employee does not work any day of the last pay period prior to retiring, the GIR/P should terminate the member's coverage. If a GIR/P does not know if the employee is retiring or if they are terminating employment, the employing agency should contact the retirement system.

Examples:

- An employee who is paid semi-monthly (or monthly) works through May 18th and retires with an effective date of June 1st. The employee worked a portion of the last pay period prior to retirement; therefore, the employing agency should not process any Membership System transactions for the employee.

- An employee who is paid semi-monthly works through May 12th and retires with an effective date of June 1st. The employee did not work any portion of the last pay period prior to retirement; therefore, the employing agency should terminate the employee's coverage (8008) on the Membership System effective May 13th.

Since the 'losing' agency is responsible for retention of the employee's insurance files, GIR/Ps should not transfer the insurance files of employees entering the retirement system either due to receiving an annuity or going on a disability leave of absence. If the org proc code has not been changed within 60 days, the GIR/P should contact the retirement system.

F. Annuitant Rehired by Agency or University

Active annuitants employed by an agency or university **and** who are receiving an annuity must be enrolled as an active full-time employee (1001) in the Group Insurance Program. Annuitants working less than full-time (50%-99%) may choose to continue coverage under their annuity or choose coverage as a part-time employee.

Annuitants working full-time must have a copy of their insurance file transferred from the agency they previously were employed by to the new employing agency. The health-deduct code (health premium) and Basic Life Units (BLUs) must be based upon the salary that the agency or university gave the annuitant at the time of rehire.

3.3 Supplemental Enrollment Information

A. Coordination of Benefits

GIR/Ps must give new members the Coordination of Benefits worksheet (see a sample worksheet in Appendix D, 'Forms Requiring Member's Signature') to complete for themselves and for each of their covered dependents. This worksheet identifies other group insurance coverage, if any. GIR/Ps must enter this information on the Membership System when enrolling the member and dependents. (See Section 12, 'Adding a New Member' for step-by-step instructions on entering Coordination of Benefits information.)

Members and/or dependents who have a group medical or dental plan in addition to the state plan are subject to Coordination of Benefit (COB) rules that specify duplicate payment by multiple insurance companies will not be made on a single claim.

B. Part-time Employee Election/Waiver of Group Insurance Participation

All part-time employees hired on or after January 1, 1980 must be given a "Part-time Employee Election/Waiver of Group Insurance Participation" to complete and sign (see Appendix D, 'Forms Requiring Member's Signature' for a sample of the form). The certificate explains the options part-time employees have regarding insurance and provides space for the employee to elect or waive health and dental coverage. Agencies must maintain a copy of all such certificates in the employee's file.

All part-time employees hired prior to January 1, 1980 and working at least 50% are considered full-time employees and are not required to complete a "Part-time Employee Election/Waiver of Group Insurance Participation."

Part-time employees whose hours are reduced to the extent that they do not meet the criteria for participation (i.e., reduced to below 50% part-time employment) are eligible to continue benefits in the group health and dental programs under COBRA.

C. Dual Membership Provisions

The State of Illinois administers health coverage for four Programs:

State Group Insurance Program
Local Government Health Plan (LGHP)
Teachers' Retirement Insurance Program (TRIP)
College Insurance Program (CIP)

The chart below represents benefits available to members enrolled in each of the following programs:

Plan	State	TRIP	LGHP	CIP
Health	X	X	X	X
Dental	X		X	X
Vision	X		X	X
Life	X			

Dual enrollment allows a retiree, survivor, member or dependent the ability to enroll in multiple groups simultaneously; however, an enrollee cannot be a member and a dependent in the same group (i.e., TRIP, CIP, State or LGHP) simultaneously, with the exception of annuitants who waive coverage to become a dependent of their state-covered spouse (see 'Annuitants' in Section 2.0.A.3, 'Eligible as Members' for more information).

Enrollee is a Member in the State Group	***Can also be a Member in:***	***Can be a Dependent in:***
LGHP	X	X
TRIP	X*	X
CIP	X**	X

Enrollee is a Dependent in the State Group	***Can also be a Member in:***	***Can be a Dependent in:***
LGHP	X	X
TRIP	X*	X
CIP	X**	X

* Effective January 1, 1998:
- **retirees and survivors** are allowed to be dual enrolled in the TRIP health plan and the state life plan.
- **active members or dependents** cannot be dual enrolled in both the TRIP and state health plans.

** Effective January 1, 1999:
- **retirees and survivors** are allowed to be dual enrolled in the CIP health/dental/vision plans and the state life plan.
- **active members or dependents** cannot be dual enrolled in both the CIP and state health plans.

D. Pre-Existing Conditions

Certain state health plans have a pre-existing condition exclusion period for new state employees enrolling in a health plan. The member may be excluded from coverage by the carrier for up to 6 months for treatment that is related to a condition which existed prior to the enrollment date.

1. **Definition of Pre-Existing Condition:** A pre-existing condition is any disease, condition (excluding maternity) or injury for which the individual was diagnosed, received treatment or services or took prescribed drugs during the three months immediately preceding the effective date of coverage under the Program. No benefits are payable for any services relating to pre-existing conditions that are incurred during the first six months of a new member's coverage. After the initial six months, the pre-existing condition exclusion no longer applies, even if the member changes from one plan to another.

Membership System Note: When viewing the pre-existing field, the number of months indicated on the Membership System will not decrease. The health plan provider will calculate whether the pre-existing condition exclusion is still in effect when individual claims are processed.

2. **Reduction of Pre-Existing Exclusion Period:** The pre-existing condition exclusion period may be reduced by the amount of coverage a member or dependent had with another insurance plan prior to enrollment with one of the state's plans, provided there was not a break in coverage of more than 63 days. This is called "creditable coverage." The member must bring the agency GIR/P a "Certificate of Creditable Coverage" (or other acceptable documentation – see Section 3.3.E, 'Certificate of Creditable Coverage') from the member's prior plan to reduce the pre-existing time period. Federal law, HIPAA (Health Insurance Portability and Accountability Act), requires all health insurance plans to provide "Certificates of Creditable Coverage" upon termination from a plan.

3. **Pre-Existing Exclusions:** HIPAA provides that coverage for the following members is not subject to the pre-existing condition limitations:

   - Newborn children
   - Adopted children
   - Pregnant members

   Additionally, should a member become a covered dependent of another member with no break in coverage, or less than a 10-day break in coverage during the transition, pre-existing condition limitations do not apply. This is also true should a covered dependent become a member with no break in coverage or less than a 10-day break in coverage.

4. **Calculation of Pre-Existing Months:** The GIR/P must calculate the number of pre-existing months for new members enrolling in the State Group Insurance Program. This number will be used to indicate the number of months a pre-existing condition will not be covered by the new carrier (i.e., exclusion period).

   There are two steps in calculating the number of pre-existing months.

   Step 1: Calculate the number of days the member or dependent experienced a break in coverage.

   - Add the days between the last day of coverage under the member's previous plan (found on the "Certificate of Creditable Coverage" letter) and the start date of state coverage.

   Note: Members having coverage for 1 – 31 days in any given month will have this period of time counted as a full month of coverage.

   Step 2: Determine number of pre-existing months that will apply to member or dependent.

   - If the number of days is 63 or greater, the member or dependent must be coded on the Membership System with a '6' month pre-existing condition exclusion period.

   - If the number of days is less than 63, the GIR/P must use the number of months the member or dependent had coverage through the previous insurer to calculate the end result.

     - If the number of months of previous coverage was **6 or greater**, no pre-existing condition exclusion period would apply. The member or dependent must be coded on the Membership System with a '0' in the pre-existing condition exclusion period field.

     - If the number of months of previous coverage was **less than 6**, the GIR/P must subtract the number of months of coverage through the previous insurer from 6. The member or dependent must be coded on the Membership System with this calculated result in the pre-existing condition exclusion period field.

Example: Break in coverage of 63 days or less:

- October 18, 2007 was employee 'A's last work day at company 'B'. 'A' had insurance coverage through company 'B' for 4 months, as indicated on the Certificate of Creditable Coverage.
- First day of state coverage is 01/22/2008.
- October and January would count as full months of coverage (due to "Note" above).
- November (30 days) and December (31 days) count toward pre-existing, **for a total break in coverage of 61 days.**
- Therefore, since the member was covered by the previous insurer for 4 months, employee 'A' must satisfy a two month pre-existing condition exclusion period. The GIR/P must code this member with a '2' in the pre-existing field on the Membership System.

Example: Break in coverage of more than 63 days:

- October 18, 2007 was employee 'A's last work day at company 'B', as indicated on the Certificate of Creditable Coverage.
- First day of state coverage is 02/22/2008.
- October and February would count as full months of coverage (due to "Note" above).
- November (30 days), December (31 days) and January (31 days) count toward pre-existing, for a total break in coverage of 92 days.
- Since the break is greater than 63 days, the months the member was covered by the previous plan **would not count toward the pre-existing months**. Therefore, the member would need to satisfy a six month pre-existing condition exclusion period. The GIR/P must code this member with a '6' in the pre-existing field on the Membership System.

E. Certificate of Creditable Coverage

New members and their dependents enrolling in a state insurance plan are required to give the GIR/P a copy of the Certificate of Creditable Coverage from the previous insurer in order to reduce or eliminate the exclusion period. Other forms of acceptable documentation include, but are not limited to, pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOB's) or verification from a doctor or former healthcare provider.

Upon receipt of the documentation, the GIR/P must calculate the applicable number of months in which the pre-existing conditions exclusion will apply (see Section 3.3.D, 'Pre-Existing Conditions'). If the new member does not have a Certificate of Creditable Coverage or other acceptable documentation, the GIR/P should enroll the member with six months of pre-existing.

F. Medicare

GIR/Ps should routinely ask members either upon employment, going on a leave of absence or returning from a leave of absence, questions about their Medicare status to ensure they are properly coded on the Membership System.

1. **Members Turning Age 65:** Upon a member (actively working or not actively working) or dependent turning age 65, the Medicare Part A and Part B 'Effective Date' field on the Membership system will be automatically defaulted to indicate the member/dependent is enrolled in Medicare Part A and Part B.

   Members and dependents *not eligible for premium-free Medicare Part A,* must provide written certification from the Social Security Administration (SSA) that they are **ineligible** for premium-free Part A based on their own work history or the work history of any current or former spouse. Without this certification, claims may be held without payment until the certification is received.

   Not actively working members and/or dependents who are eligible for premium-free Medicare Part A are required to enroll in Medicare Part B. Failure to enroll into Medicare Part B results in a reduction of benefits. Members and/or dependents that do not enroll in Medicare Part B (when required) will have their benefits reduced as if they have Medicare Part B.

2. **Updating Medicare Status on the Membership System:** If at any time a member or dependent becomes eligible for, or enrolls in, Medicare, a copy of the Medicare card **must** be provided to the agency GIR/P. The Group Insurance Division's Medicare COB Unit must be notified upon receipt of the Medicare card. **The GIR/P must also inform the Medicare COB Unit of the type of Medicare entitlement (age, disability or ESRD).** An incorrect Medicare status on the Membership file could cause substantial claim and/or financial problems for the member. It is important to update Medicare enrollment information as soon as it is received.

   All Medicare status changes on the Membership System to 'Medicare Ineligible' must be submitted to the Medicare COB Unit for processing.

   The GIR/P is not allowed to:

   - Add a member/dependent to the Membership System as 'Medicare Ineligible', or
   - Change a member/dependent's Medicare status to 'Medicare Ineligible'.

3. **Medicare Secondary Payer Notice:** Contact the Group Insurance Division's Medicare COB Unit at CMS immediately if:

   - You (the GIR/P) receive a Medicare Secondary Payer Notice from CMS (Centers for Medicare & Medicaid Services), Mutual of Omaha, WPS (Wisconsin Physicians Service) or a collection agency affiliated with the U.S. Department of Treasury.

   - A member receives correspondence from Medicare or the Medical Plan Administrator stating that the state and Medicare are both secondary payer.

4.0 General Information

Changes in group insurance coverage are only allowed outside the Benefit Choice Period when the member experiences a qualifying change in status or when the member chooses to change coverage that is not subject to the IRS rules of Irrevocability. Documentation must be provided to support the qualifying event. See Appendix B - 'Documentation Requirements' to determine the documentation required to process each transaction listed in this section.

Section 4.1 explains each qualifying change in status and the coverage changes allowed for that specific qualifying change reason.

Section 4.2 explains the IRS Irrevocability rules and the exceptions which can be granted regarding that rule.

NOTE: **GIR/Ps should make every effort to process Membership transactions immediately upon receipt.**

4.1 Qualifying Changes in Status

A. Consistency Rule

Federal regulations require that all mid-year changes in coverage, which result in a gain or loss of eligibility, be consistent with the qualifying change in status event the member has experienced. This requirement is called the Consistency Rule.

Example: A member who has a baby is only allowed to add the baby to existing coverage.

Please refer to Appendix A – 'Consistency Matrix' for a quick reference of the specific changes allowed for each qualifying change in status.

B. Qualifying Change in Status Detail

The following section gives the GIR/P specific documentation requirements, effective dates of coverage, coverage options available, Membership form requirements, eligibility requirements, pre-existing condition specifications, etc., regarding all qualifying changes in status allowed by the Program. If a qualifying change in status is not listed, please contact GID for a determination.

C. Qualifying Change in Status Index

The list below identifies the qualifying changes in status explained in this section, as well as the corresponding page numbers.

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1. Birth

Birth constitutes a qualifying change in status which allows a member to add a newborn dependent, add Child Life coverage and/or increase member Optional Life coverage.

The member must notify the agency in writing within 60 days of the birth and provide a copy of the birth certificate. ***Note:*** Hospital birth certificates are acceptable.

a. **Effective Date of Coverage:** The effective date for newborn coverage may be **retroactive** to the date of birth, if the coverage was requested within 60 days of the birth.

If coverage for the newborn is requested after 60 days, the member must wait until either a qualifying change in status occurs or until the next Benefit Choice Period to enroll the newborn. However, if at least two other dependents are currently enrolled on the member's coverage, the newborn may be enrolled any time during the plan year, effective the date the request was signed (see Irrevocability Exceptions – 'Change Dependent Health Coverage in the '2+ Dependent' Category' in Section 4.2.B.1 for explanation.)

b. **Child Life Coverage:** Newborn dependents may be enrolled with Child Life coverage without the need for Statement of Health approval, if enrolled within 60 days of birth. Coverage may be effective the date listed on the birth certificate.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Birth	Name of Form	Complete
Adding newborn	Dependent Change Form (CMS-313)	Entire form
	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Coordination of Benefits Worksheet	Entire form
Increase or add member Optional Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

2. Adoption

Adoption is a qualifying change in status which allows a member to add health/dental/vision for the adopted child, Child Life and/or increase member Optional Life coverage.

The member must notify the agency in writing within 60 days of the birth, the filing of the petition for adoption or of the final order granting the adoption.

a. **Effective Date of Coverage:** If the request for change is made within 60 days, coverage may be retroactive to the date of birth or placement for adoption.

b. **Foreign Adoption:** All foreign adoption decrees and/or court orders must be translated into English.

c. **Pre-Existing Condition**: Pre-existing condition requirements are **waived** for adopted children.

d. **Child Life Coverage:** Members may apply for **Child Life** any time during the plan year; however, if Child Life coverage is elected within 60 days of the petition for adoption being filed or of custody being granted, Statement of Health approval is **not** required.

e. **Adoption Benefit Program**: Once the adoption has been finalized, the employee may apply for an adoption benefit through the Adoption Benefit Program.

f. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Adoption	Form	Complete
Adding adopted dependent	Dependent Change Form (CMS-313)	Entire form
	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Coordination of Benefits Worksheet	Entire form
Increase or add member Optional Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See ‘Adding Dependent(s) Coverage to Existing Member’ in Section 12 for step-by-step instructions.

3. Member Awarded Custody (or permanent guardianship) or Loses Custody (or permanent guardianship) of a Child

A qualifying change in status occurs when a United States court order awards or dissolves a member's custody and/or permanent guardianship. The member may elect to add or drop (in accordance with the order) the affected dependent's coverage. The member must notify the agency in writing within 60 days of being awarded custody/guardianship in order to add dependent coverage. Members awarded custody may add Child Life coverage with Statement of Health approval.

Note: The term "custody" usually refers to the member being responsible for a natural child; whereas, the term "guardianship" usually refers to a member being responsible for a child who is not a natural child of the member.

a. **Dependent Eligibility Requirements:** Dependent eligibility, as defined in the Group Insurance Act, must be met regardless of what the court order reads.

Eligibility requirements are:

- the dependent must be eligible to be claimed on the member's taxes, and
- the dependent must be financially dependent upon the member, and
- the dependent must live with the member in a parent-child relationship at least 50% of the time (unless they are a natural child of the member).

Example: In the case of a grandchild being awarded to a grandparent, the dependent must live with the member (i.e., grandparent), be eligible to be claimed on the member's taxes and be financially dependent on the member to be eligible for coverage.

b. **Effective Date of Coverage:**

- Coverage is effective the signature date of the member's request in order to add the dependent if the GIR/P **received** a copy of the U.S. court order *awarding custody or establishing guardianship* within 60 days of the circuit clerk file stamp date.
- If the GIR/P does not receive a copy of the U.S. court order *awarding custody or establishing guardianship* within the 60-day period, the dependent may not be added until the next Benefit Choice Period or until a qualifying change in status occurs.
- Termination of coverage is effective the date of the circuit clerk file stamp of the U.S. court order *dissolving custody or guardianship*. ***Note:*** A natural child does not automatically lose eligibility because the member loses custody. Termination of coverage for a natural child is voluntary; therefore, the child would not be eligible for COBRA coverage.

c. **Child Life Coverage:** Statement of Health approval is required to add Child Life coverage for a member awarded custody of a natural child. Statement of Health approval is not required to add Child Life for a member awarded guardianship of a newly acquired child (not a natural child).

d. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Awarded/Loses Custody or Guardianship	Form	Complete
Adding dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
	Coordination of Benefit Worksheet	Entire form
Dropping dependent	Dependent Change Form (CMS-313)	Top portion of form with signature and date, Dep. Biographical, Dependent Group – include termination reason code
Add Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

4. Adjudicated Child (Court Establishes Member's Financial Responsibility for a Child's Health, Dental or Other Healthcare)

A qualifying change in status occurs when a court order establishes the member's financial responsibility for dependent health, dental or other healthcare.

Court orders establishing the member's financial responsibility of a child for the first time are referred to as Judicial Support Orders (signed by a judge) or National Medical Support Notices from the Department of Healthcare and Family Services (HFS) signed by an HFS Representative. These court orders establish a member's responsibility for a child's health, dental or other healthcare coverage.

A copy of the National Medical Support Notice signed by an HFS representative will be sent by HFS directly to the Benefits Office of the member's agency. The GIR/P must maintain a copy of this document in the member's insurance file.

A copy of the Judicial Support Order signed by a judge must be submitted to the GIR/P in the required timeframe in order to add dependent coverage.

Note: The term "adjudicated" child usually refers to a member who is determined through a blood test to be the father of a child; however, the member does not have custody of the child.

a. **Effective Date of Coverage**

- *Order Received Within 60 Days:*

  If the order is received within 60 days of the date of the circuit clerk's file stamp or HFS Representative's signature and date, coverage is **effective the date of file stamp or HFS signature date**.

- *Order Received After 60 Days:*

  A Judicial Support Order or a National Medical Support Notice **received after** the 60-day period may be processed, at most, with an effective date six months **RETROACTIVE** from the date received.

Note: The effective date cannot be prior to the date of the circuit clerk file stamp or HFS signature date.

b. **Child Life Coverage:** Child Life coverage may be added without Statement of Health approval for adjudicated child(ren), if requested within 60 days of circuit clerk file stamp date or the date of the HFS representative's signature.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Adjudicated Child	Form	Complete
Adding adjudicated dependent	Dependent Change Form (CMS-313) ***Member signature not required for National Medical Support Notices*	Entire form
	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

5. Dependent Becomes Eligible

A qualifying change in status occurs when a previously ineligible dependent becomes eligible for state group insurance coverage. Once eligible, the member may add the dependent by notifying the agency in writing within 60 days of the eligibility date.

Examples in which a dependent may become eligible for state coverage:

- A child between the ages of 19 and 23 returns to school full-time, or
- A stepchild comes to live with the member in a parent-child relationship at least 50% of the time.

If the dependent becomes eligible for other group insurance coverage, the member may drop the dependent's coverage by notifying the agency in writing within 60 days of the dependent becoming eligible for the other coverage.

Example in which a dependent becomes eligible for other group coverage:

- A student dependent is offered group insurance coverage through their school or university.

a. **Effective Date of Coverage:** The effective date of coverage is ***the later of:***

- the date of the event (if requested prior to the event), **or**
- the date the request was signed (must be within 60 days of the event).

b. **Child Life:** Child Life coverage may be added with Statement of Health approval.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Eligible Dependent	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
	Coordination of Benefits Worksheet	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination code
Add Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' and 'Terminating Dependent Coverage' in Section 12 for step-by-step instructions.

6. Marriage

Marriage constitutes a qualifying change in status which allows a member to add coverage for the spouse and any stepchild(ren) living with the member in a parent-child relationship at least 50% of the time. Members may also increase or decrease member Optional Life coverage, add Spouse Life or Child Life, opt out of health/ life/dental coverage and/or opt back into group insurance coverage if they had previously opted out. The member must notify their agency of the marriage in writing within 60 days of the marriage.

a. **Effective Date of Coverage:** The effective date of coverage is ***the later of***:

- the date of the marriage (if requested prior to the marriage), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the marriage if it was not requested prior to the marriage.

b. **Spouse and/or Child Life Coverage:** Statement of Health approval is not required to add Spouse and/or Child Life for dependents enrolled due to the marriage if enrollment occurs within 60 days of the marriage.

***Note**: A member may apply for **Spouse and/or Child Life** any time during the plan year. However, Statement of Health approval from the Life Plan Administrator is required if not added within the initial 60-day period.*

c. **Pre-Existing Condition:** Pre-existing condition limitations may apply. See Section 3.3.D, 'Pre-Existing Conditions'.

d. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Marriage	Form	Complete
Changing marital status	Member Change Form (CMS-312)	Member Biographical
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Spouse is employed	Coordination of Benefits Worksheet	Entire form
Increase member Optional Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

7. Divorce, Legal Separation or Annulment

A member who experiences a divorce, legal separation or annulment has a qualifying change in status. The member must, in the case of divorce or annulment, terminate the spouse and/or stepchild(ren) from all coverage. In the case of legal separation, the member may terminate the spouse and/or stepchild(ren)'s coverage if they wish. Members may also increase or decrease member Optional Life coverage during these changes in status and/or opt back into group insurance coverage if they had previously opted out.

The member must notify their agency in writing within 60 days of a divorce, legal separation or annulment.

a. **Termination Effective Date**: A member's spouse and stepchildren become ineligible for coverage effective midnight the day prior to the circuit clerk file stamp date on the divorce decree or annulment court order. In the case of legal separation, the member's spouse and stepchildren become ineligible for coverage effective midnight on the date of the request or the event, whichever is later.

Example: Member's divorce decree has a circuit clerk file stamp date of 2/14. The spouse and stepchildren have coverage through midnight of 2/13.

b. **Untimely Notification:** Coverage of a member's ex-spouse and stepchildren must be terminated retroactively to the effective date of the divorce. Premiums paid for the ineligible dependents are refundable if notification is received within 60 days of the event. Dependents whose coverage is terminated for untimely notification are not eligible for COBRA.

Example: Member becomes divorced 1/1, but does not notify the GIR/P until 9/1. Dependent premiums paid for the period of January 1st to August 31st will not be refunded.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Divorce, Separation/Annulment	Form	Complete
Changing marital status	Member Change Form (CMS-312)	Member Biographical
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code
Increase member Optional Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Terminating Dependent Coverage' in Section 12 for step-by-step instructions.

8. Death of a Spouse or Dependent

When a member's spouse dies, the member has a qualifying change in status which allows the member to add eligible dependents who had insurance coverage under the decedent and/or opt back into group insurance coverage if they had previously opted out.

When a member's spouse or dependent dies, the member may increase or decrease member Optional Life coverage. The member must notify their agency in writing within 60 days of the death.

a. **Effective Date of Termination of Deceased:** The deceased spouse or dependent has coverage through midnight of the date of death.

Benefits terminate the day following the actual date of death.

Example: Dependent dies 2/12. Benefits terminate effective 2/13.

b. **Effective Date of Dependent Coverage**

- **Non-State Employed Spouse Dies**

  When adding eligible dependents who were originally covered by the deceased spouse, the effective date of coverage is the date the request to add the dependents was signed, if requested within 60 days of the death.

  If the request to add the dependents is received later than 60 days after the death, the member must wait until a qualifying change in status occurs or until the next Benefit Choice Period.

- **State-Employed Spouse Dies**

  If the deceased spouse was a state employee, the surviving spouse (also a state-employed member) has 60 days from the date of the spouse's death in which to add dependents who were previously covered by the deceased spouse. A COBRA notification letter will automatically be generated and sent to each covered dependent when the spouse's death is processed on the Membership System. Dependents of the deceased spouse may be eligible for survivor benefits. Please contact the retirement system for details.

c. **Adding Dependent of Deceased Member to State-Employed Spouse's Coverage**

- If the request to add dependent health/dental/vision is made **within 10 days of the death**, the dependent(s) would not experience a break in coverage.

  If the deceased spouse had the dependents enrolled in Child Life, the member may add Child Life coverage without Statement of Health approval.

- If the request to add dependent health/dental/vision is made between **10 and 60 days after the death,** the dependent(s) may still be added but will experience a break in coverage.

  The member will need Statement of Health approval to add Child Life coverage.

- Requests **received greater than 60 days after the death** will not be processed. The member must wait until a qualifying change in status occurs or until the next Benefit Choice Period to add the dependent.

d. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Spouse/Dependent Death	Form	Complete
Dependent deceased	Dependent Change Form (CMS-313)	Dep. Bio, Dep. Group include termination reason code
Changing marital status of member	Member Change Form (CMS-312)	Member Biographical
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Increase member Optional Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Dependent Death' in Section 12 for step-by-step instructions.

9. Employment Status Changes: Part-time to Full-time

When employment status changes from a non-participating part-time employee to full-time employee, a qualifying change in status occurs which allows eligible dependents to be added to the employee's coverage. The employee must notify their agency in writing within 60 days of the employment status change.

Part-time employees whose status has changed to full-time may elect to opt out of the health, dental and vision coverage with proof of other coverage, but must maintain Basic Life coverage. Employees who have opted out may still choose optional life coverage.

The estimated annual salary (EAS) does not change when an employee becomes full-time.

a. **Effective Date of Coverage:** The effective date of coverage is ***the later of:***

- the date of the event (if requested prior to the event), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Part-time Employee Waiving Coverage (previously eligible to participate):** Part-time employees who were eligible to participate in the State Employees Group Insurance Program, **but chose to waive coverage** and are now full-time must be enrolled with health, dental and vision coverage and have the following options available:

- Add dependent children/spouse
- Add member Optional Life/Child Life/Spouse Life with Statement of Health approval
- Opt out of health, dental and vision coverage – Employees electing this option must complete the 'Opt Out & Opt In Election Certificate' (CMS-500) and provide the appropriate documentation (see Section 3.2, 'Opting (Out/In)/Waiving/Transferring/Retiring')

c. **Part-time Employee Previously Ineligible to Participate:** Part-time employees who **were previously ineligible to participate** in the State Employees Group Insurance Program and are now full-time must be enrolled with health, dental and vision coverage and have the following options available:

- Add dependent children/spouse
- Add member Optional Life/Child Life/Spouse Life without Statement of Health approval

- Opt Out of health, dental and vision coverage – Employees electing this option must complete the 'Opt Out & Opt In Election Certificate' (CMS-500) and provide the appropriate documentation (see Section 3.2, 'Opting (Out/In)/ Waiving/Transferring/Retiring')

d. **Currently Participating Part-time Employee:** Part-time employees who were **participating** in the State Employees Group Insurance Program and are now full-time, are not allowed to change coverage elections; however, they may elect to opt out of the health, dental and vision coverage with proof of other coverage.

e. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Member Becomes Full-time Employee	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Increase or add member Optional Life, Child Life or Spouse Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage – Initial Enrollment with Member' in Section 12 for step-by-step instructions.

10. Employment Status Changes: Full-time to Part-time (50% or greater)

When employment status changes from full-time employment to part-time employment, a qualifying change in status occurs which allows the employee the option to waive health and dental coverage. The member may also elect to terminate dependent spouse or child coverage with this qualifying change. The member must notify the agency in writing within 60 days of the employment status change.

Employees hired prior to 1/1/80 who have not experienced a break in state employment and who are working at least 50% of the time are considered, ***for insurance purposes***, a full-time employee. These employees do not pay a percentage of the state-paid contribution.

A reduction in salary affects the employee's estimated annual salary (EAS) and should be changed on the Membership System.

a. **Part-time Employee Choosing to Retain Coverage:** Employees whose employment status changes from full-time to part-time are only eligible for group insurance benefits if employed at least 50% of the time. A part-time employee working 50%-99% may elect to maintain coverage; however, they are responsible for a percentage of the state cost.

> ***Example:*** For a part-time employee working 75% time, the state will pay 75% of the cost of basic health, life and dental coverage. The employee would be required to pay the remaining 25%. (See Section 10.0 'Calculating Premiums' or use the 'Deduction Calculation' screen (5C) on the Membership System.)

b. **Calculating Part-time Premiums:** GIR/Ps with online access may use the Membership 'Deduction Calculation' screen (5C) to calculate health, dental and life premiums. GIR/Ps without online access may use Section 10.0, 'Calculating Premiums' or may call the Analysis and Resolution Unit for assistance with calculating the employee's premium.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Member Becomes Part-time Employee	Form	Complete
Part-time employee **waiving** health and dental coverage	Member Change Form (CMS-312)	Member Plan – Health/Dental section, indicate waive reason code
	Part-time Employee Election/Waiver of Group Insurance Participation – by signing this form the employee agrees to waive health and dental coverage until either the next Benefit Choice Period or until they experience a qualifying change in status.	Entire form

See 'Member's Employment Changes: Full-time/Part-time and Vice Versa' in Section 12 for step-by-step instructions.

11. Employee Going on a Leave of Absence

A change in employment status from actively working to leave of absence, or a change in leave status (i.e., change from one leave status to another which affects the amount of state-paid premium) represents a qualifying change in status in which the employee can change their coverage elections if the agency is notified in writing within 60 days of the start of the leave of absence. Changing an org proc code to a retirement system while one disability leave of absence is **not** a qualifying change in status.

Coverage elections remain in effect until the employee requests another change, either during the annual Benefit Choice Period or upon experiencing an eligible qualifying change in status, such as the employee's return to work. See Section 4.1.C.12, 'Employee Returning to Work from a Leave of Absence' for options.

a. **Effective Date of Coverage:** The effective date of coverage is ***the later of:***

- the date of the event (if requested prior to the event), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **State-Paid Eligible Leave:** A state-paid eligible leave of absence is a leave in which the state continues to pay its portion of the premium. Employees on a state-paid leave of absence (i.e., disability leave or seasonal leave) who maintain coverage are responsible for paying the premium to the Premium Collection Unit (PCU).

Employees on a state-paid eligible leave of absence have the following options if elected within 60 days of changing to the non-pay status:

- Opt out with proof of other coverage (full-time employees only)
- Waive health, dental, vision coverage (part-time employees only)
- Drop dependent health and dental coverage
- Drop any or all optional life coverage (includes member Optional Life, AD&D, Spouse Life and Child Life; Basic Life remains in effect while on the leave)

c. **State-Paid Ineligible Leave:** A state-paid ineligible leave of absence is a leave in which 100% of the premium must be paid by the employee.

Employees on a state-paid ineligible leave of absence have the following options if elected within 60 days of changing to the non-pay status:

- Waive health and dental coverage (full-time and part-time employees)

- Drop dependent health and dental coverage
- Drop any or all life coverage (includes Basic Life, member Optional Life, AD&D, Spouse Life and Child Life)

d. **Becoming a Dependent of a State-Employed Spouse:** Employees required to pay 100% of the state and member portions of coverage may elect to become a dependent of their state-employed spouse while they are on the leave of absence.

- Employees electing to waive, must waive all coverage including health, dental, all optional life, as well as Basic Life coverage.
- Any dependents transferred to the spouse's coverage will remain under that coverage until the employee returns to work and requests them to be re-added.
- Employees who have member Optional Life coverage must have their spouse elect Spouse Life coverage while on the leave in order for the employee to get the coverage back upon the return to work without Statement of Health approval.

e. **Termination for Non-payment of Premium:** Employees who do not pay the insurance billing statement from the Premium Collection Unit (PCU) while on a leave of absence may have their coverage terminated effective the first day of the following month by PCU for non-payment of premium. All unpaid premiums will be pursued through involuntary withholding or other means. Employees terminated for non-payment of premium are not eligible for COBRA coverage.

f. **Maximum Leave of Absence:** Employees who do not return to work after the maximum leave of absence period has expired will have coverage automatically terminated by the Membership System. These employees are eligible for COBRA. If the employee's spouse is employed by the state, the employee may elect to become a dependent of the spouse instead of electing COBRA.

g. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Employee Going on Leave	Form	Complete
Employee waives coverage or becomes a dependent of state-employed spouse	Member Change Form (CMS-312)	Member Biographical, Member Plan – waiver reason code
Employee waives dependent coverage	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code

See 'Terminating Dependent Coverage' and 'Member's Employment Changes: Leave of Absence to Active and Vice Versa' in Section 12 for step-by-step instructions.

12. Employee Returning to Work from a Leave of Absence

A change in employment status from a leave of absence to actively working represents a qualifying change in status in which the employee can change their coverage elections if the agency is notified in writing within 60 days of the return to work date. Employees **must request** within 60 days of the return to work date to have dependent health and dental coverage, as well as any optional life coverage (member Optional Life, AD&D, Child Life and/or Spouse Life) added.

The GIR/P must change the type enrollee code on the Membership System to the correct active code ('10**' type enrollee code) immediately upon an employee's return to work. Payroll must begin collecting premiums the first full pay period back to work (see 'Employee Returns to Regular Work Schedule' in Section 5.3 to determine the return to work effective date.)

Example: Employee returns to work on January 23rd. Payroll should begin collecting premiums for the February 1st – 15th pay period.

a. **Effective Date of Coverage:** The effective date of coverage is ***the later of:***

- the date of the event (if requested prior to the event), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Returning from a State-Paid Eligible Leave:** A state-paid eligible leave of absence is a leave in which the state continues to pay its portion of the premium.

Employees can elect to:

- Opt back into the Program (full-time employees only)
- Opt out of the Program with proof of other coverage (full-time employees only)
- Re-enroll in the Program (part-time employees only)
- Waive health, dental and vision coverage (part-time employees only)
- Add dependent health and dental coverage
- Add or increase member Optional Life, Spouse Life and/or Child Life coverage with Statement of Health approval

c. **Returning from a State-Paid Ineligible Leave:** A state-paid ineligible leave of absence is a leave in which 100% of the premium must be paid by the employee.

If the employee waived all coverage when they went on the state-paid ineligible leave of absence, the GIR/P **must** reactivate the employee's health, dental, vision and Basic Life coverage effective the first full pay period following the employee's physical return to work.

Employees can elect to:

- Opt out of the Program with proof of other coverage (full-time employees only)
- Waive health, dental and vision coverage (part-time employees only)
- Add dependent health and dental coverage
- Add or increase member Optional Life, Spouse Life and/or Child Life coverage with Statement of Health approval

d. **Return to Work from Being a Dependent of a State-Employed Spouse:** Upon returning to work, the employee must be restored on the Membership System with the same health, dental, vision and Basic Life coverage they had prior to the leave.

- Any dependents transferred to the spouse's coverage while the employee was on the leave will remain under that coverage unless the employee requests them to be re-added within 60 days of the return to work date.
- If the employee was covered under Spouse Life while on the leave, member Optional Life coverage may be reinstated without Statement of Health approval.

e. **Return to Work after Benefits Expire (Leave of Absence or COBRA):** Employees who return to work after the maximum leave of absence period or COBRA coverage expires, have all Benefit Choice elections available to them, with the exception of optional life coverage. Unless the employee converted or ported their life coverage while on the leave or COBRA, they must go through the Statement of Health approval process to re-add optional life coverage.

f. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Employee Returns from Leave	Form	Complete
Full-time employee opting in/opting out	Opt Out & Opt In Election Certificate (CMS-500)	Section A – opt out Section B – opt in
Part-time employee electing to re-enroll	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – qualifying change reason code
Adding a dependent	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Adding optional life coverage	Statement of Health application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' and 'Member's Employment Changes: Leave of Absence to Active and Vice Versa' in Section 12 for step-by-step instructions.

13. Spouse Gains Employment
~ OR ~
Spouse/Dependent Now Eligible for Other Group Health Coverage

When a spouse gains employment or when a spouse or dependent experiences a change in which they gain eligibility for other group health coverage a qualifying change in status occurs. The member is allowed to drop the affected spouse or dependent(s), add Child and/or Spouse Life, increase/decrease member Optional Life or elect to opt out of health, dental and vision coverage. The member must notify the agency in writing within 60 days of the employment status change. If the spouse or dependent gains other coverage, the GIR/P must collect a Coordination of Benefits (COB) form from the employee.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the date of the event (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Spouse/Dependent Employment Changes	Form	Complete
Dropping a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code
Increase member Optional Life, add Spouse Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member', 'Member's Employment Changes: Leave of Absence to Active and Vice Versa', 'Terminating Dependent Coverage' and 'Increase/Decrease Optional Life above $50,000' in Section 12 for step-by-step instructions.

14. Change in State-Employed Spouse's Eligibility or Employment Status

In situations in which two employees enrolled in the State Group Insurance Program are married and one employee loses eligibility (see loss of coverage reasons below), a qualifying change in status occurs. Due to this change, the employee who experienced the change and any dependents who were covered by that employee may be added to the spouse's coverage. The employee must notify the agency in writing within 60 days of the change in eligibility or employment status.

a. **Loss of Coverage Circumstances:**

- one spouse terminates employment, or
- one spouse loses eligibility as a result of their work schedule being reduced to less than 50%, or
- one spouse loses eligibility as a result of the expiration of a leave of absence.

b. **Request to Add Dependents:** The active member may request the addition of the spouse and eligible dependents due to the change in eligibility. If the request is received:

- **within 10 days of coverage termination**, no break in coverage will occur.
- **between 10 and 60 days after coverage termination** there will be a break in coverage for the spouse and dependents. Coverage for the spouse and eligible dependents will be effective the date the request was signed by the member.

Note: Dependents who experience a break in coverage are not eligible for the "Other" category.

c. **Spouse and/or Child Life Coverage:** If the spouse and dependents previously had life coverage, the active member may add Spouse and/or Child Life without Statement of Health approval if the request is received by the GIR/P within 10 days of the employment status change.

If the request to add Spouse and/or Child Life is received **10 days or more** after the employment status change, Statement of Health approval is required.

d. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

State-Employed Spouse Eligibility or Employment Changes	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group, include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Add Spouse Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See section 'Adding Dependent(s) Coverage to Existing Member' in the Membership Procedures Section 12 for step-by-step instructions.

15. Spouse Loses Employment
~ OR ~
Spouse/Dependent Ineligible For or Loses Other Group Health Coverage

When a spouse loses other group health coverage (due to the spouse's employer discontinuing all insurance coverage or due to the spouse becoming ineligible for other coverage) or the spouse loses employment, a qualifying change in status occurs. The change allows the member to add the affected spouse and dependents, Spouse Life, Child Life and/or elect to opt back into health, dental and vision coverage if they previously elected to opt out. The member must notify the agency in writing within 60 days of the loss of coverage.

When a dependent loses other group health coverage, a qualifying change in status occurs which allows the member to add the affected dependent and/or Child Life. The member must notify the agency in writing within 60 days of the loss of coverage.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the date of the event (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Pre-Existing Condition:** Pre-existing condition limitations may apply – see Section 3.3.D, 'Pre-Existing Conditions'.

c. **Spouse and/or Child Life Coverage:** Statement of Health approval is required to add Spouse and/or Child Life.

d. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Spouse/Dependent Loses Other Coverage	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Add Spouse or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

16. Spouse's Employer Increases Premium 30% or Greater, or Significantly Decreases Coverage
~ OR ~
Member's Insurance Premium Increases 30% or Greater

A spouse's employer increasing health insurance premiums 30% or greater, or significantly decreasing coverage, represents a qualifying change in status which allows the member to add the affected spouse and dependents, Spouse Life, Child Life and/or elect to opt back into health, dental and vision coverage if they previously elected to opt out.

Members enrolled in the State Employees Group Insurance Program whose health insurance premium increases 30% or greater experience a qualifying change in status in which they may drop their spouse/dependents. Part-time employees should be given the option to waive their health/dental coverage.

Members who have opted out of the State Employees Group Insurance Program and experience a 30% or greater increase in their non-state health insurance premium have a qualifying change in status in which they may add their spouse/ dependents and/or elect to opt back into health, dental and vision coverage. The member must notify the agency in writing within 60 days of the premium change.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the effective date of the increase (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Pre-Existing Condition:** Pre-existing condition limitations may apply – see Section 3.3.D, 'Pre-Existing Conditions'.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Coverage Changes/ Premiums Increase	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Add Spouse Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' in Section 12 for step-by-step instructions.

17. Coordination of Spouse's Annual Election Period

A member whose spouse has a different annual election period than the state's Benefit Choice Period may have an eligible qualifying change in status which would allow the member to change their coverage. **The member's request to change coverage must be consistent with, and on account of, the spouse's election change(s).** Eligible changes include add or drop a spouse or child, add Spouse Life and/or Child Life, elect to opt out of health, dental and vision, and/or elect to opt back into health, dental and vision coverage if they previously elected to opt out.

Part-time employees who coordinate with their spouse's annual election period may elect to waive health and dental coverage (refer to Section 3.2.C 'Waiving Coverage (Part-time Employees)' for details). The employee must notify the agency in writing within 60 days of the spouse's annual election period.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the effective date of coverage under the spouse's annual election period (if requested in advance), **or**
- the date the request was signed (must be within 60 days of event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Coordinating Annual Election Periods	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Part-time members waiving health and dental coverage	Member Change Form (CMS-312)	Member Biographical, Member Plan, Health/ Dental/Life – include waiver code
	Part-time Employee Election/Waiver of Group Insurance Participation	Entire form
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code
Add Spouse Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member', 'Terminating Member Coverage' or 'Terminating Dependent Coverage' in Section 12 for step-by-step instructions.

18. Change in Member/Spouse/Dependent's County of Residence or County of Work Location

A change in a member/spouse/dependent's county of residence or county of work location represents a qualifying change in status which allows the member to change health carrier. The member must notify the agency in writing within 60 days of the move. The member may not elect to terminate coverage or change dependent coverage.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the date the member/spouse/dependent's county of residence or county of work location changed (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

County Changes	Form	Complete
Changing residential county	Member and/or Dependent Address Change Form (CMS-314)	Member or Dependent Address Change section
Changing work county	Member Change Form (CMS-312)	Member Biographical and Member Group - work county

See 'Correcting Member/Dependent Address' in Section 12 for step-by-step instructions.

19. Primary Care Provider Leaving the Managed Care Plan

A member's designated primary care provider (PCP) leaving the managed care plan represents a qualifying change in status which allows the member to change health carrier.

If a member's designated PCP leaves the managed care plan, the member has 60 days to elect one of the following:

- Choose another PCP within the plan;
- Change managed care plans; or
- Enroll in the QCHP.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the date the PCP leaves the network (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Events That Do Not Warrant a Change:** The following events do not warrant a change in health plans:

- a new PCP is added to a managed care plan;
- a hospital is added or dropped to/from a health plan;
- a pharmacy is added or dropped to/from a health plan;
- a health specialist terminates their relationship with the managed care plan (unless the specialist is designated as the PCP);
- a womens' healthcare provider terminates their relationship with the managed care plan (unless the womens' healthcare provider is designated as the PCP).

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

PCP Leaves Network	Form	Complete
Changing managed care plans	Member Change Form (CMS-312)	Member Biographical, Member Plan – Health/Dental sections

See 'Changing Health/Dental Carrier' in Section 12 for step-by-step instructions.

20. Change in Medicaid Status

A gain or loss of Medicaid eligibility by a member represents a qualifying change in status. When losing Medicaid eligibility, a member may add the affected dependent(s), add Spouse Life and/or Child Life coverage and/or elect to opt back into health, dental and vision coverage if they had previously opted out.

When gaining Medicaid eligibility, a member may drop the affected dependent(s) and/or elect to opt out of health, dental and vision coverage. The member must notify the agency in writing within 60 days of the change in Medicaid eligibility.

a. **Effective Date of Coverage**: The effective date is ***the later of:***

- the date of the gain or loss of Medicaid eligibility (if notified in advance), **or**
- the date the request was signed (must be within 60 days of event).

When a member or dependent loses Medicaid eligibility, the Department of Healthcare and Family Services (HFS) sends a notice that eligibility has been lost and that benefits through HFS will cease.

b. **Pre-Existing Condition**: Pre-existing condition limitations may apply – see Section 3.3.D, 'Pre-Existing Conditions'.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Medicaid Status Change	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code
Add Spouse Life or Child Life	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Adding Dependent(s) Coverage to Existing Member' and 'Terminating Dependent Coverage' in Section 12 for step-by-step instructions.

21. Change in Medicare Status

A change in Medicare eligibility for a member and/or dependent represents a qualifying change in status. When losing Medicare eligibility the member may add an affected spouse or dependent, Spouse Life and/or Child Life coverage and/or elect to opt back into health, dental and vision coverage if they had previously opted out. The GIR/P must notify the Group Insurance Division's Medicare Coordination of Benefits (COB) Unit upon receiving notification from the member of the loss of Medicare coverage.

When gaining Medicare eligibility the member may drop the affected spouse or dependent and/or elect to opt out of health, dental and vision coverage. The member must notify the agency in writing within 60 days of the change in eligibility. The GIR/P must provide a copy of the Medicare card to the Medicare COB Unit upon receiving notification from the member of the gain of Medicare eligibility.

a. **Turning Age 65:** Prior to the member/dependent's 65th birthday, the Group Insurance Division will send a letter to the member regarding Medicare eligibility. The letter will request the member to submit a copy of the Medicare card to the agency GIR/P. If the member is not Medicare eligible, a copy of the Social Security Administration (SSA) letter explaining that the member/dependent is not eligible is required. The GIR/P must forward the information to the Group Insurance Division's Medicare COB Unit.

   Medicare coverage is always effective the first of the month - *not the date of birth*. Usually the effective date is the first day of the birth month; however, in cases in which the birth date is the first, the effective date is the first day of the preceding month.

   Example: If a person turns age 65 on August 23rd, the Medicare effective date would be August 1st. If a person turns age 65 on August 1st, the Medicare effective date would be July 1st.

b. **Disability/End Stage Renal Disease (ESRD):** Members must provide a copy of their Medicare identification card to their agency GIR/P upon Medicare eligibility from either Social Security disability benefits or on the basis of End Stage Renal Disease (ESRD). The GIR/P must forward a copy of the card, along with a note indicating whether the member/dependent is receiving Medicare based on disability or ESRD, to the Medicare COB Unit. If the information that is provided to the Medicare COB Unit changes the coordination of the member/dependent's benefits or if additional information is needed, the Medicare COB Unit will send a letter to the member/dependent.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Medicare Status Change	Form	Complete
Changing member's Medicare status	Member Change Form (CMS-312)	Member Biographical – Medicare Status, Part A begin date, Part B begin date, Part A Free (Y/N)
Changing dependent's Medicare status	Dependent Change Form (CMS-313)	Dep. Biographical, Medicare Status, Part A begin date, Part B begin date, Part A Free (Y/N)
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code

See 'Adding Dependent(s) Coverage to Existing Member', 'Terminating Dependent Coverage' and 'Changing Medicare Status' in Section 12 for step-by-step instructions.

22. Employment Status Changes: Active Employee to Annuitant (Retired)

When employment status changes from active to retired, a qualifying change in status occurs which allows the employee to add/drop dependent(s), change health carriers, elect to opt out of health, dental and vision or elect to opt back into health, dental and vision coverage if they previously elected to opt out.

a. **Premiums:** Employees who retire and have 20 years or more of creditable state service are provided health, dental, vision and Basic Life coverage at no cost. Employees having less than 20 years of creditable state service are responsible for a percentage of the state's cost of the health coverage. In these situations, the state will pay 5% of the health insurance premium for each year of creditable service. GIR/Ps should contact the appropriate retirement system for eligibility and premium amounts.

b. **Waiving Coverage:** Annuitants may waive coverage if they are required to pay a percentage of the health insurance coverage cost due to having less than 20 years of creditable service. Annuitants that are married to another member of the State Employees Group Insurance Program may elect to waive coverage and become a dependent of that member (see 'Waiver Option' in Section 2.0.A.3 for details).

c. **Opt Out:** Employees whose employment status changes from an active employee to retired and have 20 years or more of creditable service may elect to opt out of health, dental and vision coverage. Retired members who opt out may be eligible for a financial incentive (see 'Opt Out Financial Incentive' in Section 2.0.A.3 for details).

d. **Dependent Coverage:** Dependents may be added or dropped at the time of retirement. A written request to add or drop the dependent must be submitted in writing to the retirement system within 60 days of the event. The request to add a dependent must include the dependent's name, SSN, relationship to retiree, date of birth, copy of marriage certificate (if adding spouse), copy of the dependent's Medicare card (if applicable) and creditable coverage letter from the dependent's previous health insurance carrier (if applicable).

e. **Basic Life and Member Optional Life Coverage:** Employees who are under age 60 at retirement will have the same amount of Basic Life and member Optional Life coverage as the last day of their active employment status. Upon becoming age 60, an immediate annuitant's Basic Life coverage reduces to $5,000. Additionally, member Optional Life also reduces to 1 – 4 times the Basic Life amount of $5,000. **Note:** Deferred annuitants (retirees who will receive a pension after one year of leaving active state payroll) are only eligible for Basic Life coverage and are not eligible to purchase member Optional Life coverage.

f. **Spouse and Child Life Coverage:** Spouse and Child Life coverage of immediate annuitants under age 60 is $10,000. Upon the annuitant turning age 60, Spouse Life reduces to $5,000. Child Life coverage remains $10,000 regardless of the annuitant's age. Child Life and Spouse Life coverage for the survivors of annuitants and immediate annuitants prior to September 22, 1979 is $5,000. **Note:** Deferred annuitants (retirees who will receive a pension after one year of leaving active state payroll) are not eligible to purchase Spouse or Child Life coverage.

g. **Converting/Porting Life Coverage:** When a member's Basic Life coverage reduces to $5,000, the lost coverage may be converted to an individual life insurance policy offered by the Life Insurance Plan Administrator (other than a term life policy) up to the amount of Basic Life coverage lost. Optional life coverage may also be converted (to other than a term policy) or ported (term policy) up to the amount of coverage that was lost. The advantage of purchasing portable term or conversion life coverage is that the member does not need to complete a Statement of Health application.

It is the GIR/P's responsibility to give the member information regarding conversion and portability of life insurance coverage **within 31 days of the member's termination**. If the GIR/P does not give the member notice of the right to continue group life coverage within 31 days after the date the life insurance would otherwise end, an additional 15 days will be granted to the member to complete the form. The Life Plan Administrator will NOT accept forms that are received more than 46 days after the date of retirement or employment termination.

23. Employment Status Changes: Active Employee (including those on a leave of absence) to Permanent Layoff

When employment status changes from active to permanent layoff, employees eligible for the premium-free permanent layoff benefit maintain the coverage that was in effect at the time of the layoff period (refer to Section 5.2.C.2.h, 'Permanent Layoff' for eligibility requirements). Employees who had opted out may not re-enroll in the Program at this time.

Employees eligible for the premium-free benefit are considered to have experienced a qualifying change in status which allows them to drop dependent coverage, change health carriers or elect to opt out of health, dental and vision.

Employees may make changes to their coverage upon experiencing a qualifying event and/or during the annual Benefit Choice Period.

a. **Effective Date of Coverage:** The effective date for an employee electing to drop dependent coverage or change health plans is ***the later of:***

- the date of the permanent layoff (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Employee Status Changes to Permanent Layoff	Form	Complete
Dropping dependent coverage or changing health carrier	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
Opting out of health, dental and vision coverage	Opt Out & Opt In Election Certificate (CMS-500)	Section A and 'GIR Use Only' portions of form, include qualifying change reason code

24. Member Loses Other Coverage (for reason other than non-payment of premium)

If a member has opted out of health, dental and vision coverage and then loses their other health insurance (due to a reason other than being terminated for non-payment of premium), a qualifying change in status occurs which allows a member to opt back into the coverage. The member must notify the agency in writing within 60 days of the loss of coverage. The employee must provide proof of loss of other coverage (i.e., Certificate of Creditable Coverage).

a. **Effective Date of Coverage:** The effective date for a member electing to opt back into the Program is ***the later of:***

- the date of the loss of coverage (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Pre-Existing Condition:** Pre-existing condition limitations apply – see Section 3.3.D, 'Pre-Existing Conditions'.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Member Loses Other Coverage	Form	Complete
Adding member coverage for health, dental and vision	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code

25. Member Becomes Eligible for Non-State Group Insurance Coverage

If a member becomes eligible for non-state group insurance coverage, a qualifying change in status occurs which allows the member to opt out of the state's coverage. The member must notify the agency in writing within 60 days of the gain of coverage and must provide proof of other coverage.

a. **Effective Date of Coverage:** The effective date for a member electing to opt out of the Program is ***the later of:***

- the date of the event (if requested in advance), **or**
- the date the request was signed (must be within 60 days of the event).

Changes to coverage cannot be retroactive to the date of the event if it was not requested prior to the event.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Member Become Eligible for Other Coverage	Form	Complete
Terminating member coverage for health, dental and vision	Opt Out & Opt In Election Certificate (CMS-500)	Section A and 'GIR Use Only' portions of form, include qualifying change reason code

26. Military Call Up

Employees who are in the military and are called up to active duty by an Executive Order may elect to waive health, dental and vision coverage upon going on the leave of absence. These employees may also elect to terminate spouse/dependent coverage and/or change health carriers.

Employees who return to work from active duty (i.e., on military call up) must have health, dental and vision coverage reinstated upon returning to work. These employees may also elect to add spouse/dependent coverage and/or change health carriers.

Note: Employees called up for military duty who do not want the state group insurance coverage should **waive** coverage upon going on the leave. These employees should not opt out since they do not need to provide proof of other coverage.

a. **Effective Date of Coverage:** The effective date for an employee electing to waive coverage is the date of the call up Executive Order.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Military Call-Up	Form	Complete
Waiving coverage for health, dental and vision	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code

4.2 Internal Revenue Code

A. Irrevocability Rule

The Internal Revenue Code mandates that group insurance programs providing tax-exempt premiums must prohibit changes in the member's deduction during the plan year unless a qualifying change in status occurs. Coverage elected during the Initial Enrollment Period and the annual Benefit Choice Period must remain in effect throughout the entire plan year unless the member experiences a qualifying change in status. If the state is not in compliance with the IRS Irrevocability Rule the Program could lose its qualification and/or employees could be subject to an IRS audit and be required to pay additional taxes and possible penalties.

The Irrevocability Rule applies to both increases and decreases in coverage, such as adding/dropping dependents from health coverage or increasing/decreasing member Optional Life coverage below $50,000.

B. Irrevocability Exceptions and Index

Certain premiums are taxable and are considered exceptions to the Irrevocability Rule (as stated above). The coverages listed on the following pages in this section may be changed anytime during the plan year.

The list below identifies the exceptions to the Irrevocability Rule:

1. Change Dependent Health Coverage in the 2+ Dependent Category 4 - 39
2. Change in Life Coverage above $50,000 4 - 40
3. Change in Spouse or Child Life 4 - 42
4. Change in AD&D Coverage 4 - 43

1. Change Dependent Health Coverage in the '2+ Dependent' Category

Since adding or dropping a dependent while remaining in the '2+ Dependent' category does not affect a member's tax-exempt premium, a member may at any time during the plan year add or drop a dependent.

Members choosing to add or drop a dependent are not allowed to make any other changes.

a. **Effective Date of Coverage:** The effective date is ***the later of:***

- the date the request was signed, **or**
- a requested future date.

Changes to coverage cannot be retroactive.

b. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Change in 2+ Category	Form	Complete
Adding a dependent	Member Change Form (CMS-312)	Member name, date and signature, GIR/P name, date and signature; Member Group – include qualifying change reason code
	Dependent Change Form (CMS-313)	Entire form
Adding a dependent 19 or older	Dependent Coverage Certification Statement (CMS-138)	Entire form
Terminating a dependent	Dependent Change Form (CMS-313)	Dep. Biographical, Dep. Group include termination reason code

See 'Adding Dependent(s) Coverage to Existing Member' and 'Terminating Dependent Coverage' in Section 12 for step-by-step instructions.

2. Change in Member Optional Life Coverage

If Basic Life + member Optional Life is $50,000 or greater, the member Optional Life coverage is not subject to the Irrevocability Rule and therefore an increase or decrease may be requested any time during the plan year. When electing to decrease member Optional Life coverage, the total amount of life coverage cannot drop below $50,000 (Basic Life + member Optional Life).

If Basic Life + member Optional Life is less than $50,000, the member must wait until either a qualifying change in status occurs or until the annual Benefit Choice Period to change their member Optional Life election.

Example: A member with a base salary of $25,000 and 3 times member Optional Life has a total amount of $100,000 life coverage (Basic Life = $25,000, member Optional Life = $75,000).

Since Basic Life + member Optional Life is greater than $50,000, the member would be allowed to increase or decrease the coverage any time during the plan year. This member would not be allowed to decrease member Optional Life to less than 1 times since that change would make the total amount of life coverage less than $50,000.

a. **Statement of Health:** Statement of Health approval is required to increase member Optional Life coverage any time after the initial 10-day enrollment period.

b. **Life Coverage Effective Date:** The effective date of an **increase** in member Optional Life coverage is the first day of the pay period following approval from the Life Plan Administrator. The Life Plan Administrator will send a copy of the Statement of Health approval/denial letter to both the GIR/P and the member. GIR/Ps may also access the plan administrator's website to verify whose Statement of Health applications were approved or denied.

When **decreasing** member Optional Life coverage, the effective date is the date of the request. A future effective date may be requested, as long as it is within 60 days of the current date.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Life Change Above $50,000	Form	Complete
Increasing/decreasing member Optional Life	Member Change Form	Member Plan – Life section, indicate number of times optional (0 – 8)
	Statement of Health Application	Entire form – return to Life Plan Administrator

See 'Increase/Decrease Optional Life Above $50,000' in Section 12 for step-by-step instructions.

3. Change in Spouse or Child Life

Members may add or drop Spouse and/or Child Life coverage any time during the plan year without experiencing a qualifying change in status. Spouse and Child Life premiums are taxable and therefore are not subject to the Irrevocability Rule.

a. **Statement of Health:** Statement of Health approval is required to add Child Life and/or Spouse Life any time after the initial 10-day enrollment period of a new member. Exceptions to this rule are newborns added within 60 days of birth and newly acquired dependents (i.e., new spouse, stepchildren, children for whom the member has gained legal guardianship) added within 60 days of attainment.

b. **Life Coverage Effective Date:** The effective date when **adding** Spouse and/or Child Life coverage is the first day of the pay period following approval from the Life Plan Administrator. The Life Plan Administrator will send a copy of the Statement of Health approval/denial letter to both the GIR/P and the member. GIR/Ps may also access the plan administrator's website to verify whose Statement of Health applications were approved or denied.

When **dropping** Spouse or Child Life coverage, the effective date is the date of the request. A future effective date may be requested, as long as it is within 60 days of the current date.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Change in Spouse/ Child Life	Form	Complete
Adding Spouse and/or Child Life	Member Change Form (CMS-312)	Member Plan – Life section, indicate 'Y' in the appropriate column
	Dependent Change Form (CMS-313)	Dependent Biographical and Dependent Plans – Life, enter 'A' (active) and the Certificate Approval Date
	Statement of Health Application	Entire form – return to Life Plan Administrator
Dropping Spouse and/or Child Life	Member Change Form (CMS-312)	Member Plan – Life section, indicate 'N' in the appropriate column

See 'Add/Drop Spouse and/or Child Life' in Section 12 for step-by-step instructions.

4. Change in AD&D Coverage

A member may add or drop Accidental Death and Dismemberment (AD&D) life coverage any time during the plan year without a qualifying change in status since AD&D life premiums are taxable and therefore not subject to the Irrevocability Rule. Statement of Health approval is not required to add or increase AD&D.

a. **AD&D Election Choices**: Members have two choices when electing AD&D coverage:

- AD&D Basic = one times the member's annual salary,
- AD&D Combined = basic annual salary amount plus member Optional Life amount, subject to a maximum of Basic + 4 times member Optional Life. The maximum amount of AD&D coverage allowed is $3,000,000.

Example: Member's annual salary is $25,000. The member has 8 times member Optional Life ($200,000). The total 'Combined' AD&D amount the member would have is five (5) times the Basic amount or $125,000.

b. **Effective Date of Life Coverage:** AD&D coverage is effective the first day of the pay period on or after the date the request was signed.

When **dropping or decreasing** AD&D coverage, the effective date is the date of the request. A future effective date may be requested, as long as it is within 60 days of the current date.

c. **Required Forms:** All Change forms must have the information box at the top of the form completed in addition to the sections indicated. Refer to Appendix B for documentation requirements.

Change in AD&D	Form	Complete
Increasing AD&D	Member Change Form (CMS-312)	Member Plan – Life section, indicate 'B' (basic) or 'C' (combined) in the appropriate column
Decreasing AD&D	Member Change Form (CMS-312)	Member Plan – Life section, indicate 'N' (none) or 'B' (basic) in the appropriate column
Terminate all AD&D	Member Change Form (CMS-312)	Member Plan – Life section, indicate 'N' (none) in the appropriate column

See 'Add/Drop AD&D Coverage' in Section 12 for step-by-step instructions.

5.0 General Information

The Premium Collection Unit (PCU) is responsible for billing members enrolled in the group insurance program for their coverage in situations where the member is either off payroll or payroll cannot collect. There are several categories of members who must be billed by PCU, including:

- Employees on a leave of absence, including:
  - Employees who have returned to work on a reduced work schedule due to a medical condition with a doctor's statement.
  - Employees who are working a reduced work schedule due to a FMLA-protected family situation.
- Employees in a dock/suspension status.
- Employees who work for an agency or university that cannot payroll deduct part-time premiums.
- State Employees Retirement System (SERS) annuitants and survivors whose benefit check is not sufficient to deduct premiums due.
- Members who have elected dependent coverage for a non-IRS Domestic Partner (see Section 15, 'Domestic Partner Coverage' for details).
- Members who terminated state employment under one of the Alternative Retirement Cancellation Program (ARCP) options and elected coverage.
- COBRA members (see Section 6, 'Termination and COBRA' for details).

5.1 Billing, Termination and Reinstatement Procedures

A. PCU Direct Bill Procedure

Billing statements are produced the second work day of each month and indicate the amount required to be paid. Bills are produced and mailed based on the information indicated on the Membership System. Members whose type enrollee status is changed to one that qualifies to be billed by PCU after the 'Membership Cutoff' date will not receive a billing statement until the following month (see Section 5.5.B, 'Agency Cutoff Schedule Description' for more information). This billing statement will include premiums due for the current month, as well as premiums due for any outstanding pay periods. Premium payments must be received by PCU by the due date shown on the billing statement.

GIR/Ps should not advise members on questions and issues regarding their billing statement; instead, the GIR/P should direct the member to contact PCU. If an employee returns to work or makes changes to their coverage after the billing statements have been produced, PCU should be notified so that billing records can be adjusted.

Members have the following options available to pay their insurance premiums:

1. Members may mail their payment along with the bottom portion of the billing statement to:

   Department of Central Management Services
   Premium Collection Unit
   P.O. Box 10077
   Springfield, IL 62791-0077

2. With the exception of COBRA, premium payments may be made through the internet E-Pay option using a debit or credit card. Members can make their payment by accessing the E-Pay link via the Benefits website at www.benefitschoice.il.gov or by contacting PCU at (217) 558-4783.

B. Non-payment of Premium

Of the categories of members for which PCU bills, those members who fail to pay may have coverage terminated for non-payment of premium and/or be subject to involuntary withholding.

- Employees who have **not** returned to work and were billed while off payroll and did not pay their premiums **will have coverage terminated with a current effective date and an involuntary withholding order filed** to collect the unpaid premiums. The employee will be sent a letter notifying them of the effective date of the termination.

- Employees who have returned to work and did not pay their premiums while off payroll will not have coverage terminated, but **will have an involuntary withholding order filed** against them by PCU to collect the unpaid premiums.

- Part-time employees who are billed because their agency/university cannot payroll deduct part-time premiums and do not pay their premiums will have **will have coverage terminated with a current effective date and an involuntary withholding order filed** against them by PCU to collect the unpaid premiums.

- ARCP, Domestic Partner and SERS annuitants and survivors who do not pay their premiums when billed **will have coverage terminated with a current effective date and an involuntary withholding order filed** to collect the unpaid premiums. The employee will be sent a letter notifying them of the effective date of the termination.

- COBRA members who do not pay their premiums when billed will have coverage terminated effective the last day of the paid through date.

Members whose coverage is terminated for non-payment of premium lose all health, dental, vision and optional life coverage. Members who were on a **non-state paid** leave of absence (i.e., personal/general leave) also lose Basic Life coverage. Members and dependents whose coverage is terminated for non-payment of premium are **not** eligible for continuation of coverage through COBRA.

C. Reinstatement of Coverage

- Employees **who have returned to work** and whose coverage was either:
  - terminated due to non-payment of premium, or
  - waived due to going on a leave of absence (full-time employees only)

  must have coverage reinstated the first day of the first full pay period following the employee's physical return to work. The employee must be reinstated with the same health and dental coverage that was in force prior to the termination or waiver. The employee must also have Basic Life coverage reinstated, if applicable. **Dependent coverage will not automatically be reinstated** upon the employee's return to work. The return to work is a qualifying change in status in which the employee has 60 days to request, in writing, the addition of dependent and/or optional life coverage. The requested coverage will be effective the later of the date of the request or of the event, whichever is later. Refer to Section 4.1.C.12, 'Employee Returning to Work from a Leave of Absence' for available options.

- Employees **who have returned to work after waiving coverage to become a dependent of their state-employed spouse** must have coverage reinstated the date they physically return to work. The employee must be reinstated with the same health and dental coverage that was in force prior to the waiver. The employee must also have Basic Life coverage reinstated. **Upon request, dependent and optional life coverage may be transferred back** when the employee returns to work if the coverage was carried by the spouse during the leave. Refer to Section 4.1.C.12, 'Employee Returning to Work from a Leave of Absence' for available options.

- Employees **who have not returned to work** and whose coverage remains terminated due to non-payment of premium may re-enroll during the annual Benefit Choice Period. Employees choosing to re-enroll during the Benefit Choice Period must pay the premiums for the month of July in addition to all outstanding premiums before coverage will be reinstated. Coverage will be effective July 1st.

- Members whose Domestic Partner coverage was terminated for non-payment of premium may re-enroll only during the annual Benefit Choice Period with a July 1st effective date. Employees choosing to re-enroll during the Benefit Choice Period must pay the premiums for the month of July in addition to all outstanding premiums before coverage will be reinstated.

- COBRA, ARCP and SERS annuitants and survivors who had coverage terminated for non-payment of premium **are never eligible to re-enroll** in the group insurance program, unless they return to work as an active state employee.

- Employees **who return to work more than 10 days after the maximum leave of absence period expires** have all Benefit Choice elections available to them, with the exception of optional life coverage. Unless the employee converted or ported their life coverage while on the leave, they must go through the Statement of Health approval process to re-add optional life coverage.

D. PCU Refunds

Members who overpay their premiums when direct billed by PCU (e.g., member retired, returned to work or was picked up by a retirement system) will be refunded by CMS and **must not** be refunded through payroll. The member will receive a refund for the premiums regardless of the time period in which the overpayment occurred. Questions regarding overpayment of premiums should be directed to PCU. GIR/Ps should not transfer or move PCU records on GIFCS.

Exception: No refund will be given for premiums paid for an ineligible member or dependent in situations where the member failed to notify the agency or retirement system within 60 days of the ineligibility (e.g., divorce, dependent marries or the member gains outside employment while on disability).

5.2 Employee Leaves of Absence

A. GIR/P Procedures

1. **Coverage and Waiver Options** – Employees who go on a leave of absence experience a qualifying change in status in which they have certain coverage options available to them if elected within 60 days of going on the leave. Refer to Section 4.1.C, 'Employee Going on a Leave of Absence' for coverage and waiver options.

   An employee who has been on a leave of absence for greater than 60 days cannot make changes to their coverage elections, unless the leave of absence changes from a state-paid eligible leave type to state-paid ineligible leave or they experience another qualifying event. Changing from one state-paid eligible type of leave (e.g., 6001) to a different state-paid eligible type of leave (e.g., 6002) is not a qualifying change in status.

2. **Membership Coding** – The type enrollee code on the Membership System must be changed to the appropriate leave code in order for Premium Collection Unit (PCU) to bill the employee the correct premium amount due.

3. **Benefit Time Usage** – Benefit time includes vacation, sick, personal, holiday, comp and maternity/paternity time.

- When benefit time is used at the **beginning of a leave of absence**, the type enrollee code for the leave should not be entered on the Membership System until the employee leaves payroll. FMLA protection runs concurrent with the benefit time; therefore, the GIR/P must manually track the benefit time for FMLA purposes. The FMLA time period begins the last day the employee was physically at work.

  Example: A pregnant employee uses her benefit time when she is placed on complete bed rest by her physician. A week later, she has her baby.

Event	Date	Code
Pregnant employee is placed on complete bed rest by her physician; she uses her remaining sick time and FMLA clock begins	August 6th	1001
Baby is born	August 12th	
Employee is on payroll and paid 4 weeks of maternity/paternity benefit time	August 13th through September 10th	
Employee's benefit time is exhausted	September 11th	6002
Employee's physician releases her to return to work; however, employee requests to remain on leave for three more weeks	September 24th	6010
Employee returns to work and FMLA clock ends	October 15th	1001

- When benefit time is used at the **end of a leave of absence**, the type enrollee code for the leave must remain on the Membership System until the employee physically returns to work.

  Example: A pregnant employee is out of benefit time when she is placed on complete bed rest by her physician. A week later, she has her baby.

Event	Date	Code
Pregnant employee is placed on complete bed rest by her physician; she does not have any benefit time remaining and FMLA clock begins	August 6th	6002
Baby is born	August 12th	
Employee is put on payroll and paid 4 weeks of maternity/paternity benefit time	August 13th through September 10th	
Employee remains on disability leave	September 11th through 16th	
Employee's physician releases her to return to work; however, employee requests to remain on leave for three more weeks	September 17th	6010
Employee returns to work and FMLA clock ends	October 15th	1001

4. **Effective Date** – The effective date that should be shown on the Membership System for a leave of absence is the date that the Personnel Office approved the leave as indicated on the CMS-2 or Personnel Action Form; however, the 1st and 16th rule applies. Before processing the leave effective date, the following must be determined:

   When determining the effective date to enter on membership, you must take into account the member's normal work schedule and holidays - this policy applies whether the first day of the pay period occurred on a Saturday, Sunday, holiday or the employee's regularly scheduled day off.

   Example 1: A Monday - Friday employee is placed on leave of absence effective Wednesday, January 2nd; however, January 1st was a holiday. Because the employee was not scheduled to work; the date to be entered on Membership is January 1st.

   Example 2: A Tuesday - Saturday employee is placed on leave of absence effective Tuesday, July 3rd. Because July 1st and July 2nd are the employee's regular scheduled days off, the leave date entered on Membership must be July 1st (the first date of the pay period).

   Example 3: A Monday - Friday employee is placed on leave of absence effective Thursday, October 2. Because October 1st was a regular work day for the employee, the leave date entered on Membership must be October 2nd.

5. **Payroll Responsibilities** – Payroll should collect insurance premiums for all employees who go on a leave of absence on any day of the pay period, other than the first day (i.e., the 1st or 16th of the month for semi-monthly employees; the 1st of the month for monthly employees). If the employee's payroll is not sufficient to collect the insurance premiums, the agency is responsible for billing and collecting the premiums. Payroll should be coded as 'no insurance deductions' (which is an eligibility code of 'C' for most payrolls) if the employee is on a leave of absence the first day of the pay period.

B. Employee Premium While On Leave of Absence

When an employee is billed by PCU, the amount of premium for which an employee owes is determined by the reason they are away from work. Certain leaves of absence qualify the employee to continue to receive the state's contribution (state-paid eligible), whereas, other types of leave do not (state-paid ineligible).

1. **State-paid Eligible Leave of Absence:** State-paid eligible leaves of absence are those leaves in which the state and the employee continue to pay the same premium as when the employee was active on payroll. An exception is made for part-time employees on an Occupational Disability (type enrollee code 6021). These employees must be treated the same as full-time employees **for insurance purposes**.

2. **State-paid Ineligible Leave of Absence:** State-paid ineligible leaves are those for which the employee is required to pay 100% of the state and employee portions of the premium (e.g., personal/general leave).

C. Types of Non-Pay Status

The state has several types of leaves of absence available to employees who are absent from work. This section describes each type of leave of absence and identifies whether or not the leave is eligible for the state-paid contribution and indicates the maximum coverage period of the leave. The Personnel Office of each agency must determine the type of leave for which a person qualifies. Leave types specified by personnel are not always coded the same for insurance purposes.

A physical return to work of one pay period or less or a return to payroll in order to pay out benefit time (i.e., sick, vacation, etc.), does not extend the maximum length of state-paid coverage.

Upon going on the leave, an employee experiences a qualifying change in status and has certain options available if elected within the first 60 days of leave. Changes to coverage are effective the date of the signed request, or the event, whichever is later. Refer to Section 4.1.C.11, 'Employee Going on a Leave of Absence' for specific options available.

1. **FMLA-Protected Time Away From Work** – The federal **Family Medical Leave Act of 1993 (FMLA)** provides that eligible employees receive up to 12 workweeks of unpaid, job-protected leave for certain family and medical reasons. Employees may choose to substitute paid benefit time while on an FMLA-protected leave. FMLA is "job protection" for employees who are off work due to their own serious health condition, to care for a newborn or to care for a family member with a serious health condition. While on an FMLA-qualifying leave of absence, the state continues to make contributions toward the insurance premiums.

   In order to qualify for FMLA protection, employees must have been employed by the state for at least 12 months, have worked at least 1250 hours over the 12 months prior to taking the leave and cannot have used the allotted FMLA coverage for any other time away from work in the preceding 12 months.
   This section describes the FMLA-protected leaves of absence, which include Non-Occupational Disability with Retirement Benefits, Non-Occupational Disability without Retirement Benefits, Occupational Disability, Family Leave and FMLA-protected Dock time. For purposes of calculating the length of time the state will continue contributions toward the insurance premium, the state-paid coverage period begins the day the employee physically leaves work. This period includes all time away from work, including paid and unpaid time off, i.e., vacation, sick, personal, maternity/ paternity and dock time approved for an FMLA reason. Time away from work, whether paid or unpaid, runs concurrent with any other FMLA-protected time.

   Full-time employees using intermittent FMLA are limited to 450 hours (12 workweeks) of leave in which the state maintains the employer contribution and may choose this time as paid or unpaid. Part-time employees are also entitled to 12 workweeks; however, the number of hours they are eligible for is based on the average number of hours they work per week. For example, a part-time employee who works 30 hours per week would be eligible for 360 hours of FMLA benefits (12 workweeks x 30 hours).

a. **Non-Occupational Disability – No Retirement Benefits (code 6002/6027):** Employees on an agency-approved Non-Occupational Disability leave **not** receiving a disability benefit from a retirement system are eligible for the state-paid contribution for up to 24 months. At the end of the 24-month period, the employee will be terminated from the Group Insurance Program and offered COBRA. Employees on a disability leave are required to provide a physician statement to their agency Personnel Office no less than every 90 days during the period of disability, unless the nature of the illness precludes the need for such frequency (personnel will inform the employee whether further documentation is needed). Agency GIR/Ps should **always** code an employee going on a disability leave of absence as a Non-Occupational Disability – No Retirement Benefits (type enrollee code 6002/6027).

Note: If the employee was receiving a disability benefit and that benefit ends, coverage must be terminated if the employee has been in the leave status **greater than 24 months**. If the disability benefit ends and the employee has been in leave status **less than 24 months** and the agency re-approves the Non-Occupational Disability leave of absence, the employee is eligible for the remainder of the 24 months of coverage. The agency must manually process the termination once the 24 months has been exhausted.

Example:

Event	Effective Date	Type Enrollee Code	# of Months Used
Non-Occupational Disability LOA begins	February 1, 2007	6002	1
Retirement system begins paying a disability benefit	March 1, 2007	6001	2 – 16
Retirement system benefits end	May 31, 2008	8026	
Agency re-approves Non-Occupational Disability without Benefits	June 1, 2008	6002	16 - 24
Agency must manually terminate coverage	February 1, 2009	8011	

b. **Non-Occupational Disability – With Retirement Benefits (code 6001/6026):** Once an employee has been approved to receive a disability benefit, the retirement system will change the type/subtype code to Non-Occupational Disability – With Retirement Benefits (type enrollee code 6001/6026) and leave the organizational processing code (org proc code) as the employing agency. Only the retirement systems and GID can process 6001/6026 type enrollee code changes.

Once the retirement system begins deducting insurance premiums from the employee's disability benefit check (which usually occurs after the employee has received four disability checks), the retirement system will change the org proc code to indicate the retirement system as the employee's agency. Employees on an agency-approved Non-Occupational Disability leave receiving a disability benefit from a retirement system are eligible for the state-paid contribution. As long as the employee is receiving disability benefits from a retirement system, there is no limit to the number

of months in which an employee can be coded Non-Occupational Disability with Retirement Benefits.

Note: If the employee is switching to a Non-occupational Disability Leave without Retirement Benefits, please see the 'note' under Section 5.2.C.1.a, 'Non-Occupational Disability – No Retirement Benefits' for further instruction.

c. **Occupational Disability – Receiving Workers' Compensation (code 6003/6021):** Employees receiving occupational disability benefits through Workers' Compensation are eligible for the state-paid contribution. There is no limit to the number of months in which an employee can be coded as Occupational Disability. Part-time employees electing to remain in the Program are treated as full-time for insurance purposes. The GIR/P must change the work percentage for these members to 100% and the type enrollee code to 6021. Agency GIR/Ps should always code employees who are off work due to a work-related injury or illness as a Non-Occupational Disability – No Retirement Benefits (type enrollee code 6002/6027) until such time as CMS Workers' Compensation has approved the occupational disability benefit.

If the employee's Workers' Compensation benefit ends and the employee has been in leave status **greater than 24 months**, coverage must be terminated. If the Workers' Compensation benefit ends and the employee has been in leave status **less than 24 months** and the agency approves a Non-Occupational Disability leave of absence, the employee is eligible for the remainder of the 24 months of coverage. The agency must manually process the termination once the 24 months has been exhausted.

Note: Workers' Compensation only pays for medical expenses associated with the job-related injury/illness. Employees on an Occupational Disability leave must continue to pay insurance premiums to the Premium Collection Unit to ensure non-work related illnesses and injuries of the employee and any dependents are covered.

d. **Family Leave (medical, code 6010/6031):** Employees on a leave of absence due to one of the following reasons should be coded, ***for insurance purposes***, as "FMLA" on the Membership System. The GIR/P must change the type enrollee code to 6010 if the employee is full-time or 6031 if part-time.

- A leave taken to provide nursing and/or custodial care for the employee's newborn infant, whether natural born or adopted;
- A leave taken to care for a temporarily disabled, incapacitated or bedridden spouse, child or parent with a serious health condition;
- A leave taken for the employee to care for a spouse, child or parent in extraordinary need of medical or health care due to a serious health condition.

Note: When an employee takes a leave of absence for their own serious health condition, they must be coded as Non-Occupational Disability without Retirement Benefits (6002) and FMLA runs concurrent with the leave (refer to Section 5.2.C.1.a, 'Non-Occupational Disability – No Retirement Benefits' for more information regarding employee illness).

1. **Eligibility for State-Paid Coverage:** Employees who are granted an FMLA-approved Family Leave are eligible for state-paid basic health, dental and life coverage. The length of the state-paid coverage depends on the agency/university the employee works, as indicated below:

   - Employees under the jurisdiction of the Governor are ***eligible for up to 6 months***.
   - Employees of agencies **not** under the Governor and employees of universities are ***eligible for up to 12 workweeks***.

2. **Eligibility Expires:** If the employee's leave of absence extends beyond the eligible state-paid period, the leave of absence, for insurance purposes, must be changed to a Personal Leave and the type enrollee code changed to 6009 (full-time) or 6030 (part-time). If the benefit period is a continuous six months, the Membership System will automatically change the type enrollee code to Personal Leave. Those agencies that do not fall under the jurisdiction of the Governor (i.e., those agencies that receive only the 12 workweek benefit period) must manually change the leave type to a Personal Leave after the 12 workweek period is exhausted.

e. **Dock Time (FMLA Protected, code 6010/6031):** For insurance purposes dock time is any unpaid absence, whether authorized (excused) or unauthorized (unexcused). Dock time can be FMLA-protected or not FMLA protected. **For purposes of this section, only agency-approved FMLA-protected dock time is discussed.** For information about dock time that is not FMLA protected, refer to Section 5.2.C.2.b, 'Time Away From Work Not FMLA Protected – Dock/Suspension'.

   Employees are eligible for up to a total of 12 workweeks of state-paid coverage in a fiscal year for FMLA-protected dock time. Dock time is typically used intermittently for an employee's serious health condition or to allow the employee intermittent time away from work to care for a family member with a serious health condition. Since dock time is typically used intermittently, the Membership System cannot track the time automatically; therefore, all FMLA-protected dock time must be manually tracked by the agency. Any dock time used during the allotted 12 workweeks of state-paid coverage should not be coded on the Membership System unless the dock time falls on, or crosses, the first day of the pay period. If this occurs, the Membership System should be coded as Family Leave (type enrollee code 6010/6031).

   Dock time that occurs after the 12 workweeks must be coded as Dock/Suspension >30 days (6012/6032), **effective the first day for the pay period in which the dock time occurred.** Employees coded as Dock/Suspension >30 days (6012/6032) will be billed by PCU for the state and employee portion of the premium.

2. **Time Away From Work Not FMLA Protected** – This section describes the leaves of absence types that are **not** FMLA protected. Some of the leaves qualify for state-paid coverage, others do not. Refer to the specific leave type for more information.

a. **Educational/Sabbatical Leave (code 6006/6028):** Employees on an agency-approved, **work-related** educational leave are eligible for the state-paid contribution for a **24-month lifetime benefit**. Employees receiving a partial salary while on the leave must also be coded on the Membership System as Educational/Sabbatical. To ensure that the Estimated Annual Salary (EAS) and the Basic Life Units (BLUs) remain at 100%, payroll must be coded as 'no insurance deductions' and PCU will bill. Upon exhausting the 24-month benefit, the employee must return to work, be coded as a Personal Leave or be terminated from the Program. If an employee exhausts the 24 months, they must be coded as an 8011 (maximum leave of absence).

For purposes of calculating the 24-month lifetime benefit, only the time spent on the Educational/Sabbatical leave is counted. For example, an employee who is on a 50% Educational/Sabbatical leave and working the other 50% of the time for one year has used only six months of the lifetime benefit. In addition to coding the leave on the Membership System, GIRs must manually track the time used toward the lifetime benefit. Since the Membership System cannot pro-rate the lifetime benefit, a maximum benefit termination code (8011) will be automatically processed at the end of the continuous 24-month period. In order to reinstate the Educational/Sabbatical part-time leave, the GIR must contact the Membership Unit.

b. **Dock/Suspension (code 6011/6032; 6012/6033):** For insurance purposes, Dock/Suspension time is any unpaid absence, whether authorized (excused) or unauthorized (unexcused). Dock time can be FMLA protected or not FMLA protected. **For purposes of this section, only the dock time that is not FMLA protected is discussed.** For information about dock time that is FMLA protected, refer to Section 5.2.C.1.e, 'FMLA-Protected Dock Time'.

Employees in dock or suspension status are eligible for state-paid contributions for up to 30 calendar days per fiscal year. Dock/Suspension days in any given fiscal year must be manually tracked by the GIR/P. During this initial 30-day period, only those days which occur on or cross the first scheduled work day of a pay period must be processed on the Membership System.

Once the 30 days have been exhausted, employees are no longer eligible for the state-paid contribution and the GIR/P must manually change the member's type enrollee code from 6011/6032 (Dock/Suspension status ≤ 30 days) to 6012/6033 (Dock/Suspension status > 30 days). The type enrollee change must be effective the first day of the pay period in which the non-pay status occurs.

Effect of FMLA on Dock/Suspension: Uses of unpaid FMLA-protected leave run concurrently with the 30 days of state-paid contributions under Dock/Suspension ≤ 30 days (type enrollee code 6011). Once an employee exhausts 30 days of state-paid contributions, any additional dock or suspension time must be coded Dock/Suspension > 30 days (type enrollee code 6012). Employees who have exhausted

their FMLA protection, have had at least 30 days in unpaid status and incur additional Dock/Suspension time, whether or not FMLA related, must be coded as 6012.

Example: An employee uses 24 days of unpaid FMLA-protected leave from July through December. On January 15th the employee is placed on a 30-day suspension and is coded 6011 on the Membership System. The 24 days of FMLA count toward the employee's 30 days of state-paid contributions; therefore, the employee's state-paid contributions end January 20th and the GIR/P must manually process the type enrollee code change of 6012.

c. **Family Leave (non-medical, code 6009/6030 – same as Personal/General Leave):** The Family Leave reasons listed below are **not** medical or healthcare related and therefore do not qualify for FMLA protection. Employees on these types of leave would be coded as a Personal Leave (type enrollee code 6009/6030) ***for insurance purposes***. The employee would be eligible to continue group insurance coverage for up to 24 months *provided* the employee pays the full cost of coverage.

- A leave taken to respond to the temporary dislocation of the family due to a natural disaster, crime, insurrection, war or other disruptive event;
- A leave taken to settle the estate of a deceased member of the employee's family or to act as conservator if so appointed and providing the exercise of such functions precludes the employee from working;
- A leave taken to perform family responsibilities.

d. **Personal/General Leave (code 6009/6030):** Employees on an agency-approved Personal Leave (including certain leaves for union business) are eligible to participate in the Group Insurance Program for a maximum of 24 months but are not eligible for the state-paid contribution. Participation is entirely at the employee's expense (100%). If the employee does not return to work at the end of the 24-month period, coverage will be terminated as a 'Maximum Leave of Absence – COBRA Eligible' (type enrollee code 8011) on the Membership System.

The Group Insurance Division does not recognize part-time or intermittent Personal Leaves. An employee who is granted an approved part-time Personal Leave by personnel must be coded as a part-time employee (type enrollee code 1016) on the Membership System, if eligible (i.e., working 50% or greater).

Example 1: A full-time employee is granted a Personal Leave in which they will work 3 days per week for eight months (not FMLA qualified). The employee must be coded on the Membership System as part-time 60% which makes the employee responsible for the member and 40% of the state-paid portion of premium. These employees cannot waive coverage to become a dependent of their state-employed spouse.

If the part-time percentage is calculated as being less than 50%, the member must be placed on a 100% Personal Leave, waive coverage or become a dependent of their state-employed spouse (refer to Section 4.1.C.11 for specific options available).

Example 2: A full-time employee is granted a Personal Leave in which they will work 2 days per week for eight months (not FMLA qualified). The employee must be coded on the Membership System as Personal Leave at 100% which makes them responsible for 100% of the member and state-paid portion of premium.

e. **Family Military Leave (code 6009 – same as Personal/General Leave):** The Family Military Leave Act (P.A. 94-0589) was established to allow up to 30 days of unpaid leave to an employee who is the current spouse or parent of a person called to military service lasting longer than 30 days pursuant to orders of the Governor or the President of the United States. Employees who have been granted a Family Military Leave may continue health, dental, life and vision benefits by paying 100% of the cost for coverage. The effective date of the leave is the first day without pay. The return to work date is the first day the employee physically returns to work. For group insurance purposes, the employee must be coded 6009, Personal/General leave of absence.

To be eligible for Family Military Leave, the employee must have been employed for at least 12 months and worked at least 1250 hours during the 12-month period immediately preceding the commencement of the leave prior to requesting the leave. Additionally, the employee must exhaust all accrued vacation days, personal days, compensatory days and any other benefit time, except sick time, prior to being eligible for Family Military Leave.

f. **Military Leave (code 6039/6089/6019/6020):** Employees on a Military Leave must be coded as a Military Leave with Benefits (6039/6089), Military Call Up on Payroll (6019) or Military Call Up on Direct Pay (6020). Once the employee has been deactivated, the type enrollee code must be changed (refer to 5.2.C.2.f.3, 'Military Deactivation' for more information).

1. **Military Leave with Benefits (code 6039/6089)** is used for employees on an unpaid Military Leave who are **not** called by an Executive Order. An example would be an employee who enlists in the military. **Note: Employees who are active on payroll** during training periods, such as basic, special or advanced training, should **not** be coded as Military Leave.

   Effective 7/1/05: Military employees, and their dependents, are eligible for state-paid contributions for health, dental, vision and life coverage for 24 months. After the 24-month period, health, dental and vision coverage terminate; however, state-paid Basic Life coverage will continue for the duration of the leave (not to exceed 4 years). The employee may elect to continue member Optional Life, Child Life, Spouse Life and AD&D coverage for up to 4 years while on Military Leave. The Premium Collection Unit (PCU) will bill for coverage throughout the duration of the leave. **Note:** AD&D benefits will not be paid if an employee is killed or dismembered while enlisted in the military during a period of war, whether declared or undeclared.

Prior to 7/1/05, employees on a military leave of absence were coded 6016 (Military Reserves ≤ 30 days) or 6017 (Military Reserves > 30 days). Members had state-paid health, dental, vision and life coverage for the first 30 days of the leave (6016). After 30 days, health, dental and vision coverage terminated; however, state-paid Basic Life continued under the 6017 code. Members coded 6017 were eligible to continue optional life coverage for up to 4 years at their expense.

2. **Military Call Up (code 6019/6020)** applies to employees who are ordered to active duty by a Presidential call up. Employees may also be ordered to active duty for a local emergency by a call up executed by the Governor via an Executive Order.

   - Military Call Up on Payroll (6019) applies to employees who are receiving a pay differential that is sufficient to deduct premiums.

   - Military Call Up on Direct Pay (6020) applies to employees who are **not** receiving a pay differential or whose pay differential is insufficient to deduct premiums. This code is only used in rare instances.

3. **Military Deactivation** – Pursuant to Executive Order 2003-6, military employees released from active duty are entitled to 1 week (if stationed in the U.S.) or 2 weeks (if overseas) of pay and state-paid group insurance benefits before they physically return to work.

   Military employees who have been released from active duty under the U.S. Armed Forces and are exercising their rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA) are entitled to 90 days of job protection and group insurance coverage. Employees receiving the 1 or 2 weeks of pay, as well as those utilizing paid benefit time, continue to receive state-paid insurance coverage and must be coded as actively working even though they may not have physically returned to work. Employees who are using unpaid time will be responsible for 100% of the cost of group insurance coverage for the balance of the 90-day period and must be coded as Personal Leave (6009/6030).

g. **Furlough (code 6018):** Furlough is available only to certain employees of the Illinois School for the Deaf and Illinois School for the Visually Impaired, as defined in the AFSCME contract. These employees and their dependents receive premium-free health, dental and life coverage through the summer months. Coverage is automatically terminated effective September 1st of each year.

h. **Permanent Layoff (code 6008):** In order for an employee to be **eligible** for premium-free coverage upon being laid off, the employee's position must have been permanently eliminated (i.e., no intent of rehiring in the future). Only employees who work for an agency under the Governor are eligible.* **Note:** State employees not under the Governor's Office, such as employees of the Comptroller, Secretary of State, Treasurer, Attorney General, as well as employees of universities choosing not to reimburse 100% of the premium, are not eligible for the permanent layoff benefit but are eligible to continue life coverage (refer to Section 5.2.C.2.i, 'Permanent Layoff with Life Only' for more information).

* ***Special Note for Universities:*** Universities may elect to reimburse CMS for the total cost of a permanently laid off employee's coverage. The cost must be calculated at the prevailing University Permanent Layoff Reimbursement rates. Each pay period, participating universities must complete and submit a University Permanent Layoff Reimbursement Calculation Worksheet, along with the calculated payment and a listing of those receiving the extended benefit, to the CMS Bureau of Benefits Accounting Unit.

- ***Employees Entitled To The Premium-free Coverage***: Effective July 1, 2004, employees placed on a permanent layoff who are eligible for the premium-free benefit are entitled to one month of premium-free health, dental, vision and life coverage for each full year of creditable service up to a maximum of 24 months. A minimum of 6 months of coverage is afforded to all employees eligible for the permanent layoff benefit with less than 7 years of creditable service. This benefit is afforded to both the employee and their covered dependents. **Note:** Prior to July 1, 2004, permanently laid off employees were only eligible for 6 months of premium-free coverage.

  The premium-free benefit is based upon the coverage in effect at the time of the layoff. Employees are given the option to make certain election changes upon being permanently laid off. Refer to Section 4.1.C.23, 'Employment Status Changes: Active Employee to Permanent Layoff' for options. Additionally, during the permanent layoff period employees eligible for the layoff benefit are allowed to make changes consistent with any qualifying change in status they incur, as well as make changes during the annual Benefit Choice Period.

  At the end of the layoff period, the Membership System will automatically terminate the employee's coverage. At that time, the employee may elect COBRA health, vision and dental (if dental was previously elected) coverage for themselves and/or their dependents; however, the coverage would be entirely at the employee's expense. COBRA coverage, if elected, will be effective the date of the expiration of the permanent layoff benefit (no break in coverage).

- ***Employees Ineligible for Premium-free Coverage:*** Employees not eligible for the premium-free layoff benefit will have all insurance coverage (including any dependent coverage) terminated effective immediately upon the layoff. These employees have the right to continue health, dental and vision coverage for up to 18 months under COBRA, effective the date of the layoff. The GIR/P must code these employees on the Membership System with the type enrollee termination code 8015.

- ***Membership System Processing:*** GIR/Ps are currently restricted from entering the Permanent Layoff code (6008) on the Membership System and are required to send the Membership Unit documentation verifying that each position has been permanently eliminated (e.g., CMS-2, documentation that the employee was put on a recall list or Re-employment Register).

  Once the documentation is received and approved by the Membership Unit, the type enrollee code will be changed to 6008.

- ***Permanent Layoff and Disability:*** Employees on a disability leave of absence who are designated to receive the premium-free permanent layoff benefit must exhaust the disability leave before the permanent layoff benefit can be extended. The employee must satisfy the guidelines of the disability leave of absence and continue to provide an agency-approved physician statement. The disability type enrollee code must remain on the Membership System (Non-Occupational – 6001/6026; 6002/6027, Occupational – 6003/6021) until the employee is no longer eligible for the disability leave.

  Once the employee no longer qualifies for the disability leave of absence, they must contact either their agency GIR/P or the Membership Unit in order to have their leave status changed to permanent layoff and receive the premium-free coverage.

- ***Employee Accepts a Part-time Position Following Layoff:*** Employees who were eligible for the premium-free benefit under the jurisdiction of the Governor and accept an intermittent or part-time position with another state agency or university shall have their first year of health, dental, vision and life insurance coverage treated as if they continued to work as a full-time employee (i.e., they would not be charged the part-time percentage for the premiums). GIR/Ps should code the employee as a full-time employee (type enrollee code 1001) and track the 12-month period. Once the employee has received the 12 months of full-time insurance coverage, the GIR/P should change the employee to a part-time type enrollee code, if applicable.

i. **Permanent Layoff with Life Only (code 6013):** All permanently laid off employees are eligible to continue life coverage **at their expense**, under the Group Insurance Program for 12 months. Permanently laid off employees electing to continue the 12 months of life coverage must be coded on the Membership System with the type enrollee code 6013.

   The 12-month time period begins according to the following:

   - Permanently laid off employees who were ineligible for the premium-free benefit are eligible for the 12 months of life coverage at the time of **termination of state service**.

   - Permanently laid off employees eligible for the premium-free benefit are eligible for the 12 months of life coverage at the time of **termination of the premium-free layoff benefit.**

The GIR/P **must** supply all permanently laid off employees with conversion and portability forms before, or at the time of, the permanent layoff. The employee may elect to convert or port their life coverage once their life coverage under the group plan ceases (i.e., at the time of the layoff, or at the end of the 6 – 24 months of premium-free coverage, if they were eligible). The premium for converted or ported coverage, if elected, will be direct billed by the Life Plan Administrator. ***Note:*** *Employees interested in converting or porting life coverage should be referred to the 'State of Illinois Group Life Insurance Program' booklet.*

j. **State Agency and University Seasonal Leave (code 6029):** Part-time agency and university seasonal workers (type enrollee code 1021 while active on payroll) are required to pay the same premium on leave as when actively working. Coverage is terminated automatically at the end of 6 months if the employee has not returned to work. *Examples include part-time employees of Department of Natural Resources, Secretary of State, Department of Employment Security, Department of Healthcare and Family Services, university employees eligible for unemployment such as groundskeepers and carpenters.*

k. **University Full-Time Faculty and 'Academic-Year' Non-Faculty Annual Break (code 6023):** Full-time faculty and academic year non-faculty employees (type enrollee code 1001 while active on payroll) pay the same premium during the summer break period as when actively working. Employees who do not return to active status by September 1st of each year have coverage automatically terminated. The maximum leave period is 3 months. *Examples include full-time faculty, food service, health service and residence hall clerks.*

l. **University Paid 'Academic Year' Annual Break (code 6022):** This code is used when a university chooses to pay all or a portion of their employees' premium during the annual summer break. Employees who do not return to active status by September 1st of each year have coverage automatically terminated. The university should contact the Premium Collection Unit (PCU) if interested in this option.

m. **University Part-Time Faculty Annual Break (code 6036):** University part-time faculty (type enrollee code 1019 while active on payroll) must pay the same premium on leave as when actively working. Part-time faculty employees who do not return to active status by September 1st of each year have coverage automatically terminated.

n. **University Part-Time 'Academic-Year' Non-Faculty Annual Break (code 6037):** University part-time academic year non-faculty employees (type enrollee code 1020 while active on payroll) must pay the same premium on leave as when actively working. Part-time non-faculty who do not return to active status by September 1st of each year has coverage automatically terminated. *Examples include part-time food service, health service and residence hall clerks.*

D. Leave Expiration Due to Maximum Length of Participation

Employees who do not return to work after the maximum length of participation has expired will have coverage terminated on the Membership System as 8011 (maximum length of participation).

The employee, and their dependent(s), may elect one of the following options at the time of termination of coverage:

(1) May elect to become an eligible dependent of another state employee, or

(2) May elect coverage under the COBRA Program.

5.3 Employee Returns to Regular Work Schedule

Employees physically returning to work experience a qualifying change in status in which they have certain coverage options available if elected within 60 days. Refer to Section 4.1.C.12, 'Employee Returning to Work from a Leave of Absence' for coverage and waiver options.

A. System Procedures

1. **Membership Coding** – The type enrollee code on the Membership System must be changed to the correct active code (10**) to show the employee is no longer on leave in order for Premium Collection Unit (PCU) to stop billing.

2. **Payroll Responsibilities** – If the return to work effective date is the 1st or 16th, payroll must begin collecting insurance premiums that pay period. Otherwise, deductions begin the following pay period.

B. Determining Effective Date

Correctly determining the return to work date is important and, for group insurance purposes, may vary from the date indicated on the CMS-2 or Personnel Action Form. Upon notification of an employee's return, the GIR/P must verify the employee has physically returned to work and was not simply returned to payroll in order to be paid benefit time (i.e., maternity/paternity, sick, vacation or personal). If an employee has been returned to payroll only to pay out benefit time, the return must not be entered on the Membership System.

Before processing the return to work effective date, the following must be determined:

Employee Physically Returns to Work on either:

- ***the first regularly scheduled work day of the pay period:*** The effective date for employees who physically return to work on the first regularly scheduled work day in the pay period is the first day of the pay period (1st or 16th). This policy applies whether the first day of the pay period occurred on a Saturday, Sunday, holiday or the employee's scheduled day off.

> ***Example 1:*** An employee is on a Personal Leave of absence during the month of March. The employee physically returns to their normal work schedule (Monday through Friday) on April 2nd, which is a Monday. Since the ***employee physically returned to work on the first regularly scheduled work day of the pay period***, the return to 'Active' status from 'Leave of Absence' status (***for insurance purposes***) would be April 1st. Deductions for the first pay period in April should be taken on payroll by the agency.

- ***a day that is not the first regularly scheduled work day of the pay period:*** The effective date for employees who physically return to work on a day which is not their first regularly scheduled work day in the pay period is the actual date of return.

> ***Example 2:*** An employee is on a Personal Leave of absence during the month of March. The employee physically returns to their normal work schedule (Monday through Friday) on April 3rd, which is a Tuesday. Since the ***employee returned to work on a day which was not the first regularly scheduled day of the pay period***, the return to 'Active' status from 'Leave of Absence' status (***for insurance purposes***) would be April 3rd. The Premium Collection Unit (PCU) will bill the employee for the April 1st – 15th pay period. Payroll should begin collecting premiums for the April 16th – 30th pay period.

Note: Refer to Section 5.1.C, 'Reinstatement of Coverage,' to determine the effective date of coverage for employees who **waived coverage** upon going on a leave, had coverage **terminated for non-payment of premium** or whose benefit period expired.

5.4 Employee Returns to Work on a Reduced Schedule

Employees approved by their Personnel Office to return to work on a reduced schedule due to a medical condition are provided a benefit that allows them to continue coverage for a certain period of time with no change in premium. Once the employee is coded the appropriate type enrollee code (i.e., 6040, 6041 or 6014/6034), the time period is monitored by the Group Insurance Division. Employees must continue to provide acceptable medical documentation to their Personnel Office in order to be eligible for this benefit.

The type enrollee code should be made effective the date the employee physically returns to work. Employees who return to work on a reduced schedule continue to direct pay premiums through the Premium Collection Unit. Deductions should not be taken on payroll (must code as 'no insurance').

Even though the employee is working a reduced schedule, the Estimated Annual Salary (EAS) and Basic Life Units (BLU's) should **not** be reduced based upon the part-time pay. Once the benefit ends, if an employee's request to remain on a reduced work schedule is approved by the agency, the employee's type enrollee code on the Membership System must be changed to the appropriate part-time type enrollee code. The Estimated Annual Salary (EAS) should then be reduced based upon the part-time pay.

Employees physically returning to work experience a qualifying change in status in which they have certain coverage options available if elected within 60 days. Refer to Section 4.1.C.12, 'Employee Returning to Work from a Leave of Absence' for coverage and waiver options.

A. Non-Occupational Disability – No Retirement Benefits (code 6040)

Full-time employees on a Non-Occupational Disability leave of absence returning to work on a reduced schedule should be coded Return to Work Part-Time Non-Occupational Disability leave of absence (type enrollee code 6040). The state-paid contribution will continue for a maximum period of 3 months, providing the employee:

a. Has not exhausted their 24 months of state-paid disability coverage, and
b. Provides a physician's statement indicating they may only return to work on a reduced schedule due to their medical condition, and
c. Has approval from their agency's Personnel Office to return to work on the reduced schedule.

Employees working a reduced schedule may not surpass the 24 months of state-paid coverage during the combined leave and part-time return to work period (see examples below).

Employees still working a reduced schedule after three months **or** at the end of the 24-month period (whichever comes first) must be changed on the Membership System to a part-time type enrollee code (1016, 1017, 1018, 1019, 1020) with the appropriate part-time percentage. Agencies **must** begin to payroll deduct premiums at the part-time percentage, unless the member is coded as Employee Part-time – Direct Pay (type enrollee code 1017), in which case PCU continues to bill.

Example 1: An employee goes on a disability leave of absence effective March 1, 2006. The employee returns to work with a physician's statement indicating they may only return to work on a reduced schedule due to their medical condition. The Personnel Office allows the employee to return to work effective December 1, 2007 (which is 21 months after the start of the disability leave). The employee returns to a full-time work schedule March 1, 2008.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Disability LOA begins	March 1, 2006	6002	100%	PCU
Approved for Disability Benefits by Retirement System	April 1, 2006	6001	100%	PCU
Approved to work a reduced schedule	December 1, 2007	6040	100%	PCU
Employee returns to work full-time	March 1, 2008	1001	100%	Payroll
The employee exhausted both the 3 months of state-paid coverage allowed when working a reduced schedule and the 24 months of disability leave of absence coverage at the end of February 2008.				

Example 2: An employee goes on a disability leave of absence effective March 1, 2006. The employee returns to work with a physician's statement indicating they may only return to work on a reduced schedule due to their medical condition. The Personnel Office allows the employee to return to work effective November 1, 2007 (20 months after the start date of the leave). The employee returns to a full-time work schedule July 1, 2008.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Disability LOA begins	March 1, 2006	6002	100%	PCU
Approved to work a reduced schedule	November 1, 2007	6040	100%	PCU
3 months of coverage allowed when working a reduced schedule expires	February 1, 2008	1016	PT%	Payroll
Employee returns to work full-time	July 1, 2008	1001	100%	Payroll
The employee exhausted his 3 months of state-paid coverage allowed when working a reduced schedule at the end of January, 2008. Even though the employee had not exhausted the 24 months of disability leave of absence coverage, the 3 month maximum was exhausted.				

Example 3: An employee goes on a disability leave of absence effective March 1, 2006. The employee returns to work with a physician's statement indicating they may only return to work on a reduced schedule due to their medical condition. The Personnel Office allows the employee to return to work effective February 1, 2008 (23 months after the start date of the leave). The employee returns to a full-time work schedule July 1, 2008.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Disability LOA begins	March 1, 2006	6002	100%	PCU
Approved to work a reduced schedule	February 1, 2008	6040	100%	PCU
3 months of coverage allowed when working a reduced schedule expires	March 1, 2008	1016	PT%	Payroll
Employee returns to work full-time	July 1, 2008	1001	100%	Payroll
The employee exhausted the 24 months of disability leave of absence coverage at the end of February. Even though the 3 months of state-paid coverage allowed when working a reduced schedule was not exhausted, the 24 months of disability coverage had exhausted.				

Example 4: An employee goes on a disability leave of absence effective March 1, 2006. The employee returns to work with a physician's statement indicating they may only return to work on a reduced schedule due to their medical condition. The Personnel Office allows the employee to return to work effective April 1, 2008 (25 months after the start date of the leave). The employee is approved by their agency to continue working a reduced schedule indefinitely.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Disability LOA begins	March 1, 2006	6002	100%	PCU
The 24 months of disability LOA benefits expire	March 1, 2008	8011	Termed	N/A
Approved to work a reduced schedule – must be changed to part-time	April 1, 2008	1016	PT%	Payroll
The employee exhausted his 24 months of disability leave of absence coverage at the end of February. Both the 3 months of state-paid coverage allowed when working a reduced schedule and the 24 months of disability leave of absence coverage had exhausted. The employee's coverage must be terminated on the system and they would be offered COBRA. The employee would remain on COBRA, if elected, until they returned to work. Since the employee was out of insurance benefits and did not return to a full-time work schedule, they must be coded a part-time percentage on the Membership System and have premiums payroll deducted.				

B. Non-Occupational Disability – With Retirement Benefits (code 6001)

Employees under the State Universities Retirement System (SURS) who return to work on a reduced schedule from a Non-Occupational Disability leave of absence continue to receive a disability benefit. These employees remain coded Non-Occupational Disability – With Retirement Benefits (6001) on the Membership System. **Note:** All other employees (SRS and TRS) are not eligible for a retirement benefit while working reduced schedule.

C. Occupational Disability Leave – Receiving Workers' Compensation (code 6041)

Employees on an Occupational Disability leave of absence that have been approved by Workers' Compensation to return to work on a reduced schedule must be coded Return to Work Part-time Occupational Disability (type enrollee code 6041). These employees receive pay from their agency for the percentage of time actually worked as well as pay from Workers' Compensation for the percentage of time not worked. There is no maximum length of time an employee may work the reduced schedule; however, the employee must continue to receive benefits from Workers' Compensation in order to receive state-paid coverage. Agencies must **not** payroll deduct premiums until the employee returns to a full-time work schedule. If Workers' Compensation benefits end and the employee does not return to a full-time work schedule, the type enrollee code on the Membership System must be changed to a part-time code (1016, 1017, 1018, 1019, 1020). **Note:** If the employee has been on the Workers' Compensation benefit for less than 24 months they may be eligible for the 3-month Return to Work Non-occupational Disability benefit. See Section 5.4.A, 'Non-Occupational Disability – No Retirement Benefits' for coding instructions.

Example 1: An employee goes on an Occupational Disability leave of absence effective March 1, 2006. The employee returns to work on December 1, 2006 with restrictions indicating he may only work a reduced schedule due to his medical condition. The employee continues to receive a benefit from Workers' Compensation through December 31, 2006, at which time the employee returns to a full-time work schedule effective January 1, 2007.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Occupational Disability LOA begins	March 1, 2006	6003	100%	PCU
Approved to work a reduced schedule	December 1, 2006	6041	100%	PCU
Employee returns to work full-time	January 1, 2007	1001	100%	Payroll
The employee must continue to pay premiums directly to the Premium Collection Unit (PCU). Payroll must not deduct premiums while the member is still in Workers' Compensation status.				

Example 2: An employee goes on an Occupational Disability leave of absence effective May 1, 2006. The employee returns to work on February 1, 2007 with restrictions indicating they may only work a reduced schedule due to their medical condition. The employee continues to receive a benefit from Workers' Compensation through February 28, 2007, at which time the benefits from Workers' Compensation end. Even though the employee is released to return to a full-time work schedule, the agency approves the employee's request to continue to work a reduced schedule.

Event	Effective Date	Type Enrollee Code	% on System	Premium Collected By
Occupational Disability LOA begins	May 1, 2006	6003	100%	PCU
Approved to work a reduced schedule	February 1, 2007	6041	100%	PCU
Approved to return to work full-time, but continues working reduced schedule	March 1, 2007	1016	PT%	Payroll
Since Workers' Compensation benefits have ended and the agency approves the employee's request to remain on a reduced work schedule, the employee's type enrollee code on the Membership System must be changed to part-time. Payroll must begin insurance deductions for the part-time percentage beginning with the March 1st – 15th pay period.				

D. Family Leave (medical related, code 6014/6034)

An employee who is granted a Family Leave (medical related) protected by FMLA and who returns to work on a reduced schedule, or begins working a reduced schedule while on the approved leave, qualifies for up to six months of state-paid basic health, dental and life insurance while on the leave. The total accumulated time a person may be coded 6010/6031 and 6014/6034 may not exceed 6 months if under the jurisdiction of the Governor or 12 weeks for agencies **not** under the jurisdiction of the Governor.

The examples below illustrate two different scenarios in which a 6014/6034 code may be used. In each example the, the GIR/P needs to change the leave code to a Personal Leave at the end of the 6-month accumulative leave period (type enrollee code 6009/6030). **Note:** The examples assume the employee works for an agency that falls under the jurisdiction of the Governor.

Example 1: An employee is granted a Family Leave protected by FMLA effective April 1st – June 30th (3 months). The employee would be allowed to continue coverage under FMLA (6010/6031) during this time. The employee returns to work part-time on July 1st (four days per week). The GIR/P must change the leave code to 6014/6034 effective July 1st (the date the employee returned to work). The employee would be allowed to continue coverage under FMLA RTW PT DIR PAY (6014/6034) until September 30th (6 months total from the date the leave started).

Example 2: An employee is granted a Family Leave protected by FMLA to care for her ill parent effective August 16th. The employee changes her schedule to work 3 days per week (60% part-time) at the beginning of the leave. The employee is given total leave time of 6 months (i.e., August 16th through February 16th). The employee would be allowed to continue coverage under FMLA RTW PT DIR PAY (6014/6034) from August 16th through February 16th (6 months total from the date the leave started).

5.5 Reports and Schedules

A. Leave of Absence Reports

The Premium Collection Unit distributes to each agency various reports. Some are available through MOBIUS; others are direct mailed to the agency. For a complete explanation of all Premium Collection Unit (PCU) Reports, see Section 14.0.C, 'Premium Collection Unit (PCU) Reports'.

B. Agency Cutoff Schedule Description

At the beginning of each fiscal year, CMS will send all GIR/P's an 'Agency Cutoff Schedule'. The schedule is an aid for the GIR/P to be aware of important dates (i.e., processing of terminations, mailing of reports, etc.). A sample section of the 'Agency Cutoff Schedule' is shown in the chart below. Use the sample chart to compare example dates in the description table below.

Coverage Month	Membership Cutoff	Bills Mailed By	Terminations Processed By
July	7/1 – T (Tuesday)	7/7	9/30

Sample Section of Agency Cutoff Schedule

Description Table for Premium Collection Unit Cutoff Dates		
Title	**Example**	**Description**
Month	*July*	The month in which the monthly bills will be generated. PCU will bill the member for the current month and any previous months which have not previously been billed. ***Example:*** PCU bills will be generated for the month of July's liability.
Membership Cutoff	*7/1*	All Membership transactions affecting PCU bills must be processed by this date in order to have premium due calculated for the "month." ***Example:*** All Membership transactions must be processed by 7/1 in order to have the change/correction affecting July liability included on the bill for July premium.
Bills Mailed By	*7/7*	Monthly billing statements will be mailed to the member for the "month" by this date. ***Example:*** The member's bill will be mailed from PCU by 7/7.
Terminations Processed By	*9/30*	PCU begins processing terminations the first working day following the due date for premiums not paid or postmarked by the due date. ***Example:*** PCU begins processing the termination of coverage for member's whose premium was not received by PCU by the due date (20th of the month). Terminations will be processed by the last day of the month. Termination letters will be sent to the member by 9/30.

5.6 Time Away From Work Chart

FMLA-Protected Time Away From Work

Time away from work that qualifies for FMLA protection is state-paid eligible. All time away from work categories listed below run concurrent for FMLA state-paid benefits.

Time Away From Work Category (State-paid Eligible)	FT Code	PT Code	Maximum Coverage Period
Family Leave – Medical Related/Caring for Newborn	6010	6031	6 months 12 weeks
Family Leave – RTW on a Reduced Schedule	6014	6034	6 months 12 weeks
Non-Occupational Disability with Benefits	6001	6026	n/a
Non-Occupational Disability without Benefits	6002	6027	24 months
Non-Occupational Disability without Benefits RTW - Reduced Schedule	6040	6040	3 months
Occupational Disability	6003	6021	n/a
Occupational Disability RTW - Reduced Schedule	6041	6041	n/a

Benefit Time	Time Used	Membership Coding
• Maternity/Paternity (3-4 weeks) • Sick • Vacation • Personal • Intermittent Dock time that does not fall on the 1st day of a pay period taken for an FMLA reason	At the beginning of a leave period	Do not change the type enrollee code
	During or at the end of a leave period	Do not change the type enrollee code until the employee physically returns to work

Time Away From Work Not FMLA Protected

Time away from work that **does not** qualify for FMLA protection can be either state-paid eligible or state-paid ineligible.

Time Away From Work Category (State-paid Eligible)	FT Code	PT Code	Maximum Coverage Period
Dock/Suspension ≤ 30 days *	6011	6032	30 days
Educational Sabbatical	6006	6028	24 months
Furlough	6018	6018	4 months
Military Call Up on Direct Pay	6020	6020	n/a
Military Call Up on Payroll	6019	6019	n/a
Military with Benefits	6039	6039	48 months
Permanent Layoff	6008	6008	24 months
State Agency and University Seasonal Leave	n/a	6029	6 months
University 'academic year' FT Faculty and Non-faculty	6023	n/a	3 months
University 'academic year' Part-time Faculty	n/a	6036	6 months
University 'academic year' Part-time Non-faculty	n/a	6037	6 months

Time Away From Work Category (State-paid Ineligible)	FT Code	PT Code	Maximum Coverage Period
Dock/Suspension > 30 days *	6012	6033	23 months
Family Leave – not medical related or state-paid Family Leave coverage expired	6009	6009	12 months
Family Military	6009	6009	1 month
Permanent Layoff – Life Only	6013	6013	12 months
Personal/General	6009	6030	24 months

* For insurance purposes, Dock/Suspension time is any unpaid absence, whether authorized (excused) or unauthorized (unexcused).

State-paid eligible means the state will continue to pay the same portion of the premium as when the employee was active on payroll. An exception is made for part-time employees on Occupational Disability (type enrollee code 6021), in which case the employee must be treated the same as a full-time employee **for insurance purposes**.

State-paid ineligible means the employee is required to pay 100% of the state and employee portions of the premium.

For more information regarding any time away from work category, refer to Section 5.2, 'Employee Leaves of Absence'.

6.0 General Information

Members and dependents enrolled in the State Employees Group Insurance Program have coverage terminated for various reasons, which are described in this section. When a member's coverage is terminated, the dependent's coverage is automatically terminated with the same effective date.

Certificate of Creditable Coverage
All members and dependents whose health coverage is terminated will receive a Certificate of Creditable Coverage from CMS when the termination is processed on the Membership System. The Certificate of Creditable Coverage is a letter that may be used as proof that the member/dependent had health coverage. The certificate lists the period of time the member/dependent had coverage. Federal law mandates that the member/dependent must receive the certificate within 14 days of the coverage termination date; therefore, it is imperative the GIR/P process the transaction on the Membership System as soon as they are aware of the termination. The certificate will automatically be generated by CMS and sent directly to the address on file. In the event the member/dependent did not receive a Certificate of Creditable Coverage, the GIR/P may generate a copy via the Membership System (see Section 12 'Requesting Forms to be Printed').

Life Coverage
Employees terminating group insurance coverage have certain life benefit options available to them and their dependents regarding portability and conversion. The agency GIR/P must supply conversion and portability information to the member/ dependent as soon as they have been made aware of the employee's termination. See Section 1.4.C, 'Plan Descriptions – Life Plan' for the specific information which must be distributed to the employee. Note: If the employee is age 60 or older and retiring, the GIR/P must supply the conversion and portability information due to the reduction in life coverage.

If a member had Spouse Life or Child Life coverage, the dependents would also be entitled to convert to an individual life insurance policy if they lose coverage due to 1) the member no longer being eligible for coverage, 2) the member's death or 3) the dependent no longer meeting the definition of an eligible dependent. These dependents must also be given information regarding conversion privileges of Spouse Life and Child Life.

GIR/Ps should refer members to the 'State of Illinois Group Life Insurance Program' booklet for specific information regarding these portability and conversion options. For additional information, GIR/Ps should refer to Appendix F.

6.1 Termination of Coverage

There are three points to keep in mind when processing a termination of coverage:

- the termination must be processed timely
- the actual date of termination must be processed (refer to Section 6.1.B, 'Termination Reasons and Effective Dates')
- the correct termination type enrollee code must be used (refer to Section 6.1.D, 'Termination Coding/COBRA Notification')

A. Timely Processing of Termination

The timely processing of terminations directly affects COBRA eligibility/ineligibility letters and Premium Collection Unit (PCU) billing statements.

- **COBRA:** In order to be in compliance with federal regulations, PCU must generate and mail a COBRA eligibility/ineligibility letter 14 days from a member or dependent's termination date. The GIR/P should process the termination immediately upon notification to ensure compliance with COBRA law, as well as reduce any financial hardship on the potential COBRA enrollee.
- **Premium Collection Unit (PCU):** Employees billed by PCU (e.g., employee on leave of absence) will continue to receive billing statements until the termination is processed.

B. Termination Reasons and Effective Dates (Member Coverage)

This section explains the various reasons for termination, the type enrollee code to be used, whether or not COBRA benefits will be offered, etc. ***Note:*** The effective date of the termination (the date entered on the Membership System) must be the day following the last day the member/dependent was eligible for insurance coverage.

Example: The employee's last day of work was March 20th. The effective date of termination would be March 21st. **COVERAGE DOES NOT CONTINUE THROUGH THE END OF THE PAY PERIOD.**

1. **Resignation/Separation of State Employment:** Employees who are either resigning from state employment or are terminated by the agency/university have coverage through midnight on the last day the member was physically at work. Employees may not extend the date of separation by using accrued benefit time.

   Employees terminating employment must be coded with a type enrollee code of 8008 (terminate employment). Employees who terminate employment have the option to become a dependent of their state-employed spouse, in which case they must be coded with a type enrollee code of 8009. Employees coded 8008 will receive a COBRA eligibility notice from CMS. This notice is generated based on the termination effective date or processing date, whichever is later. **Note:** An employee who is terminating state employment cannot be added to an active member's coverage until the termination has been processed on the Membership System.

   Note: Employees terminated for Gross Misconduct must be coded with the type enrollee code 8012. These members will receive a COBRA ineligibility notice; however their dependents will receive a COBRA eligibility notice.

2. **Resignation/Separation of University Faculty:** Full-time university faculty and part-time faculty eligible for coverage during the academic summer break automatically receive group insurance through 8/31. If the employee does not wish to continue coverage through 8/31, they may request to terminate the coverage. The effective date of the termination would be the date of the request or any future date. To determine if a part-time faculty employee is eligible for coverage during the summer break, see Section 2.0.A.2.

3. **Change from Full-time Employment to Less than 50% Part-time Employment:** An employee's coverage terminates at midnight on the date of the change from full-time to less than 50% part-time. The employee must be coded with the type enrollee code of 8014 (change to less than 50% employment). Employees who lose eligibility have the option to become a dependent of their state-employed spouse, in which case they must be coded with a type enrollee code of 8009. Employees coded 8014 will receive a COBRA eligibility notice from CMS. This notice is generated based on the termination effective date or processing date, whichever is later. **Note:** An employee who is losing eligibility cannot be added to an active member's coverage until the termination has been processed on the Membership System.

4. **Termination for Non-payment of Premium:** If a member fails to pay the premium due when billed, the Group Insurance Division (GID) will terminate the member's coverage the first day of the current month. The Membership System will be updated with the appropriate termination code (6015, 6035, 8010, 8030, 8035 or 1007). These members are ineligible to continue coverage under COBRA and will not receive a COBRA notification letter (eligible or ineligible). CMS will take action to collect all outstanding premium(s) which may include involuntary withholding.

5. **Permanent Layoff <u>with</u> Premium-Free Benefits *(universities reimbursing 100% of the premium and agencies under the Governor):*** An employee's coverage terminates at midnight of the day of the expiration of the premium-free permanent layoff benefits (i.e., 6 – 24 months after the layoff). The Membership System automatically terminates the employee's coverage with the type enrollee code 8011 (these employees will receive a COBRA eligibility notice). Laid off employees may continue life coverage under the Group Insurance Program for up to 12 months from the date their premium-free life coverage terminates. Employees electing this option will be coded with the type enrollee code 6013 by the Membership Unit. Following the expiration of the employee's life coverage under the Group Insurance Program, employees may elect to convert or port their coverage.

6. **Permanent Layoff <u>without</u> Premium-free Benefits (universities and other constitutional offices):** An employee's coverage terminates at midnight of the day prior to the status changing to permanent layoff. The GIR/P must code these employees with the type enrollee code 8015 and will receive a COBRA eligibility notice. Laid off employees may continue life coverage under the Group Insurance Program for up to 12 months following the layoff. Employees electing this option will be coded with the type enrollee code 6013 by the Membership Unit. Following the expiration of the employee's life coverage under the Group Insurance Program, employees may elect to convert or port their coverage.

7. **Death:** Coverage for a deceased member remains in force until midnight of the date of death. The GIR/P must enter the actual date of death in the Membership System. The system will automatically post the 8001 termination code effective the day <u>after</u> the member's death (see Section 12, 'Member Death').

   Example: Member dies on 5/10. The termination effective date on the Membership System would be 05/11.

   The GIR/P should follow the 'Death Claim Workflow' procedure in Appendix F for step-by-step instructions regarding the filing of a death claim when a member's beneficiary or survivor requests life benefit assistance.

   COBRA benefits are available for dependents of deceased members. In order for dependents to receive COBRA notification in a timely manner, the member's date of death must be processed on the Membership System. The GIR/P should advise the beneficiary to contact the appropriate retirement system for possible survivor benefits.

C. Termination Reasons and Effective Dates (Dependent Coverage)

An enrolled dependent's coverage terminates at midnight:

- Simultaneous with termination of a member's coverage.
- On the requested date of a voluntary termination of a dependent in the two or more category that does not affect premiums.
- On the requested date of a voluntary termination due to a qualifying change in status (refer to Section 4 for specific qualifying change in status reasons and rules).
- On the date of the dependent's death.
- On the date preceding the dependent's entrance into the military service *(for example, a dependent enters the military February 1st; state coverage would end midnight of January 31st; the Membership termination effective date would be February 1st).*
- On the date preceding the dependent's enrollment in the state's group insurance program as a member *(for example, a dependent enrolls in the state program as a member February 1st; state coverage as a dependent would end midnight of January 31st; therefore, the Membership termination effective date would be February 1st).*
- On the date preceding the dependent's marriage *(for example, a dependent marries February 1st; state coverage would end midnight of January 31st; the Membership termination effective date would be February 1st).* ***
- On the date preceding divorce *(for example, a member produces a court order divorcing their dependent spouse with a circuit clerk file stamp date of February 1st; state coverage would end midnight of January 31st; the Membership termination effective date would be February 1st).* ***
- The last day of the month in which a dependent child turns 19 years old, unless the dependent qualifies in the student, handicapped or "other" category.
- The last day of the month a dependent student graduates*****, drops below full-time status*****, or becomes 23 years of age, whichever is earliest, unless the dependent qualifies in the handicapped or "other" category.

* **Members who fail to notify their GIR/P within 60 days of dependent ineligibility will not receive a refund for premiums paid during the ineligible period**, nor will these dependents be eligible for COBRA. The GIR/P must contact the Analysis and Resolution Unit to have any overpayment purged. The dependent will receive a COBRA **ineligibility** letter from the Premium Collection Unit.

D. Termination Coding/COBRA Notification

The GIR/P must use the termination code which best describes the reason for termination. The following chart lists all the termination type enrollee codes. Some members/dependents whose coverage has been terminated may not be eligible for COBRA benefits. Proper coding ensures that members receive COBRA eligible or ineligible letters. COBRA letters are automatically system generated the later of the process date or the termination date based on the termination code processed on the Membership System.

Members	
COBRA-Eligible Letter Generated	**No COBRA Letter Generated**
8008 = Terminate employment 8011 = Maximum leave of absence ends 8014 = Change to less than 50% employment 8015 = Permanent layoff w/o premium-free coverage	8001 = Member death 8003 = Tefra waiver 8007 = Never eligible 8009 = Dependent of another member 8010 = Non-payment of premium 8016 = Non-state paid leave of absence waiver
COBRA-Ineligible Letter Generated	
8012 = Employment terminated due to gross misconduct 8017 = Termination - no COBRA	

Dependents	
COBRA-Eligible Letter Generated	**No COBRA Letter Generated**
8001 = Member death 8012 = Dependent of employee terminated for gross misconduct 8055 = Dependent marriage 8056 = Divorce/Legal Separation 8057 = Failure to recertify 8058 = Dependent child turns 19 8059 = Dependent child turns 23 8066 = Dependent becomes ineligible **	8050 = Dependent voluntary terminated * 8051 = Transfer to another member 8053 = Military service 8054 = Enrolled as a member 8060 = Defra waiver 8065 = Dependent never eligible
COBRA-Ineligible Letter Generated	
8070 = Dependent loss of eligibility notification untimely ***	

* The 8050 code, 'Dependent Voluntary Termination,' must be used when a member voluntarily chooses to drop a dependent, such as during the Benefit Choice Period, when the member is in the 2+ category or when no other qualifying event code applies. Voluntary termination is ineligible for COBRA; therefore, these dependents will not receive a COBRA letter.

** The 8066 code, 'Dependent Becomes Ineligible,' must be used when a dependent becomes ineligible, such as when a student dependent graduates or does not return to school full-time. These dependents are eligible for COBRA coverage.

*** The 8070 code, 'Dependent Loss of Eligibility Notification Untimely,' must be used when notification of ineligibility is more than 60 days following the event date. These dependents are not eligible for COBRA and will receive a COBRA ineligibility letter. Note: The 8070 code must be used in these situations instead of the 8055, 8056 or 8066 code.

E. Member's Coverage Terminated in Error

If a member or dependent has had coverage terminated in error, the GIR/P must submit a letter or memo to the Membership Unit explaining the error. Failure to include an explanation of the error will delay the processing of the correction.

6.2 COBRA

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), the state must provide qualified members and dependents that lose eligibility under the Program the option to continue health, dental and vision coverage. All inquiries regarding COBRA eligibility, enrollment or premium payment should be directed to the Group Insurance Division's COBRA Unit. This unit is responsible for the administration of the COBRA Program and becomes the GIR for terminated employees electing to enroll in COBRA.

A. New Hire's COBRA Rights

Federal law has very strict notification requirements for notifying employees of their COBRA rights upon commencement of employment. CMS is required to provide new employees with a COBRA Rights Notification letter **within 10 days of the employment start date** as COBRA law dictates (see Appendix I, 'Sample Letters' for a sample copy of the COBRA Rights Notification letter).

B. COBRA Eligibility/Ineligibility Notification (Upon Termination of Coverage)

COBRA eligibility/ineligibility notices must be sent by CMS within 14 days of the employee or dependent's termination of coverage; therefore, **it is imperative that the employee or dependent's termination of coverage is processed on the Membership System immediately.**

To be eligible for COBRA, an individual must be enrolled in the group health program on the day before the qualifying event takes place and have coverage paid up to date. Employees terminated for gross misconduct are ineligible for COBRA as are dependents whose termination notification is more than 60 days after the qualifying event.

1. **COBRA Eligible:** The following individuals **are offered COBRA** if they lose state coverage due to certain qualifying events (see Section 6.1.D, 'Termination Coding/COBRA Notification' for qualifying events eligible for COBRA coverage). These individuals are considered "qualified beneficiaries".

   - Employees
   - Annuitants
   - Survivors previously receiving an annuity
   - Spouses and dependents of employees, annuitants or survivors, if previously covered

2. **COBRA Ineligible:** The following individuals **are not offered COBRA** upon losing state coverage:

   - Members who have elected to opt out of the health coverage under the State Employees Group Insurance Program. The dependents are also not eligible for coverage.
   - Members who terminate state employment while on a leave of absence in which they had waived health coverage. The dependents are also not eligible for coverage.
   - Part-time employees who had waived health coverage prior to terminating state employment. The dependents are also not eligible for coverage.
   - Members whose coverage was terminated for non-payment of premium. The dependents are also not eligible for coverage.
   - Dependents terminated due to untimely notification.
   - Employees who were terminated due to gross misconduct (as determined by agency personnel).

   Gross Misconduct – Under federal regulations, continuation of health insurance through COBRA may be denied by the employer if the employee has been discharged due to gross misconduct. COBRA regulations do not specifically define gross misconduct. It is the employing agency's responsibility to determine if the employee is being discharged for gross misconduct.

   Dependents of these members are eligible for continued coverage under COBRA.

C. Enrollment

Within 14 days of receiving notification that coverage was terminated, CMS will send a letter regarding COBRA rights. Premium rate information based on the plan(s) in effect at the time of termination and an enrollment form will be included with the letter.

At no time is COBRA coverage provided to a qualified beneficiary or a newly-acquired dependent **unless the premium for the first period of COBRA coverage is paid**.

Example 1: A semi-monthly employee terminates employment July 18th. The COBRA premium amount due for August 1st - 31st must be paid in order for the employee to obtain coverage for the period of July 18th – August 31st.

Example 2: In order to add a newborn (i.e., newly-acquired dependent) with an effective date of July 27th, the COBRA premium for August 1st - 31st must be paid in order for coverage to be retroactive to the date of birth.

1. **Enrollment Period:** Qualified beneficiaries have 60 days from the date of the COBRA notification letter to elect COBRA coverage. Those who fail to complete and return the enrollment form within 60 days will forfeit all COBRA rights. Qualified beneficiaries who return the enrollment form within the 60-day time frame have an additional 45 days (for a total of 105 days from the date of notification) to pay all premiums which have accrued from the date of the qualifying event through the current month. Enrollments will not be processed until the election form and required payments are received by the Premium Collection Unit. Once payment is received, coverage will be retroactive to the date of the qualifying event. Qualified beneficiaries who fail to submit payment within the 105-day time frame forfeit all COBRA rights.

2. **Electing Coverage:** Members may elect member-only coverage and/or dependent coverage at the time of the qualifying event. Dependents may elect COBRA in their own right even if the member decides not to enroll.

   Dependents electing coverage in their own right are enrolled under their Social Security number and pay premiums at the member rate. A divorced or widowed spouse who has dependent coverage would be considered the member and charged the member rate. Any children of the divorced or widowed spouse would be covered as dependents and charged applicable dependent rates.

   If COBRA is elected only for dependent children, each child would be considered a member and charged the member rate.

3. **Coverage Options:** With the exception of initially enrolling in COBRA or experiencing a qualifying change in status, qualified beneficiaries may only change benefit coverage during the annual Benefit Choice Period. Benefit Choice elections are effective July 1st. Changes due to a qualifying change in status are effective the date of the event or the request, whichever is later.

   Health: Qualified beneficiaries may change health carriers at the time of initial enrollment, during the annual Benefit Choice Period or on the date of request following a qualifying change in status if requested within 60 days of the event. The pre-existing condition exclusion period does not apply to individuals electing COBRA unless the pre-existing period has not previously been met.

   Dental: Qualified beneficiaries may elect to participate in the dental plan upon initial enrollment in COBRA. However, qualified beneficiaries who are not participating in the dental plan when they lose eligibility under the State Employees Group Insurance Program may not elect to participate in the dental plan until the next annual Benefit Choice Period.

   Life: Life coverage is not provided under COBRA; however, qualified beneficiaries may have the option to port or convert Basic and/or member Optional Life coverage. Qualified beneficiaries may also convert Spouse and/or Child Life. See the ‘State of Illinois Group Life Insurance Program’ booklet and Appendix F for details.

Adding Dependent Coverage: Members may only enroll a dependent in COBRA if the dependent was enrolled in the State Employees Group Insurance Program at the time the member lost eligibility, with the following exceptions:

- Existing dependents may be enrolled during initial enrollment if the dependent loses other coverage at the same time the member loses eligibility for the Program (e.g., spouse also terminates employment and loses coverage at the same time as the member). Proof of the loss of coverage must be provided.

- Newly-acquired dependents may be enrolled during the plan year if the coverage is elected within 60 days of the member acquiring the dependent. Newly acquired dependents include new spouse, newborn child, adopted child, stepchild or child for whom the member obtains legal guardianship. Refer to the appropriate qualifying change reason in Section 4 for effective dates.

4. **Waiver of COBRA/Revocation of Waiver:** A qualified beneficiary may waive rights to COBRA coverage during the 60-day election period. The qualified beneficiary has the right to revoke the waiver before the end of the 60-day enrollment period.

   If a qualified beneficiary revokes a waiver of coverage before the end of the 60-day enrollment period, the coverage is still retroactive to the qualifying event and all retroactive premiums are due.

D. COBRA Premium

The state does **not** contribute to any portion of the premium for COBRA coverage. When state coverage terminates mid-pay period, a qualified beneficiary must purchase COBRA coverage for the next period in order to continue coverage.

Example 1: An individual on a semi-monthly pay schedule whose coverage terminates 08/12 must pay the COBRA premium for 08/16-08/31 to enroll in COBRA.

Example 2: An individual on a semi-monthly pay schedule whose coverage terminates 08/25 must pay the COBRA premium for 09/01-09/30 to enroll in COBRA.

Example 3: An individual on a monthly pay schedule whose coverage terminates 08/12 must pay the COBRA premium for 09/01-09/30 to enroll in COBRA.

1. **Billing:** Once enrolled in COBRA, the Premium Collection Unit will mail monthly billing statements to the address indicated on the Membership System on or about the 5th of each month. Bills for the current month are due by the 25th of the same month. Members who fail to pay the premium in full will be sent a Final Notice with payment due by the 20th of that month.

   Failure to pay the COBRA premium by the due date will result in termination of coverage retroactive to the last date of the month in which full premiums were paid. Members terminated from COBRA for non-payment of premium are ineligible for health conversion privileges.

It is the member's responsibility to notify the Premium Collection Unit of any address change and/or billing problems.

Payment should be mailed to the Premium Collection Unit at the following address:
Central Management Services (CMS) Premium Collection Unit P.O. Box 10264 Springfield, IL 62791-0264

2. **Refund Policy:** COBRA refunds are entered on the Group Insurance Financial Control System (GIFCS) by the Analysis and Resolution Unit upon the request of the Premium Collection Unit. Refunds are processed and mailed directly to the COBRA member. No taxes are withheld from COBRA refunds.

   Refunds of COBRA premiums will be considered under the following circumstances:

   - Employee's discharge has been reversed
   - Member becomes eligible for coverage through one of the five state retirement systems

   Refunds of COBRA premiums will not be given if the member's coverage was retroactively terminated due to ineligibility (e.g., obtained Medicare, obtained other insurance with no pre-existing clause).

E. Termination of COBRA Coverage

COBRA coverage ends when the **earliest** of the following occurs:

- On the last day of the month that the maximum continuation period ends (see Section 6.2.F, 'Conversion Privilege for Health Coverage').

- On the last day of the month for which appropriate premiums were paid.

- On the last day of the month the dependent child becomes age 19 and does not qualify for the student, handicapped or other category. *

- On the last day of the month the dependent student graduates, drops below full-time student status or attains age 23 (or attains age 25 for military student). *

- The day preceding the date of a dependent's: *
  - Entrance into military service
  - Marriage
  - Divorce from the member

- The date a covered member or dependent becomes a participant in another group health plan which does not impose a pre-existing conditions exclusion or limitation (e.g., through employment or marriage).

- On the last day of the month a covered member or dependent becomes entitled to, or reaches the qualifying age for, Medicare. Special rules apply for End-Stage Renal Disease (ESRD) (contact the Premium Collection Unit for more information on ESRD).

- On the date when a covered member notifies the Premium Collection Unit (PCU), **in writing,** of their desire to voluntarily terminate their COBRA coverage.

* Dependents losing eligibility may be eligible to continue COBRA as a member for the remainder of the eligibility period (contact PCU for more information regarding eligibility).

F. Conversion Privilege for Health Coverage

COBRA members have the right to convert health coverage (only) to an individual health plan if they meet ALL of the following requirements:

- have been covered by the **same health carrier** for at least 3 months, and

- have exhausted coverage under COBRA, and

- request conversion within 31 days of exhausting COBRA coverage, and

- are not enrolled in Medicare or other group health coverage.

Approximately two months before COBRA coverage is scheduled to end, the Premium Collection Unit will send a letter to the member with instructions on how to apply for conversion of health benefits.

If issued, the converted health coverage becomes effective the day after the COBRA coverage ends. The State Employees Group Insurance Program is not involved in the administration or premium rate structure of coverage obtained through conversion. The member should call their health plan's Conversion Specialist for information regarding the conversion of a State of Illinois policy. No provisions exist for converting dental coverage.

G. Additional COBRA Provisions

1. **Address Correction:** COBRA notification letters will be mailed to the address indicated on the Membership System at the time the termination is processed. Qualified beneficiaries eligible for COBRA benefits who are moving to a new address must have an updated address on the Membership System prior to, or at the time the termination is processed. If a dependent has a different address than the member, that address must be entered on the Membership System on the "Dependent Address" screen prior to, or at the time of, the termination being processed.

2. **Dependent Recertification of COBRA Members:** COBRA dependents are subject to the same dependent recertification process as dependents of active state members (see Section 2.1, 'Dependent Recertification' for details).

3. **Illinois Spousal Law:** Under this law, a divorced spouse who is age 55 – 62 on the date of the divorce is eligible to continue COBRA coverage until they become Medicare entitled or reach the qualifying age for Medicare.

4. **Medicare Impact on COBRA:** If a member and/or a dependent's Medicare entitlement occurs **before** a COBRA qualifying event, affected qualified beneficiaries are allowed to elect COBRA for the maximum continuation period. Medicare will be primary payer in this situation; however, the member will continue to pay the full premium.

   If Medicare entitlement occurs **on or after** a COBRA qualifying event, affected qualified beneficiaries are no longer eligible for COBRA coverage.

7.0 General Information

The Group Insurance Financial Control System (GIFCS) is an online payroll adjustment system which allows the user to view Membership liability and pay record history files side-by-side for a fast and easy analysis of a member's account. This system provides the agency with the capability of correcting pay record codes on previously submitted payroll records and/or direct payment records, adding pay records, transferring member paid premiums, and requesting premium refunds.

The following GIFCS policies were designed to maintain the financial integrity of the Group Insurance Program and fulfill contractual obligations with our vendors.

7.1 Updating of GIFCS

A. Monthly Reconciliation

Liability for GIFCS is calculated during the monthly reconciliation process. The monthly reconciliation is performed the first week of each month and identifies Candidate for Termination (CFT) and Priority members. Monthly discrepancy reports are generated and distributed to the agencies to be reviewed and resolved.

All payroll records are received and processed on a weekly basis. Membership liability is calculated as pay records are loaded to GIFCS. If a pay record is not received, the Membership liability will be calculated at the time of the monthly reconciliation. All agency pay records for a particular month are not received by CMS until the end of the following month. Therefore, all agency payroll records for the month of July are received by CMS by the end of August and are processed during the September monthly reconciliation.

B. Tolerance Level

The Group Insurance Financial Control System has a tolerance level of $3.50. This amount has been arbitrarily chosen by the Group Insurance Division to limit the number of discrepancies needing to be resolved. Members who are overpaid or underpaid by an amount less than $3.50, are not considered discrepant and will not appear on an agencies discrepant member listing (screen one of GIFCS).

C. Membership Liability Upload to GIFCS

Transactions processed on the Membership System are not reflected immediately on GIFCS. The Membership liability displayed on GIFCS is updated through a batch process at the end of each business day. Therefore, changes processed on the Membership System are reflected on GIFCS the following day.

If a Membership change is not reflected on GIFCS the following day, the GIR/P should contact ARU.

7.2 Candidates for Termination and Priority Members

CFT and Priority cases are the most critical discrepancies and should be researched and resolved by the agency upon receipt of the monthly reports.

A. Candidates for Termination (CFT)

Candidate for Termination (CFT) Members: A member becomes a CFT if they meet any of the following criteria:

- Member premium is underpaid for two or more months of *current* Membership liability **and** is at least $15.00 underpaid. 'Current' Membership liability is the amount the member owes for premiums based on the member's coverage as of **today**, or
- No pay record appears on GIFCS for two or more months, or
- Membership coding does not agree with pay record coding for two or more months **and** is at least $15.00 underpaid (e.g., health carrier code on pay record does not agree with health carrier code on Membership System).

The 'Candidate for Termination Report', which identifies CFT members, is generated for agencies the first week of each month. At this time, the online GIFCS Discrepant Account List (screen 1) is updated indicating the number of months a member has been reported to the agency as CFT. (See section 13, 'GIFCS Procedures' for a description of screen 1).

Upon receipt, the GIR/P should review the CFT report and identify the specific errors and determine a plan of action to resolve the discrepancies. The GIR/P must send a completed Discrepancy Response Form (CMS-321) to the Analysis and Resolution Unit (ARU) indicating the plan of action and request a delay of termination. (See Appendix C, 'Agency Completed Forms' for a sample of the CMS-321 form.)

If the Response form is not submitted by the end of the month in which it was reported, the GIR/P will receive a 'Members Receiving Warning Letters' (MRWL) report. In addition, the member will receive a letter advising them that there is a problem and to contact the GIR/P immediately. Members listed on the MRWL report will have coverage terminated if the GIR/P does not send a delay of termination request to ARU by the cut-off date indicated on the memorandum that accompanies the MRWL report. The cut-off date is generally the last week of the month.

ARU will accept agency Discrepancy Response forms (CMS-321) through the close of business of the cut-off date.

If a Discrepancy Response form (CMS-321) requesting a delay of termination is not completed properly and does not indicate a resolution for the discrepancy, the form will be returned ***and the delay will not be initiated***.

If the GIR/P does not resolve the member's reported discrepancies and submit the CMS-321 requesting delay of termination by the delay termination cut-off date, the member may experience denial of services and/or claim payment. Ultimately, failure to resolve the discrepancies will result in termination of the member's coverage.

B. Priority Members

Priority Members: A Priority member is a member whose insurance account is overpaid by at least $3.50 (system tolerance level) and meets either of the following criteria:

- The member-paid premium is overpaid by two or more months of *current* Membership liability, or
- Membership liability does not exist, however, pay records are received for two or more months.

Priority members are determined at the time of the monthly reconciliation. The first week of each month the online GIFCS Discrepant Account List (screen 1) is updated indicating Priority members and the number of months the member has been reported. (See section 13 for a description of screen 1).

Priority discrepancies (i.e., overpayments) must be resolved in a timely manner since they are subject to the Retroactive Policy. (The Retroactive Policy can be found on page 15 of the Member Handbook.) The GIR/P must request ARU to purge overpayments which occurred prior to the most recent 6 month period via a Discrepancy Response form (CMS-321).

7.3 Overpayments

When an overpayment is indicated on GIFCS, the first step the GIR/P must take when reconciling an overpayment is to determine whether a true overpayment exists or whether the solution to the overpayment is correcting the Membership file. The GIR/P must then determine whether the overpayment occurred on payroll or direct pay, as well as the time period for which the overpayment occurred, and refund accordingly.

A. Retroactive Policy

The Retroactive Policy states that premium overpayments may be refunded retroactively for the current month and the previous 6 months. Premium overpayments prior to the 6 month period will not be refunded and the GIR/P must request a purge. (See 'Purging Overpayments' in this section for details).

The GIR/P should begin counting the current plus six month refund period with the month the Analysis and Resolution Unit (ARU) received the Discrepancy Response Form (CMS-321) requesting the refund.

The GIR/P must send a Discrepancy Response form (CMS-321) to the ARU requesting the overpayment be purged. **The amount to be purged and the dates the overpayments occurred must be indicated on the form.**

Example:

- Premiums are overpaid from October through May.
- Discrepancy Response form (CMS-321) received by ARU on May 16.
- Payroll may refund premiums for November 1st through May 31st on the May 31st payroll (which includes November, December, January, February, March, April, May).
- ARU will purge the October overpayment.

Note: The Retroactive Policy only applies to premium overpayments. All underpayments must be collected in their entirety.

The chart below indicates which months may be refunded (right column) based upon when the Discrepancy Response Form (CMS-321) was **received** by ARU (left column).

Notification / ARU Receipt Date	Six Month Policy Time Period
January 1 – January 31	July 1 – January 31
February 1 – February 29	August 1 – February 29
March 1 – March 31	September 1 – March 31
April 1 – April 30	October 1 – April 30
May 1 – May 31	November 1 – May 31
June 1 – June 30	December 1 – June 30
July 1 – July 31	January 1 – July 31
August 1 – August 31	February 1 – August 31
September 1 – September 30	March 1 – September 30
October 1 – October 31	April 1 – October 31
November 1 – November 30	May 1 – November 30
December 1 – December 31	June 1 – December 31

B. Refunding Premiums

Before refunding, the GIR/P must determine whether the overpaid premiums were payroll deducted or paid via direct pay. Payroll overpayments occurring within 6 months of the current month, must be refunded via agency payroll, or requested through the ARU.

- **Overpayment Occurred Through Payroll Deduction:**
  - Overpaid premium for members currently active on payroll must be refunded via the agency payroll system.
  - Overpaid premium for members **not** currently active on payroll must be refunded via the agency payroll system by using the Refund Request screen (screen 8) on GIFCS. Users may only enter refunds for overpayment which occurred during the previous 6 month period.
  - Overpayments of less than $5.00 may not be refunded via GIFCS. These overpayments must be purged by ARU. The GIR/P must submit a Discrepancy Response Form (CMS-321) requesting ARU to purge the overpayment.

- **Overpayment Occurred Through Direct Payment:** Overpaid premiums that are direct paid **cannot** be refunded through payroll. The GIR/P must request the premium refund via screen 8 or a CMS-329. (See Appendix C, 'Agency Completed Forms' for a sample of the CMS-329 form.)

C. Purging Overpayments

Payroll overpayments beyond the six month Retroactive Policy must be purged. Most premium collected through payroll are tax exempt. Premiums collected through direct pay are not subject to tax. The following guidelines should be used to determine whether or not a purge should be requested.

- **Payroll amounts $3.50 or less:** No action is required for overpayments of $3.50 (system tolerance level) or less. However, the GIR/P may refund overpayments of $3.50 or less on payroll, if they so choose (Retroactive Policy applies). The GIR/P also has the option of submitting a Discrepancy Response Form (CMS-321) with a note in the "remarks" section requesting ARU purge the overpaid amount.

- **Payroll amounts greater than $3.50 occurring within the previous 6 month period:** Overpayments greater than $3.50 (system tolerance level) should be refunded to the member via payroll (Retroactive Policy applies).

  The GIR/P must request a purge of overpayments which cannot be refunded via payroll that are under the $5.00 minimum requirement for GID refund processing.

- **Payroll amounts greater than $3.50 occurring prior to the previous 6 month period:** Overpayments greater than $3.50 (system tolerance level) which occurred prior to the previous 6 month period must be purged (see 'Retroactive Policy'). The GIR/P must submit a Discrepancy Response Form (CMS-321) with a note in the "remarks" section requesting that ARU purge the overpaid amount.

- **Overpayments of less than $5.00 for terminated members:** The GID will not process a refund for less than $5.00. These overpayments for terminated members must be purged. The GIR/P must submit a Discrepancy Response Form (CMS-321) with a note in the "remarks" section requesting ARU purge the overpaid amount.

7.4 Underpayments

Underpayments of member premiums must be collected **regardless of the amount**.

A. Collecting Underpayments on Payroll

Payroll underpayments of **members currently active on payroll** (i.e., due to a missed payment on payroll, a change in coverage affecting premium liability, etc.) must be collected via agency payroll deduction. GIR/P's are responsible for collecting underpayments from a previous agency where the member has transferred to their agency. All underpaid premiums, including amounts from past fiscal years, must be collected within two months (four semi-monthly payrolls or two monthly payrolls). In situations of extreme hardship or large underpayments, the GIR/P may contact ARU to request approval to extend the payment period.

B. Billing Member for Payroll Underpayments

Members with payroll underpayments greater than $3.50 who are **no longer receiving a paycheck** (i.e., terminated employment, leave of absence), must be billed by the agency. All underpaid premiums, including amounts from past fiscal years, must be collected.

When billing the member, the agency must include the following information in the billing letter (see Appendix I, 'Sample Letters' for a sample of the billing letter):

- amount of underpayment
- pay periods of underpayment
- due date of payment (agency should give member at least two weeks to respond).
- address where payment should be sent
- check or money order should be made payable to the agency (not CMS)
- consequences of not paying the billed amount

Based on whether or not the member paid the bill, the agency must either request a retroactive termination or submit the payment to the Analysis and Resolution Unit (ARU). See below for instructions on both options:

- **Member Billed - Payment Received:** Submit the payment to the agency payroll office. The payroll office will either:
  - deposit the check into the agency's clearing account with the Treasurer's Office and request a non-negotiable draft for the member's payment amount, or
  - request an agency voucher for the payment amount.
  - The non-negotiable draft, or agency voucher, and completed 'Non-payroll Member and Direct Payment Report' (CMS-328) must be sent to CMS Group Insurance Division, 201 E. Madison, Suite 2B, P.O. Box 19208, Springfield, IL 62794-9208. Once received, the payment will be uploaded to GIFCS and credited to the member's account.
- **Member Billed - Payment Not Received**: Forward a copy of the billing letter to ARU along with a Discrepancy Response form (CMS-321) requesting termination of coverage. Once the letter and Discrepancy Response form (CMS-321) are received, ARU will terminate the member's coverage retroactive to the last day of the pay period for which premiums were paid. The terminated member is not eligible for COBRA.

C. Purging Underpayments

- **Inactive Members:** No action is required to collect underpayments of $3.50 or less (tolerance level) from inactive members.
- **Active Members:** Underpayments of members active on payroll cannot be purged, regardless of the amount, or when the underpayment occurred. The GIR/P must collect these underpayments on the next payroll.

Underpayments which **occurred** while a member was in a nonpay status (i.e., a leave of absence, suspension/dock, etc.,) will be billed by the Premium Collection Unit (PCU).

7.5 Termination of Member Coverage

Member coverage may be terminated for various reasons, including termination of employment, nonpayment of premium, no longer eligible, etc. Below is an explanation of ARU terminations and a description of the codes used when terminating member coverage.

A. Termination by the Analysis and Resolution Unit (ARU)

ARU will process a termination of member coverage when:

- A member has been a Candidate for Termination (CFT) for greater than two months.

  Agencies receive a report of members appearing as a CFT for the first time advising them that a discrepancy exists and must be corrected. A member who remains CFT for a second month will receive a warning letter advising them that coverage could be terminated if the discrepancy is not corrected. A report is also sent to the agency GIR/P. If the agency does not submit a delay termination by the end of the second month, the member's coverage will be terminated.

- A member is billed for a payroll underpayment and does not pay.

  Upon receipt of a Discrepancy Response form (CMS-321) and a copy of the billing letter from the GIR/P, ARU will terminate the coverage. The termination will be effective midnight the last day of the pay period in which premiums were paid.

B. Termination Codes

Active members whose insurance coverage has been terminated due to nonpayment of premium will be coded either a 6015, 6035, or an 8010. The section below describes the difference between the codes.

- **6015**: The 6015 code is used to terminate the coverage of employees who were responsible for only the employee portion (state-paid eligible) of premium. The 6015 code indicates the employee's health, dental, vision, optional life and dependent coverage has been terminated by PCU. Note, however, that state-paid Basic Life coverage remains in effect until the member terminates State employment, or has been coded 6015 (or a combined total of 6015 and either a non-occupational disability without benefits (6002) or an educational/sabbatical (6006) leave) for 24 months, or returns to active status.

- **6035**: The 6035 code is used to terminate the coverage of part-time members who were responsible for a percentage of their health and dental premium. The 6035 code indicates the employee's health, dental, vision, optional life and dependent coverage has been terminated by PCU. ***Note:*** State-paid Basic Life coverage remains in effect until the member terminates State employment, or has been coded 6035 (or a combined total of 6035 and either a non-occupational disability without benefits (6002/6027) or an educational/sabbatical (6006/6028) leave) for 24 months, or returns to active status.

- **8010**: The 8010 code is used to terminate the coverage of employees who were on a leave of absence in which they were responsible for 100% of the state and employee portion of premiums (state-paid ineligible). Members coded 8010 have had coverage terminated by either ARU or PCU due to (a) not paying the payroll underpayment when billed by the agency, (b) incorrect payroll deductions, or (c) not paying the premium due while on a leave of absence in which the member was responsible for paying both the member and state portion of the premiums (i.e., members on a personal leave or members in a dock/suspension status > 30 days).

7.6 Reinstatement of Coverage

Members whose coverage has been terminated for nonpayment of premium by the Analysis and Resolution Unit may have coverage reinstated, all or in part, based on the request date.

Reinstatement Requested ≤ 30 Days: GIR/P's requesting reinstatement of the member's coverage within 30 days of the Membership System's termination process date will be permitted to reinstate the same coverage in force prior to the termination, with no break in coverage.

Reinstatement Requested > 30 Days: GIR/P's requesting reinstatement of the member's coverage greater than 30 days after the Membership System's termination process date may have health, dental, vision, basic and optional life coverage reinstated retroactively 6 months, if there was no break in coverage. However, if there was a break in coverage (due to the termination effective date occurring more than 6 months ago), the member's optional life coverage cannot be reinstated. Members whose optional life coverage cannot be reinstated must wait until either the next Benefit Choice Period or Qualifying Change in Status to request optional life coverage. (***Note:*** Statement of Health approval is required when requesting optional life coverage.)

Example: Member has coverage terminated effective 01/16/01. Termination was processed on 10/2/01. GIR/P requests reinstatement of the member's coverage on 11/15/01. Coverage is reinstated retroactive to 5/01/01. The member has a break in coverage from 1/16/01 – 4/30/01 and cannot have optional life reinstated.

7.7 Member Transfers to New Agency

When a member transfers to a new agency, the new agency 'inherits' any discrepancies of the transferring member. The new agency must correct all discrepancies, collect any underpayments and/or refund any overpayments.

Retirement System Exception: Discrepancies of members whose coverage is being transferred to a retirement system remain the responsibility of the last employing agency. The agency is responsible for correcting all discrepancies, including billing the member for underpayments incurred at an earlier time.

7.8 Discharge Reversal Policy

Group insurance coverage for discharged employees who have been awarded reinstatement through the grievance process is determined by an Arbitrator's Award. A grievance resolution may deem that the member *be "made whole" and receive back wages, be placed on a suspension, not be "made whole*", or may grant the member specific resolution provisions.

If the arbitrator's award indicates that the member be "made whole" or "receive back wages" the member's insurance records must be corrected to indicate that they never left payroll. Consequently, these members **must pay group insurance premiums for the entire period for which they were reinstated**. The employee does not have the option to waive retroactive coverage reinstated through an Arbitrator's Award. Additionally, the member must maintain this level of coverage until the next Benefit Choice Period or a qualifying change in status occurs.

Members who are *"made whole" or who receive back wages,* must have health, dental, vision, and life (basic and optional) coverage, as well as dependent coverage, reinstated retroactive **with no lapse in coverage**. The coverage must be the same as what was elected prior to the discharge. However, since HMO contracts prohibit retroactive reinstatement beyond the previous 6 months, the member will be placed in the Quality Care Health Plan if the reinstatement time period goes beyond the previous 6 months, and/or time periods for which the employee's carrier is no longer offered. The GIR/P must deduct the premiums due, which may either be a lump sum deduction from the member's back wages, a payroll deduction taken over a maximum of two months, or the member direct pays the agency and the payment is received via an Agency Direct Payment report (CMS-328).

If an Arbitrator's Award *does not make an employee "whole" or states that the employee does not receive back pay*, no state-paid benefits are available. These employees must be placed on a personal leave of absence (type enrollee code 6009/6030) until they physically return to work. If the Arbitrator's Award states that the employee must be placed on a suspension, the member is eligible for 30 days per contract year of state-paid insurance (type enrollee code 6011/6032). After the thirty days, the member must be placed on a dock status > 30 days (type enrollee code 6012/6033).

Members whose discharge is reversed will receive Quality Care Health and Dental for the period for which the member was terminated, if beyond the previous six months.

The GIR/P must forward a copy of the grievance resolution documentation to the Analysis and Resolution Unit (ARU) for review, along with a Membership Correction form (CMS-340) indicating the changes required due to the award agreement. The GIR/P must include the member's salary at the time of discharge, as well as any salary increases. ARU will process all necessary transactions related to the discharge reversal.

The Retroactive Policy does not apply to discharge reversals with respect to the collection or refunding of premium.

Example: Employment terminated 3/01/01 – member had managed care health/dental provider prior to termination. Member receives an Arbitrator's Award making them whole. Member returns to work on 12/16/01. Member will be reinstated with Quality Care Health and Dental from 03/01/01 – 12/16/01.

7.9 Fiscal Year Transfers

A fiscal year transfer is processed to balance a member's premium payment for each fiscal year. The GIR/P must process a transfer when an overpayment occurs in one fiscal year and is refunded in the next fiscal year. Likewise, when an underpayment occurs in one fiscal year and is collected during the next fiscal year, a fiscal year transfer must be processed.

GIR/P's with online access should process the fiscal year transfer via screen 6 (see section 13, 'Transfer'). GIR/P's without online access should submit a Discrepancy Response form (CMS-321) to the Analysis and Resolution Unit requesting a fiscal year transfer be processed identifying the pay periods, carriers, and amounts involved in the transfer.

Example:

- Underpayment occurred on the 6/30/01 pay period. The GIR/P collected the premium on the 8/15/01 pay period. The GIR/P must transfer the overpaid premium from the 8/15/01 pay period to the underpaid 6/30/01 pay period.

- Overpayment occurred on the 6/30/01 pay period. The GIR/P processed the refund on the 8/15/01 pay period. The GIR/P must transfer the overpaid premium from the 6/30/01 pay period to the 8/15/01 pay period.

7.10 Member Employed By Two Agencies/Universities

Occasionally a member is employed by two state entities. The member may be working full-time at both an agency and/or university, part-time at both an agency and/or university, or part-time at one agency or university and full-time at the another agency or university.

A. "Reporting" Agency

For members employed by more than one agency and/or university, the "reporting" agency will be the agency for which the member is employed the greater part-time percentage. If the member is working full-time at both agencies, the agency for whom the member was first employed will be the "reporting" agency. The "reporting" agency is responsible for collecting insurance premiums. The "non-reporting" agency must code the member 'C' on payroll, indicating that the member is receiving a payroll check, but is not having premiums deducted.

B. Calculating Work Percentage

The work percentage the member must be coded is the percentage the member is scheduled/contracted to work at each agency/university added together. The GIR/P must use this percentage when coding the member's work percentage on the Membership System. If the combined percentage equals 100% or greater, the member is considered a full-time employee and must be coded 100%.

C. Calculating Basic Life Units

The basic life units from each agency/university must be added together. This total must be coded on the Membership and Payroll systems by the "reporting" agency.

7.11 GIFCS Forms / Report Requests

A. Nonpayroll Member and Direct Payment Report Form (CMS-328)

GIR/P's receiving payment from members billed by the agency for underpaid premiums, must complete a 'Nonpayroll Member and Direct Payment Report' form (CMS-328). The CMS-328 requires the GIR/P to complete all member and payment information on the form.

The GIR/P must complete the date, agency/facility, preparer's name and phone number section at the top of the form. The GIR/P must also complete every box on the payment detail portion of the form, even if no payment was received for a specific carrier. Each fiscal year payment must be indicated on a separate line of the form; however, only one payroll record will be loaded to GIFCS for each entry on the form.

Example: Payment is received for May 1st through August 31st. The payment for May 1st through June 30th must be indicated on one line of the form, and the payment received for July 1st through August 31st must be indicated on another line (separate fiscal years). Two payments will appear on GIFCS - one for the pay period end date of 6/30, and the other for the pay period end date of 8/31.

Once completed, the form and payment must be sent to ARU for processing. Once processed, the member payment will be loaded for the appropriate pay period on GIFCS.

B. GIFCS Sorting Sequence Request

Agencies may request a special GIFCS report from the Analysis and Resolution Unit. These reports list all discrepant members for a specific organizational processing code (org proc code). The 'Agency Report of Discrepant Members' report may be sorted using one of three different report formats. The format descriptions are listed below:

- Highest CFT values, followed by highest Priority values – both in dollar order
- Highest dollar value
- Last name, then highest dollar value

Agencies may customize the report by selecting a specific facility, setting a different tolerance level, and/or requesting multiple copies.

The report displays member name, Social Security Number, CFT/Priority count, health/dental/life carrier balances, and total balance of all carriers.

Agencies must submit a 'Special GIFCS Reports – Sorting Sequence Request' form (CMS-325) to the Analysis and Resolution Unit for generation of the report. (See Appendix C, 'Agency Completed Forms' for a sample of this form.)

C. Discrepancy Response Form (CMS-321)

The purpose of the Discrepancy Response Form (CMS-321) is as follows:

- to advise the Analysis and Resolution Unit of action taken/needed to resolve a member's discrepancy(s), or
- to request a delay of termination for a member who has appeared on the Candidate for Termination (CFT) report or Members Receiving Warning/Termination Letter listing, or
- to request reinstatement of coverage for a member or dependent who has been terminated for nonpayment of premium by the Analysis and Resolution Unit.

The Discrepancy Response form (CMS-321) must include documentation to support the request, or resolve the discrepancy, such as Membership forms, personnel action forms or payroll voucher reports. Corrective action must be indicated on the form in order for the termination to be delayed, or the reinstatement to be considered. It is recommended that agencies retain a copy of all documentation sent to ARU in the member's file.

D. Description of Discrepancy Response Form Fields

Field	Description
Date	Required – enter the date the Discrepancy Response form is completed.
Member Name/SSN	Required – enter the name and SSN of the person for whom the agency is responding.
Agency Name, GIR/P name, Phone #	Required – enter the name of the agency, GIR/P name and phone number responding to the discrepancy.
Org Proc Code	Required – enter the agency's organizational processing code.
Requesting	Required – check the appropriate reason for submitting the form. Indicate only ***one*** reason.
Attachments	Check the line indicating whether appropriate Membership documentation and/or Nonpayroll Direct Payment Report form is attached for documentation.
Adjustments – Payroll	Check if an adjustment has been processed to collect and/or refund member paid premium. Enter the pay period ending date for a single pay period, or the beginning and ending dates if the adjustment has been processed over several pay periods. Enter the amount of the adjustment for each type of coverage. If the adjustment is a refund, encase the dollar amount in parenthesis. ***Example:*** ($25.00)
Adjustments – Create (Add) Pay Records	Check if a pay record needs to be created for the member whom the agency is responding. Enter the beginning and ending dates of the pay period(s) for which a pay record needs to be created. Enter the eligibility code of the member for the pay period(s). If the eligibility code does not match for all pay periods added, separate lines must be used. Pay records will be created for the carrier, deduction, part-time %, and basic life units displayed on the Membership file for the pay period(s).
Adjustments – Correct Pay Record Code(s)	Check if pay record codes need to be corrected. Enter the pay period beginning and ending dates of the pay period(s) that need corrections. Enter the original (incorrect) codes(s)/SSN reported on the pay record(s). Enter the correct codes(s)/SSN that should have been reported on the pay record(s). All erroneous codes must be corrected. The corrected codes must match the member's coverage for the pay period(s). **The pay code on the pay record should never be corrected.**

Description of Discrepancy Response Form Fields (cont')

Field	Description
Adjustments – Transfer Member Paid Premium	Check if member paid premium needs to be transferred from one fiscal year to another or one carrier to another by GID. Enter the beginning and ending dates of the pay period(s) the member is/will be overpaid. Enter the amount of overpayment for each type of coverage. Enter the beginning and ending dates of the pay period(s) the member is/will be underpaid. Enter the carrier code and amount of underpayment for each type of coverage.
Remarks	Explain in detail any other information needed to resolve the discrepancy. Request the purge of overpayments in this area.

E. Cutoff Schedule Description

At the beginning of each calendar year, CMS will send all GIR/P's an 'Agency Cutoff' schedule for the Group Insurance Financial Control System (GIFCS). The GIR/P should reference the most recent cutoff schedule in order to be aware of important dates (i.e., processing of terminations, mailing of reports, etc.). A sample section of the 'Agency Cutoff' schedule is shown in the chart below. Use the sample chart to compare example dates in the description table below.

Coverage Month	Agency Direct Pay Cutoff	Delay Termination Cutoff Date for CFT's	Online Transaction Cutoff/GIFCS Monthly Run Date	Monthly Reports On MOBIUS	Analysis & Resolution Terms Proc.
Jul 02	8/27	9/3	9/4 -W	9/5	10/2

Sample Section of Cutoff Schedule (Based on 2002 schedule)

EXAMPLE: Description Table for Agency Cutoffs for Coverage		
Title	**Date**	**Description**
Coverage Month	*July '02*	This is the month for which the monthly run is calculating liability. ***Example:*** Monthly run in September calculates July liability.
Agency Direct Pay Cutoff	*8/27*	Date agency direct payments must be received by CMS in time for the monthly run. CMS-328's and university diskettes must be received by this date to be loaded during monthly run. ***Example:*** Need CMS-328 by 8/27 in order to update July payroll records.
Delay Termination Cutoff Date for CFT's	*9/3*	If a delay of termination (CMS-321) is not received by the close of business on this date, a CFT letter will be mailed to the member advising them of the possibility that coverage could be terminated if the problem is not resolved.
Online Transaction Cutoff/GIFCS Monthly Run Date	*9/4 (W)*	Membership transactions must be processed by close of business on this date in order to have liability correctly calculated during the monthly run. ***Example:*** All July and prior month Membership transactions processed on the system by close of business of 9/4 will have liability calculated during the monthly run.
Monthly Reports on MOBIUS	*9/5*	All monthly GIFCS reports are now available on MOBIUS.
Analysis and Resolution Terminations Processed	*10/2*	If a CMS-321 requesting a delay of termination is not received by ARU by the date indicated on the MRWL's memo, a termination will be processed on this date. ***Example:*** All CFT members whose agency GIR/P does not send ARU a delay of termination form by 9/25 will be terminated 10/2.

8.0 General Information

The Flexible Spending Account (FSA) Program offers two plans which are administered by the FSA Plan Administrator Fringe Benefits Management Company (FBMC). The two plans are:

- The **Medical Care Assistance Plan (MCAP)** uses tax-free dollars to pay eligible, medically necessary expenses incurred by the plan participant, spouse and dependent(s) during the plan year. Participants can request a stored-value card to use for MCAP eligible expenses to avoid paying out of pocket at the time of service (see Section 8.6 'EZ REIMBURSE® MasterCard® Card' for more information).

- The **Dependent Care Assistance Plan (DCAP)** uses tax-free dollars to pay eligible child and/or adult day care expenses during the plan year.

The FSA Program is an optional benefit that allows eligible state employees to set aside up to $5000 tax-free to MCAP and/or DCAP annually.

- MCAP: An employee's state-employed spouse may enroll for an additional $5000, for a combined maximum benefit of $10,000 per couple per calendar year. Spouses not employed by the state may have a different plan maximum; however, each state employee cannot exceed $5000 per plan year.

- DCAP: Employees may enroll in DCAP up to the maximum amount allowed under the IRS guidelines; however, the total combined maximum contribution for a married couple (whether or not the spouse is a state employee) cannot exceed the maximum contribution amount allowed under the IRS rules per calendar year (see Section 8.3.A.2 for specific contribution limits).

Plan Year: The FSA plan year is the same as the state's fiscal year, which is July 1 through June 30. Participants who wish to participate are required to re-enroll each year. An open enrollment period occurs each year during the annual Benefit Choice Period which allows the participant to coordinate their FSA deductions with the medical benefits they elect.

Deduction Amounts: When enrolling in an FSA, participants designate the amount they wish to have deducted from each paycheck. The minimum monthly contribution is $20.00; the maximum monthly contribution is $416.66. University employees paid over 9 months are allowed to contribute a monthly maximum of $555.54. No employee is allowed to exceed the annual $5000 maximum per calendar year. The designated amount is deposited into the participant's MCAP and/or DCAP account before any state, federal or Social Security taxes are withheld. At the end of the calendar year, the participant's W-2 will reflect the contributed amount subtracted from the taxable income, resulting in reduced taxes and greater disposable income.

8.1 Administration of Flexible Spending Accounts

A. Address and Phone Number Updates

The FSA database uploads address data from the Membership database; therefore, when a participant wishes to update their address, the change must be made on the Membership System. Employees can request their address be updated by submitting a written request or email to their GIR/P or by contacting the FSA or Membership Unit directly. Once the change has been made on the Membership System it will be immediately reflected on the FSA System. Employee phone numbers that are updated on the FSA System will automatically be updated on the Membership System.

B. FSA Forms

Employees can access all FSA booklets and forms on the Benefits Website at www.benefitschoice.il.gov. Please note, only one FSA form (Enrollment Form or Change in Status Form) should be submitted for each type of transaction. For example, to enroll an employee in MCAP due to a Change in Status, only an MCAP Enrollment form should be completed and submitted to the FSA Unit for processing. The five different FSA forms are listed below:

- ***MCAP Enrollment form (CMS-332):*** This form should be used by employees who enroll in MCAP at initial hire, during the annual Benefit Choice Period or upon experiencing a qualifying change in status (i.e., mid-year enrollment). The qualifying changes in status that allow a mid-year enrollment are listed on the form.

- ***DCAP Enrollment form (CMS-333):*** This form should be used by employees who enroll in DCAP at initial hire, during the annual Benefit Choice Period or upon experiencing a qualifying change in status (i.e., mid-year enrollment). The qualifying changes in status that allow a mid-year enrollment are listed on the form.

- ***MCAP Change in Status form (CMS-330M):*** This form should be used to increase or decrease MCAP deductions or to revoke enrollment in the plan due to experiencing a qualifying change in status (i.e., mid-year change). The qualifying changes in status that allow a mid-year change are listed on the form.

- ***DCAP Change in Status form (CMS-330D):*** This form should be used to increase or decrease DCAP deductions or to revoke enrollment in the plan due to experiencing a qualifying change in status (i.e., mid-year change). The qualifying changes in status that allow a mid-year change are listed on the form.

- ***MCAP COBRA Election form (CMS-334):*** This form should be used to continue MCAP contributions when a participant terminates state service, retires or is off payroll due to being on an unpaid leave of absence. Participants electing to pay deductions on an after-tax basis must make monthly COBRA payments via a personal check or money order payable to CMS. Payment should be sent to the FSA Unit.

C. FSA Transaction Processing

Agencies with online access to the FSA System have 'Inquiry' only access; however, some agencies may be given access to enter Benefit Choice enrollments each year during the months of May and June. Once an enrollment form has been received by the agency, the form must be signed by the GIR/P. If the agency does not have access to enter the enrollment, they must send the form to the FSA Unit for processing. The GIR/P should keep a copy in the participant's file and send a copy to their agency's payroll office in order to have payroll deductions initiated. See Section 11.6, 'FSA System,' for Inquiry screen information.

Once enrolled, participants will receive a Welcome Packet from the FSA Plan Administrator. The packet will include an MCAP and/or DCAP information sheet, a direct deposit application and a claim form. Also upon enrollment CMS will send the participant a Key Points sheet which explains the program in which they enrolled (MCAP or DCAP) and a verification form.

D. Documentation Requirements

In most cases, documentation is not required to enroll, revoke or change an election. However, due to IRS regulations, changes in status must be consistent with the change requested. Therefore, in certain circumstances for which an employee has a change in status and consequently requests to enroll, revoke or change an election, the FSA Unit may, at their discretion, request documentation to verify the request is consistent with the qualifying event. The changes in status that are reviewed on a case-by-case basis are indicated with an asterisk on the Enrollment and Change in Status forms.

E. FSA Account Statements

Participants will receive a monthly statement from the plan administrator around the middle of each month. It is the participant's responsibility to carefully review the statement and retain it for their records. The participant should contact FBMC at 1-800-342-8017 if they have questions regarding their account. A copy of the statement is also available on FBMC's website in pdf format.

Items indicated in BLUE on the statement are EZ REIMBURSE® card transactions that must be substantiated. Substantiating a transaction means the participant must send follow-up documentation (e.g., an Explanation of Benefits or an itemized bill) to the plan administrator to verify the eligibility of the type of service and the amount that was reimbursed. **An EZ REIMBURSE® Card Transmittal Cover Sheet must be included with the documentation – employee's should not complete a claim form with the substantiation documentation**.

Items indicated on the monthly statement in BLUE for more than two consecutive months will cause the participant's card to be suspended. Items that are never substantiated will cause the card to be PERMANENTLY SUSPENDED, which includes all future plan years. For more information regarding the EZ REIMBURSE® card, refer to Section 8.6, 'EZ REIMBURSE® MasterCard® Card.'

F. Contact Information

The plan administrator of the Flexible Spending Accounts (FSA) Program is Fringe Benefits Management Company (FBMC). FBMC can assist participants with information regarding claims submission, eligibility and reimbursement. FBMC's Customer Service Unit can be reached at (800) 342-8017.

The Flexible Spending Unit at CMS can provide participants with information regarding enrollment, payroll deposits and qualifying changes in status. The FSA Unit can be reached at (217) 558-4509.

8.2 Eligibility and Enrollment

A. Participant Eligibility

In order to be eligible to participate in MCAP or DCAP, State of Illinois employees must:

- work full-time or part-time not less than 50%;
- be eligible to participate in one of the state's health plans (note: employees who have waived or opted out of the health coverage are still eligible to participate in the FSA program);
- make a minimum monthly contribution of $20 (maximum monthly contribution is $416.66; however, for university employees paid over 9 months, the maximum monthly contribution is $555.54, not to exceed $5000 for the plan year).

The following rule applies to DCAP only:

- The spouse of a married state employee must be either gainfully employed, a full-time student, disabled and incapable of self-care, or seeking employment and have income for the year.

Temporary, intermittent or contractual employees, retirees/annuitants and survivors are not eligible to participate in either FSA program. Exception: Retirees/annuitants may continue participation in MCAP through the end of the plan year for which they are currently enrolled by either pre-paying their deductions or by electing to pay their deductions through MCAP COBRA. If the retiree/annuitant would like to pre-pay the remaining plan year deductions, the GIR/P should take the outstanding amount out of the last payroll or supplemental check. If the retiree/annuitant would prefer to make monthly after-tax MCAP COBRA payments, the GIR/P should refer the retiree/annuitant to the FSA Unit.

It is not required for a participant's dependents to be covered under the participant's state health insurance plan in order for medical expenses to be eligible for MCAP reimbursement; however, the dependent must meet the "dependent" criteria for the health plan per IRS regulations.

B. Participant Ineligibility

Certain events disqualify FSA participants from being eligible for MCAP and/or DCAP (see chart below). Once notified that a participant is no longer eligible for the program, the GIR/P must notify:

- Payroll to stop all future deductions until the employee returns to work and RE-ENROLLS in the program, and the
- FSA Unit to terminate the participant's enrollment and cease the participant's eligibility for reimbursement.

Participants become ineligible for the program based upon the following:

MCAP* & DCAP Participants	DCAP Participants Only
• Retirement • Termination of employment • Work percentage changes to less than 50% and employee does not elect health COBRA * MCAP participants may elect to continue enrollment by pre-paying their deductions out of their last paycheck or by making MCAP COBRA payments. Refer to Section 8.2.E, 'MCAP Continuation Options' for more information.	• DCAP participant leaves work for a period greater than two-weeks * * The IRS makes an exception for DCAP participants who are away from work for short periods due to being sick or on a leave of absence as long as the period does not exceed two weeks. These participants may remain in DCAP without revoking participation. Missed deductions must be made up.

Employees may re-enroll in either FSA plan upon returning to payroll (see Section 8.2.D, 'Re-enrollment' for more information). Re-enrollment is not automatic and payroll deductions should not begin until the employee re-enrolls.

C. Enrollment

Enrolling in, withdrawing from or making changes to an FSA account must take place during the annual Benefit Choice Period, with the following two exceptions: 1) upon the initial hire of an employee; or 2) upon an existing employee experiencing an eligible qualifying change in status. Eligibility in MCAP and/or DCAP begins the first day of the pay period following the date the enrollment form was signed by the employee or the date of the qualifying event, ***whichever is later***.

♦ ***Initial Enrollment:*** New employees have 60 days from the date of employment to enroll. Employees electing the EZ REIMBURSE® card will have the $20.00 non-refundable card fee automatically deducted from their MCAP account after the first deposit has been made into the account.

- ***Enrollment Due to a Qualifying Change in Status:*** Employees who experience an eligible change in status have 60 days from the date of the qualifying event to enroll, change or revoke participation *on account of and consistent with* the nature of the event (see Section 8.2.D, 'Qualifying Changes in Status'). Employees electing the EZ REIMBURSE® card will have the $20.00 non-refundable card fee automatically deducted from their MCAP account after the first deposit has been made into the account.

D. Qualifying Changes in Status

MCAP and/or DCAP participants experiencing an eligible qualifying change in status have 60 days in which to contact their GIR/P to make a change to their FSA election. Participants may change the deduction amount for either MCAP or DCAP **if** the change is consistent with the qualifying event (e.g., MCAP participant who had a baby cannot lower the deduction since lowering their MCAP deduction would not be consistent with adding a dependent). The participant is required to complete either the MCAP Change in Status form or the DCAP Change in Status form to increase, decrease or revoke participation in the plan. A complete list of all qualifying changes in status is included on the MCAP and/or DCAP Change in Status forms.

Special Notes:

- **MCAP participants** on a paid leave of absence and still on payroll are not considered to have experienced a qualifying change in status. No revocation or change in deduction amount is allowed.

- **DCAP participants** experiencing a change in the cost of care are considered to have a qualifying change in status that allows the participant to change the deduction amount. The requested change must correspond with the increase or decrease in the cost of care.

E. Eligibility of Participants Off Payroll

In general, FSA participants who are off payroll are not eligible to participate in the FSA Program until they return to payroll (see 8.2.B, 'Participant Ineligibility' for exceptions). Reasons for ineligibility include termination of employment, retirement, being on an unpaid leave of absence or experiencing a change in work percentage resulting in a less than 50% work schedule. The last payroll deduction should be taken from the employee's final paycheck (not the vacation/sick supplemental paycheck). **Example:** Employee goes on an unpaid leave of absence for two months effective February 5th. The last deduction should be taken on the 2/1 – 2/15 pay period.

Participants who may continue participation in an FSA are:

- MCAP participants that elect to pre-pay deductions out of their final paycheck or supplemental check; or

- MCAP participants who elect to pay deductions on an after-tax basis via MCAP COBRA (see Section 8.2.G, 'MCAP COBRA Continuation Option' for more information); or

- MCAP or DCAP participants who elect COBRA for their health coverage due to their work percentage changing to less than 50% (i.e., employee lost eligibility to remain in the health plan) may remain enrolled in an FSA as long as they are still on payroll.

F. Re-Enrollment

Re-enrollment in the Flexible Spending Accounts (FSA) Program is not automatic, whether the participant is beginning a new plan year or returning to payroll.

- ***Annual Re-Enrollment:*** All participants currently enrolled in either MCAP or DCAP will receive a re-enrollment packet at the start of the annual Benefit Choice Period (packets are usually mailed in April). Participants are responsible for making sure they re-enroll whether or not they receive the re-enrollment packet. If the participant does not receive a re-enrollment packet by the first week of May, they should contact the agency GIR/P. The GIR/P should give the participant an FSA Booklet which contains enrollment forms for both programs (MCAP and/or DCAP). Employees enrolled in MCAP must indicate on the enrollment form each year their desire to enroll or re-enroll in the EZ REIMBURSE® card program.

- ***Re-enrollment Upon Returning to Payroll****:* Employees have 60 days from the date they return to payroll to complete and submit a new MCAP or DCAP Enrollment Form to the GIR/P. The effective date will be the first day of the pay period following the date the enrollment form was signed by the employee or the date the employee returned to payroll, ***whichever is later***. Employees who had an EZ REIMBURSE® card prior to going off payroll will have their card automatically reactivated by the plan administrator if they re-enroll in MCAP during the same plan year.

  Employees who wish to re-enroll in an FSA within 30 days of terminating their enrollment must enroll for the same deduction amount as they were enrolled prior to the termination. An exception can be made for employees who have experienced an eligible qualifying change in status during the previous 60 days. These employees would be allowed to increase or decrease their deduction amount.

G. MCAP Continuation Options

MCAP participants who terminate state service, retire, are not on payroll due to being on an unpaid leave of absence or who change employment status to less than 50% part-time, may continue participation in MCAP through MCAP COBRA. This option to continue participation applies only to MCAP participants.

Pre-Pay Option: Employees who have terminated employment or retired may elect to have any remaining plan year deductions taken from their final paycheck or their vacation/sick supplemental check as a lump sum deduction. Deductions must be taken for the remainder of the plan year allowing the participant to file claims through the end of the plan year.

MCAP COBRA Option: Employees who have terminated employment, retired or who are on an unpaid leave of absence may elect to make direct payments to the FSA Unit monthly through a check or money order for their MCAP deductions. Participants electing the direct payment option will not receive the pre-tax benefit; however, the participant may continue to file claims through the end of the period for which they paid, whereas, if the participant does not elect to continue their deductions, they would only be allowed to request reimbursement for services incurred through the end of their eligibility period based on the date they went off payroll (see Section 8.4.C., 'Claim Reimbursement' for more information).

Employees enrolled in MCAP who are interested in the pre-pay option should contact their GIR/P. Those interested in **continuing participation** through direct payments should contact the FSA Unit. The FSA Unit will set up the employee on an MCAP COBRA payment plan.

8.3 Contributions and Deductions

A. Contribution Limits

New state employees electing to participate in the FSA Program, or existing participants who experience an eligible change in status, cannot exceed a maximum contribution of $416.66 per month for the months remaining in the plan year. For example, a new state employee (paid over 12 months) who is hired during the month of October is limited to a contribution maximum of $416.66 per month. In this example, the participant's maximum annual contribution should be calculated by taking the number of remaining deductions and multiplying by $416.66; the GIR/P should **not** calculate the annual deduction by dividing $5000 by the number of remaining deductions. Note: The maximum monthly contribution amount for university employees paid over 9 months is $555.54.

GIR/Ps may use the 'Deduction What If Screens" found on the Inquiry Menu to assist with determining the correct pay period deduction amount, annual deduction amount, as well as deduction start and end dates.

1. **MCAP Participants:** Both the participant and their state-employed spouse may contribute a maximum of $5000 per plan year to their separate MCAP accounts, for a combined contribution of $10,000. Employees with spouses not employed by the state may have a higher combined annual contribution based on the spouse's MCAP plan guidelines.

2. **DCAP Participants:** The following is a description of the maximum allowable amount of DCAP contributions for each tax filing status:

   - Single and head of the household — $5000
   - Married and filing jointly — $5000
   - Married and filing separately — $2500 per person
   - Total family contribution if both spouses participate — $5000
   - If the participant or the participant's spouse earns less than $5,000 a year, the participant's maximum is the lower of the two incomes.
   - If the participant's spouse is a full-time student or incapable of self care, the participant's maximum contribution is $250 per month for one dependent or $416.66 per month for two or more dependents for each month of the plan year during which the participant's spouse was a student or disabled. The maximum for two or more dependents of university employees paid over 9 months is $555.54 per month.

B. Deductions

The FSA Program is a tax-based program in which payroll deductions correspond to the check issue date, not the pay period.

1. **Initial Deduction:**

- ***Employees Enrolled During Benefit Choice:*** The Flexible Spending Account Program begins July 1st each year. Deductions for MCAP and DCAP should be taken from the first paycheck that has an **issue date** of July 1st or later.

Payroll deductions will begin with the first paycheck that has an issue date of July 1 or after.

- ***Employees Enrolled due to a Qualifying Change in Status:*** Employees who enroll in MCAP/DCAP outside the annual Benefit Choice Period due to experiencing a qualifying change in status must have the first deduction taken from the check **issued** within the first pay period of coverage. In situations where the payroll has already closed for that pay period, the GIR/P will need to take a double deduction on the next pay period (see Section 8.3.B.2, "Missed Deductions" for more information).

The following table should be used to determine the effective date and number of deductions to be taken for mid-year enrollments:

Date of the Request or Event, whichever is later	1st Deduction taken from		Effective Date of Enrollment
	Delayed	Anticipated	
07/01-07/15	07/01-07/15	07/16-07/31	16-Jul
07/16-07/31	07/16-07/31	08/01-08/15	01-Aug
08/01-08/15	08/01-08/15	08/16-08/31	16-Aug
08/16-08/31	08/16-08/31	09/01-09/15	01-Sep
09/01-09/15	09/01-09/15	09/16-09/30	16-Sep
09/16-09/30	09/16-09/30	10/01-10/15	01-Oct
10/01-10/15	10/01-10/15	10/16-10/31	16-Oct
10/16-10/31	10/16-10/31	11/01-11/15	01-Nov
11/01-11/15	11/01-11/15	11/16-11/30	16-Nov
11/16-11/30	11/16-11/30	12/01-12/15	01-Dec
12/01-12/15	12/01-12/15	12/16-12/31	16-Dec
12/16-12/31	12/16-12/31	01/01-01/15	01-Jan
01/01-01/15	01/01-01/15	01/16-01/31	16-Jan
01/16-01/31	01/16-01/31	02/01-02/15	01-Feb
02/01-02/15	02/01-02/15	02/16-02/28	16-Feb
02/16-02/28	02/16-02/28	03/01-03/15	01-Mar
03/01-03/15	03/01-03/15	03/16-03/31	16-Mar
03/16-03/31	03/16-03/31	04/01-04/15	01-Apr
04/01-04/15	04/01-04/15	04/16-04/30	16-Apr
04/16-04/30	04/16-04/30	05/01-05/15	01-May
05/01-05/15	05/01-05/15	05/16-05/31	16-May
05/16-05/31	05/16-05/31	06/01-06/15	01-Jun
06/01-06/15	06/01-06/15	06/16 – 06/30	16-Jun

2. **Missed Deductions:** When a deduction for a participant's MCAP or DCAP account was not taken for a certain pay period (e.g., a new state employee enrolls in the program, but the first payroll deduction was not taken), the GIR/P should advise the participant that missed deductions must be taken on payroll in two pay periods or less.

3. **Deductions Taken in Error:** When a deduction for a participant's MCAP or DCAP was taken in error (e.g., employee did not re-enroll in FSA upon returning from a leave of absence, however, payroll continued to take deductions), the participant must be refunded the deduction with the appropriate taxes withheld. If the refund can be processed on a paycheck issued during **the same** fiscal and calendar year (January 1st through June 30th or July 1st through December 31st), it must be processed via payroll. The FSA Unit will process all other refunds.

   For personnel of state agencies: Refunds processed by the FSA Unit through the Comptroller's office will be net of appropriate payroll withholding tax. The Comptroller will bill each agency for the employer portion of the payroll tax.

   For personnel of universities: Refunds processed by the FSA Unit will be the gross amount of the deduction taken in error. It is the responsibility of the employee and the university to make the appropriate payroll tax contribution. Upon completion of the refund process, the FSA Unit will notify the employee and the employing university of the anticipated refund.

4. **Deductions While Off Payroll:** The FSA Unit must be advised any time an employee goes off payroll for a period that is greater than two weeks. The unit will then update the FSA System with the correct eligibility dates. If the unit is not notified of the change in eligibility, the FSA Program will be at risk for paying ineligible claims. Reasons for ineligibility may include termination of employment, employee's retirement, unpaid leave of absence or a change in work percentage resulting in a less than 50% work schedule.

   Example: *An MCAP participant goes on an unpaid leave of absence effective November 20th; however, the GIR/P does not notify the FSA Unit to process the termination. The ineligible employee is not on payroll and therefore, no longer making payroll contributions but continues to send the plan administrator claims for reimbursement for services incurred after November 20th. All of the payments made to the employee should have been denied due to ineligibility; however, all were paid.*

8.4 Claims

A. Claim Forms

Participants may print a blank FSA Reimbursement Request Form (used for both the MCAP and DCAP plans) from any of the following websites:

- FBMC's website (www.myfbmc.com)
- Benefits Website (www.benefitschoice.il.gov) - click on 'State Employees,' then 'Forms,' then 'FSA Reimbursement Request Form'
- CMS Intra-net (http://www.cms-intra.state.il.us/) - click on 'Manuals and Forms,' 'Forms,' then 'FSA Reimbursement Request Form'

Participants who need to substantiate EZ REIMBURSE® card transactions **must complete the EZ REIMBURSE® Card Transmittal Cover Sheet** available on the Benefits Website under 'Forms' or on the plan administrator's website (the participant must log into the website to obtain a form on the plan administrator's website).

B. Claim Submission

Participants must use a separate claim form for each plan years' expenses. Claims that are either incomplete, do not include the participant's signature, do not have adequate documentation or cross plan years (with the exception of those incurred during the "grace period" – see Section 8.4.E for an explanation of the grace period) will be returned to the participant unpaid. The plan administrator will send a letter to the participant indicating the reason the claim was unpaid and will request that the participant send the missing and/or correct information for processing.

Completed and signed claims, along with the required documentation, should be submitted to the claims processor either by fax at 1-850-514-5817, toll-free fax at 1-866-440-7152 or via USPS at:

Fringe Benefit Management Company (FBMC)
PO Box 1810
Tallahassee, FL 32302-1810

The participant has three months from the close of the plan year (i.e., September 30) to submit claims for reimbursement. This three-month period is referred to as the "run-out period." IRS regulations require forfeiture of any funds not requested by September 30.

C. Claim Reimbursement

Medical Care Assistance Plan (MCAP): Once enrolled, an MCAP participant is eligible to be reimbursed for the entire amount for which they enrolled for claims that were incurred on or after their date of eligibility, or for employees who enrolled during the Benefit Choice Period, beginning July 1st. Participants who revoke participation during the plan year may file claims for dates of service that were incurred between the eligibility begin date and the last day of the pay period from which the last deduction was taken if on an Anticipated Payroll, or if on a Delayed Payroll, between the eligibility begin date and the last day of the Pay Period in which the final paycheck was issued.

The following examples illustrate the different dates through which an MCAP participant is allowed to file a claim based on a delayed versus an anticipated payroll system.

- ***Delayed Semi-monthly Payroll***: Participant revoked MCAP participation October 4th. The last deduction was taken from the October 1st – 15th pay period. The participant received his last paycheck (i.e., the check was "issued" to the employee) on October 22nd. Therefore, the participant would be allowed to file claims through October 31st (i.e., the end of the pay period in which the last paycheck was **issued**).

- ***Anticipated Semi-monthly Payroll***: Participant revoked MCAP participation October 4th. The last deduction was taken from the October 1st – 15th pay period. The participant received his last paycheck (i.e., the check was "issued" to the employee) on October 10th. Therefore, the participant would be allowed to file claims through October 15th (i.e., the end of the pay period in which the last paycheck was **issued**).

Dependent Care Assistance Program (DCAP): Enrolled participants may be reimbursed only the amount that is in the DCAP account at the time the claim is received by the plan administrator. If the claim amount exceeds the balance in the participant's DCAP account, the outstanding balance will be carried over until the next deposit is received. The remaining portion of the claim will be paid automatically once the deposit is received into the participant's DCAP account. Expenses incurred while the participant and/or the participant's spouse is not actively at work, looking for work or while incapable of self-care, are ineligible for DCAP reimbursement.

D. Reimbursement of Over-the-Counter Medications

Most over-the-counter (OTC) medications are reimbursable through a participant's MCAP account through either the paper-claim process or the EZ REIMBURSE® card. Documentation must be sent to the FSA Plan Administrator unless the items were purchased at a location that has implemented the IIAS System (see a definition of IIAS in Section 8.6.B, 'EZ REIMBURSE® Card Definitions'). All OTC items must meet IRS regulations in order to be reimbursed. A list of eligible OTC categories can be found on the plan administrator's website and is updated quarterly. Items not eligible for reimbursement include hair loss/replacement medications (such as Rogaine) and vitamins/supplements unless accompanied by a physician's Letter of Medical Necessity stating the item is needed to treat a specific disease or condition. For example, Rogaine may be prescribed for a patient who has hair loss due to a medical condition, such as cancer.

Over-the-counter items that are deemed eligible for reimbursement by the IRS during the fiscal year can be submitted for reimbursement even if the item was purchased prior to the date the item was added to the list. However, a participant cannot enroll in MCAP or increase their MCAP contribution simply because an OTC item they use is added to the list of eligible items. This change, in and of itself, does not constitute a qualifying change in status.

E. Grace Period

As allowed under the Internal Revenue Notice 2005-42, the State of Illinois implemented a "grace period" beginning with the FY07 plan year (July 1, 2006 – June 30, 2007). The grace period applies to all participants enrolled in the MCAP plan only.

Effective with this change, MCAP participants are permitted to submit eligible medical care expenses that are incurred through September 15 for reimbursement out of the prior plan year's MCAP account. As with all claims, reimbursement requests must be received by the end of the run-out period (i.e., September 30th of each year).

The entire prior plan year's remaining available balance is eligible for reimbursement during the "grace period". Expenses incurred during the grace period will be paid from the funds remaining in the prior plan year's MCAP account before funds from the current plan year are accessed. Once the prior year's MCAP account balance has been depleted, any other service incurred during the grace period will be reimbursed out of the new plan year's MCAP account.

Example: FY07 plan year (grace period = July 1, 2007 through September 15, 2007): Participant enrolled in MCAP for plan years FY07 and FY08. On the last day of FY07 (June 30, 2007), the participant had $500 remaining in their MCAP account. On July 28, 2007 (FY08), the participant incurred $700 in eligible dental expenses. The $500 remaining in the FY07 account will be accessed and depleted with the remaining balance of $200 being paid out of the FY08 account.

F. Checking Claim Status Online

Participants may check the status of an FSA claim on the plan administrator's website via the Internet. The participant should:

1. Go to the website: www.myFBMC.com

2. Under 'Registered Users,' enter your Email Address and Password. See the instructions in the note below for participants registering on the FBMC website for the first time.

3. Click on the
   - 'Claims' tab; then,
   - 'Claims Status,' then,
   - Click the arrow on the right side of the pull down box menu, then
   - Select 'All Claims'

Note: The first time a participant logs on to FBMC's website they will need to register. They should click on 'Click here to register a new account' under 'New Users.' The participant will need to complete the required fields, which include first and last name, mailing zip code and email address.

In the second section of the registration screen, the participant will need to enter either their SSN or FBMC ID (the FSA Unit can provide the member with their FBMC ID). State of Illinois employees do not have an Employee ID.

In the third section of the registration screen, the participant will need to enter a password.

In the fourth section of the registration screen, the participant will need to enter the characters they see in the box. The entry of these characters is case sensitive.

8.5 Dental/Orthodontia Services

The section below relates to orthodontia services, as well as, non-orthodontia services.

A. General Guidelines

- **It is to the participant's benefit and strongly recommended that the participant obtain a Pre-Treatment Estimate from CompBenefits**. In order to obtain a more accurate deduction estimate for the plan year, participants enrolling during the annual Benefit Choice Period should allow 4-6 weeks to obtain the estimate.
- There is a maximum lifetime benefit of $1,500 for orthodontia services per individual through CompBenefits. Payments made for orthodontia during the plan year are applied to the annual $2000.00 maximum dental benefit per year.
- The $100 deductible that is assessed each benefit year will be applied to orthodontic braces if no other dental services have been utilized.
- Neither the State of Illinois nor CompBenefits are responsible for changes in treatment plans.
- Orthodontic treatment, other than braces, is reimbursed just as any other dental claim.
- It is the participant's responsibility to track the number of remaining months of treatment when calculating months of payment for the benefit year.

B. Reimbursement Options for Orthodontic Braces

For orthodontic care that extends beyond one or more plan years, eligible MCAP expenses may be reimbursed in the following amounts (once the initial service, such as banding, has been incurred):

- The initial down payment, with the remaining balance spread out under a payment plan (copy of the patient's contract is required); or
- The full contract amount spread out under a payment plan (copy of the patient's contract is required with the dentist/orthodontist performing treatment); or
- The full contract amount paid monthly by coupon submitted each applicable month (copy of contract required with the first claim);or
- The full payment amount paid entirely up front once the banding process begins – the banding must occur in the plan year the participant is enrolled in MCAP, regardless of when payment is made.

8.6 EZ REIMBURSE® MasterCard® Card

A. General Information

Effective October 1, 2004, the State of Illinois began offering employees enrolled in MCAP the option to have their medical, dental, vision and pharmaceutical expenses paid directly to the healthcare provider through a stored-value card. This stored-value card, referred to as the EZ REIMBURSE® MasterCard®, allows participants to electronically access their MCAP account for immediate reimbursement. There is an annual non-refundable $20.00 fee for the card. This fee is automatically deducted from the participant's MCAP account after the first payroll deduction has been deposited into the account. Participants must elect (or re-elect) the card each year.

If the participant elects the card, it will be activated and loaded with the annual amount for which the participant enrolled and can be used the first day of eligibility. Funds in an MCAP account can be accessed by either using the EZ REIMBURSE® card or by submitting paper claims for reimbursement.

There is no risk of overspending or exceeding the MCAP account limits. If funds are not available because the annualized amount has been spent down, the EZ REIMBURSE® MasterCard® card transaction will be denied. The card will not pay partial payments if the amount swiped is greater than the account balance; the entire transaction will be rejected. If the participant's expenses are greater than the account balance and the participant knows the amount remaining in their account, the merchant can enter the amount of the remaining account balance into their credit card machine; the participant will need to pay the remaining balance due by other means.

B. EZ REIMBURSE® Card Definitions

Specific terminology is used when describing the various processes used with regard to the EZ REIMBURSE® card. A description of each of those terms is below:

Auto Adjudication – Auto Adjudication is an automatic process which allows medical, pharmacy, over-the-counter and vision services with known co-payments to be paid directly out of a participant's MCAP account upon the participant presenting their EZ REIMBURSE® card. When the participant uses the card to pay for an item or service that has a known co-payment, documentation is not required.

Auto Substitution – Unsubstantiated transactions appear on monthly FSA statements in BLUE. Participants have 60 days to substantiate these transactions. Once the 60-day time period passes, any paper claims received by the plan administrator for a different medical expense (incurred during the same plan year) will be automatically substituted to offset the outstanding EZ REIMBURSE® card transactions.

Inventory Information Approval System (IIAS) – The IIAS automatically processes eligible **over-the-counter and prescription** items by reading the barcode. Documentation is never required for eligible expenses when the card is used at a location that has this system. Most major discount and pharmacy stores have implemented the system. For a list of stores that have implemented IIAS, check the FBMC website (www.myFBMC.com).

Substantiation – Transactions with known co-payments, such as physician office visits, are determined by a specific schedule of benefits and therefore do not typically require follow-up documentation (i.e., they are auto adjudicated). However, in situations where a medical, dental, pharmaceutical or vision service or item does not have a specific co-payment amount, follow-up documentation must be submitted to FBMC. **When substantiating a claim, the participant must send documentation to the plan administrator with an EZ REIMBURSE® Card Transmittal Sheet. Claim forms will not be accepted and may actually slow the reimbursement process.**

Suspension – Participants have two consecutive monthly statement cycles to send the plan administrator documentation for any unsubstantiated claims (indicated in blue on the statement). If the documentation is not received at FBMC by the last business day of the second month and/or if another claim is not auto substituted for the unsubstantiated claim(s), the participant's card will be permanently suspended for the remaining plan year and all future plan years, until the documentation or payment for the transaction is received.

Follow-up Documentation – Acceptable documentation includes itemized bills and Explanation of Benefits (EOBs). **Documentation must be sent to the plan administrator with an EZ REIMBURSE® Card Transmittal Sheet.** Claim forms will not be accepted and may actually slow the reimbursement process.

C. Requesting the Card

Participants may elect the EZ REIMBURSE® card at the time of enrollment or any time throughout the plan year. If electing the card upon initial enrollment into the plan, the participant should simply check the 'EZ REIMBURSE® CARD' box in Section C of the MCAP enrollment form. Participants who do not elect the card upon initial enrollment, then later decide they want the card should contact the plan administrator. The card will generally be issued within 3 weeks of the plan administrator receiving the application.

Employees must elect the card each year on the MCAP Enrollment form. If they do not mark the 'EZ REIMBURSE® Card' box on the form, the EZ card will not be reactivated and funds will not be loaded to the card. It is important that participants understand there is a $20.00 non-refundable fee for the card.

D. Medical and Vision Expenses

Participants may use the EZ REIMBURSE® MasterCard® card to pay their out-of-pocket medical and vision expenses including items such as co-payments, deductibles, co-insurance and other health-related expenses, including over-the-counter and mail-order pharmacy items. Participants should present the EZ REIMBURSE® MasterCard® to the provider at the point of service. The expenses will be paid directly out of the MCAP account at the time the card is swiped. Participants should tell the provider to only swipe the card for the portion of expenses that are eligible for reimbursement (i.e., the participant should subtract the portion of the charges that insurance will pay from the total).

E. Dental Expenses

The state's insurance benefit for dental services is based upon a Schedule of Benefits that allows a maximum amount to be paid for the eligible dental service. Since dental benefit levels are not "co-payments", but are instead a "maximum benefit amount", the FSA Plan Administrator cannot automatically adjudicate any dental service. If the provider does not exclude the portion that will be paid by insurance, the participant will be responsible for reimbursing the plan administrator for any amount swiped that was paid by insurance. For this reason, it is to the participant's advantage to ask the provider to exclude the portion of the service covered by insurance when swiping the card.

Additionally, since any dental service can be paid for with the EZ card (including non-eligible cosmetic services), follow-up documentation must be provided for all dental services in order to prove eligibility of the service and charges. If an ineligible service or an amount that includes the portion paid by insurance is swiped, the plan administrator must be repaid for the ineligible portion of the swiped amount. Repayment to the plan administrator can be in the form of auto substitution (i.e., an eligible claim from another date of service is substituted for the ineligible amount paid) or a personal check made payable to the State of Illinois for the ineligible amount.

Note: Due to the 6 – 8 week processing time for the dental claims plan administrator to pay a provider for a dental claim, an EZ REIMBURSE® card participant may not receive their Explanation of Benefit (EOB) statement within the two statement cycles required by FBMC. However, even though the EOB may not yet have been created and sent, the claim itself is usually processed on the dental plan administrator's system 7 – 10 days following the receipt of the claim from the dental provider. Therefore, participants should be encouraged to go online to the claims history screen on the dental plan administrator's website and print the claim history for the transaction for which they used their EZ REIMBURSE® card. The participant can then submit that documentation to FBMC to substantiate the dental claim and avoid having their card suspended.

F. Prescription and Over-the-Counter (OTC) Expenses

Effective January 1, 2008, participants may only use the EZ REIMBURSE® MasterCard® to purchase eligible over-the-counter items and prescriptions at merchant locations that have implemented the IIAS System (see Section 8.6.B, 'EZ REIMBURSE® Card Definitions') or at locations that are considered a pharmacy under the IRS definition. Documentation is not necessary for items purchased at these locations since the system can identify the barcode as an eligible FSA item.

Prescription medication and OTC items purchased at a pharmacy **may** require documentation if the pharmacy has not implemented IIAS. Pharmacies will be required to implement the IIAS System effective January 1, 2009. Employees should keep all receipts when using the EZ REIMBURSE® card.

Documentation Required	Documentation Not Required
Pharmacy that does **not** use the IIAS System (online or storefront) - documentation required for eligible OTC and prescription medications that are not of a known co-payment amount	Any merchant when prescription is a known co-payment amount
	Merchant uses IIAS System
	Mail Order Prescriptions
If a merchant, other than a pharmacy, does not use IIAS after December 31, 2007, the EZ REIMBURSE® card will not be accepted for FSA purchases. Check the FBMC website periodically for a list of IIAS merchants.	

G. Multiple Co-pays

The EZ REIMBURSE® card will automatically adjudicate **multiple co-payments of the <u>same amount</u>, up to 5 co-payments.** For example, five prescriptions for $10 each can be purchased at the same time without the need for documentation (e.g., $10+$10+$10+$10+$10). If the transaction exceeds five <u>like-amount</u> co-payments, documentation will need to be submitted for the entire transaction.

The card will also automatically adjudicate combinations of **multiple co-payments of <u>various amounts</u> up to an amount equal to the largest co-payment**. For example, co-payment amounts for a prescription through an HMO are $10, $20 and $40. Since $40 is the largest co-payment amount, the participant can use the card for multiple prescriptions, not to exceed a total of $40 without the need to provide documentation (e.g., $10+$10+$20). If the total amount exceeds the highest co-payment amount, in this case $40, documentation will need to be submitted for the entire transaction.

H. Participants Who Have Waived or Opted Out of Health Coverage

Part-time employees who waive coverage or full-time employees who opt out of coverage may still elect to receive the EZ REIMURSE® card; however, since these employees do not have coverage through the State of Illinois, the co-payment amounts are not known by the FSA plan administrator. For this reason, the co-payment amounts of these participants cannot be auto adjudicated (i.e., reimbursed without the need for follow-up documentation) and the participant must send the plan administrator proof (i.e., follow-up documentation, such as an Explanation of Benefits (EOB) or itemized bill) that the service or item was an eligible expense for all transactions, with the exception of OTC and pharmacy items purchased at a location that has implemented IIAS.

I. Substantiating EZ REIMBURSE® Outstanding Transactions

Substantiation means that certain claims, even though paid when the participant's EZ REIMBURSE® card was swiped, must have follow-up documentation submitted to FBMC, per Internal Revenue Service regulations. Examples of follow-up documentation include itemized bills and Explanation of Benefits (EOBs). Transactions with known co-payments, such as physician office visits and emergency room visits, are determined by a specific Schedule of Benefits and therefore do not typically require follow-up documentation. On the other hand, follow-up documentation must be submitted for transactions that do not have a known co-payment amount, such as all dental procedures. Providing follow-up documentation is called substantiating the claim. Substantiation must be completed so that FBMC has proof that the amount swiped is eligible. For example, Quality Care Health Plan (QCHP) members may use the card to pay for eligible medical expenses; however, the Explanation of Benefits (EOB) may need to be submitted to FBMC to substantiate QCHP claims that are not in the amount of a known co-payment.

Participants are notified on their monthly statement which transactions need to have documentation submitted. Items indicated in blue on the statement are EZ REIMBURSE® card transactions that must be substantiated with documentation. All documentation must include an EZ REIMBURSE® Card Transmittal Sheet. Claim forms cannot be used when substantiating a claim since the plan administrator may incorrectly process the transaction as a claim instead of substantiating the necessary transaction.

Once an unsubstantiated transaction is 60 days old (i.e., documentation has not been received by FBMC), the transaction will be subject to auto substitution.

Example of Auto-Substitution: On October 1st, Participant A uses their card at the dentist office for a dental claim of $50.00. Participant A does not submit the Explanation of Benefits (EOB) from the dental plan administrator to FBMC. Participant A's card is suspended and can no longer be used effective December (because it has been shown in blue on two consecutive monthly statements). Participant A then goes to their pharmacist on December 2nd and receives two prescriptions totaling $72.00. Due to the card being suspended, the amount due will not be paid at the point of service; instead, Participant A must file a paper claim for the $72.00. Once FBMC receives the paper claim and supporting documentation for the $72.00, the amount that would have normally been reimbursed to Participant A from FBMC (either by check or direct deposit)

will instead be applied toward the $50.00 unsubstantiated dental office claim. At this point, Participant A's card will be unsuspended and the remaining claim amount of $22.00 will be paid to the participant.

J. Suspension and Reactivation of the EZ REIMBURSE® Card

Transactions that require substantiation are indicated in BLUE on the participant's monthly statement. Documentation must be provided to the plan administrator within two statement cycles. If documentation is not submitted approximately 7 – 10 business prior to the end of the second month, the participant's card will be suspended effective the last business day of that month.

In order to reactivate a suspended card, the participant must either:

- Submit proper documentation for the outstanding, unsubstantiated expense(s) to FBMC with an EZ REIMBURSE® Card Transmittal Sheet, or

- Submit paper claims for other eligible expenses incurred during the same plan year along with third-party receipts in amounts equal to, or greater than, the unsubstantiated claim amounts. This option is referred to as auto-substitution since these paper claims will automatically be substituted to offset the outstanding EZ REIMBURSE® card transactions.

Participants who do not substantiate outstanding claims by the end of the run-out period will have their card permanently suspended and will not be able to use the card at any time in the future, including future plan years. Under no circumstance will the annual fee be refunded. **Unsubstantiated transactions may be subject to involuntary withholding and/or reported to the IRS as income. Adjustments will be made on the participant's W2 accordingly.**

9.0 Smoking Cessation Program

The Smoking Cessation Program is a benefit which applies to state employees participating in the Group Insurance Program and their covered dependents.

The benefit is a rebate toward the cost of an approved Smoking Cessation Program. Beginning July 1, 2001, the rebate amount is $200 and is limited to one rebate per plan year based upon completion of an approved program. Charges not eligible include hypnosis, acupuncture, prescription drug therapy and non-prescription drug therapy. Members who have questions regarding whether or not a specific smoking cessation program is an approved program should call GID Member Services.

Reimbursement

Documentation required for reimbursement include the following:

- Receipt of payment for the program.
- Program certificate verifying the number of sessions and completion of the program.
- Employee's name, Social Security Number and telephone number. If a dependent received the treatment, their name must be submitted as well.

The documentation must be submitted to the following address:

Smoking Cessation Program
CMS/Group Insurance Division
201 E. Madison, Suite 1C
P.O. Box 19208
Springfield, Illinois 62794-9208

CMS/Group Insurance Division is the plan administrator of the Smoking Cessation Program. See the most recent Benefit Choice Options booklet for the plan administrator's telephone number.

9.1 Adoption Benefit Program

All State of Illinois employees working either full-time or part-time (but not less than 50% part-time) may apply for the adoption benefit. The adoption must be **final** before expenses are eligible for this benefit. The request for reimbursement must be filed within one year from the end of the plan year the adoption became final.

The program pays eligible expenses up to a maximum of $1500 for a waiting child, and up to $1000 for any other eligible child. If more than one child is adopted, benefits are available for each child. FICA tax is deducted from the adoption benefit.

Waiting children are:

- Minority children age three and over.
- Caucasian children age eleven and over.
- Children with mental, physical or emotional disabilities.
- Children who need to be adopted with brothers and sisters.
- Foreign children age three and over.

A. Eligible Expenses

- Legal fees.
- Court fees.
- Adoption agency fees, including foreign adoption fees (adoption agency must be licensed by the State of Illinois).
- Required medical exams for the child.
- Initial immunizations for the child.
- Transportation costs to bring the child to the adopting parents (or for the adult, other than the adopting parent, accompanying the child to the United States).

B. Ineligible Expenses

- Expenses for adopting stepchildren.
- Expenses for adopting children related to either parent, such as nephews, nieces, cousins, brothers or sisters.
- Transportation for the adopting parents.
- Medical examination fees for the adopting parents.
- Cost of personal items for either parents or child during or after the adoption, such as clothing, food, etc.
- Expenses provided by other adoption assistance programs.

C. Health Coverage for Adopted Child

Once a court order for a petition for adoption has been finalized, or custody of the child has been granted, the child may be enrolled in the State Employees Group Insurance Program.

If custody is obtained and the child is added to the State employee's plan within 60 days of the child's birth, the effective date of coverage can be retroactive to the child's date of birth.

If coverage is requested for an adopted child (other than a newborn) within 60 days of either the court order for a petition for adoption being finalized or of custody being granted, the effective date of coverage is the later of the two events. Adopted dependents are not subject to the pre-existing conditions limitation.

D. Reimbursement Documentation Requirements

The following documentation must be submitted:

- An informal memo to CMS/Group Insurance Division stating than an adoption has been completed of a child who is **not related** to the employee or the spouse. The memo should include the employee's name, address, Social Security Number and telephone number.

- A copy of the adoption decree from a court in the United States or a DCFS home study approval letter for adoption of a child outside the United States.

- Itemized bills or receipts for eligible expenses.

The documentation must be submitted to the following address:

Adoption Benefit Program
CMS/Group Insurance Division
201 E. Madison, Suite 1C
P.O. Box 19208
Springfield, Illinois 62794-9208

For More Information

CMS/Group Insurance Division is the plan administrator of the Adoption Benefit Program. See the most recent Benefits Choice Options booklet for the plan administrator's telephone number.

For questions about adoptions in general, please contact the Adoption Information Center of Illinois at (800) 572-2390.

9.2 Hospital Bill Audit Program

The Hospital Bill Audit Program applies only to **non-QCHP** hospital charges. The Program provides that if the plan participant should discover an error or overcharge on a non-QCHP hospital bill and obtains a corrected bill from the hospital, the plan participant will be eligible for 50% of the resulting savings, up to a maximum of $1000 per admission.

Note: QCHP hospital charges are not eligible under the Hospital Bill Audit Program, as the Plan pays claims based on the negotiated rate, not on actual charges. Related bills such as radiologist or surgeon are not eligible under the Plan.

Reimbursement Documentation Requirements

- Original incorrect bill.
- Copy of corrected bill.
- Employee's name, Social Security Number and telephone number. If a dependent received the treatment, their name must be submitted as well.

The documentation should be submitted to the following address:

Hospital Bill Audit Program
CMS/Group Insurance Division
201 E. Madison, Suite 1C
P.O. Box 19208
Springfield, Illinois 62794-9208

9.3 Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a free, voluntary and confidential assessment service that links the employee to an EAP counselor. The EAP counselors are experienced in providing support, understanding, and guidance for a broad range of needs including issues such as anger management, stress, emotional difficulties, elder care concerns, grief/loss, etc. The program is available to all active state employees and their covered dependents.

There are two separate Employee Assistance Programs for active employees. These programs are the EAP through Magellan Behavioral Health and the Personal Support Program (PSP) through AFSCME Council 31.

- **Magellan Behavioral Health**: Active employees not represented by the master contract agreement between the State of Illinois and AFSCME must contact Magellan Behavioral Health by calling 1-866-659-3848. Getting help is easy, convenient and available 24 hours a day, seven days a week.

- **Personal Support Program:** Bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME must access EAP services through the Personal Support Program by calling 1-800-647-8776.

Even though the EAP is a free service for employees and their families, if the employee or dependent requires help beyond the scope of EAP, the counselor may refer the employee or family member for additional services through their respective health plan. The additional services resulting costs and co-payments, as applicable, are the employee's responsibility.

Management consultation is available when an employee's personal problems are causing a decline in work performance. In critical incident situations that occur at the workplace, Critical Incident Stress Management is available through the EAP.

9.4 Commuter Savings Program (CSP)

A. Program Information

This program is authorized by the Federal IRS and offers State of Illinois employees eligible to participate in the group health insurance program the opportunity to pay for eligible transportation and parking expenses with tax-free, payroll deducted contributions.

The CSP offers both a transit and a parking benefit. Transit media (i.e., passes) are mailed directly to the participant's home. Participants enrolled in the parking benefit may either pay the parking provider directly and be reimbursed by the plan administrator or they can elect to have the plan administrator pay the parking provider directly each month.

Typically, the IRS increases the allowable monthly maximum contribution at the beginning of each calendar year. For calendar year 2008, employees may contribute a combined annual maximum of $4,020.00 in pre-tax dollars for both programs ($115/month for transit; $220/month for parking). CSP contributions are deducted from the employee's paycheck before state, federal and Social Security taxes are withheld.

Eligible employees may enroll in the program any time. In order to be eligible, employees must be working 50% or greater and be paid through the Comptroller's Office (at this time, university employees are not eligible for this program). A qualifying change in status is not required to enroll mid-year and the employee may stop or change deductions at any time. To enroll, change or cancel participation, the employee must notify the plan administrator by the 10th of the month in order to have their benefit begin, increased/decreased or stopped effective the first day of the following month. Program elections are on a monthly basis.

Employees may enroll, change or cancel the benefit online through the plan administrator's website or by calling the plan administrator.

B. GIR/P's Role

Monthly Report: GIR/Ps will receive a monthly report from the FSA Unit at CMS between the 20th and 29th of each month. The report lists all employees who are enrolled in CSP and is divided into sections: New Enrollments, Deduction Changes, Deduction Cancellations and No Change.

Effective Dates: The effective date of parking and transit benefits depends on the day of the month the employee enrolls in the program or makes the change. Enrollments/ changes received the 1st through the 10th of the month are effective the first day of the following month. Enrollments/changes received the 11th through the end of the month are effective the first day of the second month after the transaction was made (see example below).

Date of Enrollment or Change	Effective Date of Benefit
September 1st through 10th	October 1st
September 11th through 30th	November 1st

Payroll Deductions: Deductions are listed on the report in semi-monthly amounts. Changes to the deduction amount should be made the first pay period of the month in which the enrollment/change is effective. When calculating the payroll deduction for a monthly payroll, the GIR/P must multiply the semi-monthly deduction amount by two.

Example:

Date of Enrollment or Change	Effective Date Of Benefit	First Pay Period Deduction Should be Taken
September 1st through 10th	October 1st	October 1st – 15th
September 11th through 30th	November 1st	November 1st – 15th

Agency Transfer: If an employee enrolled in CSP transfers to a different state agency, the GIR/P must contact the new agency's GIR/P and inform them of the employee's election and deduction amount in order for the new agency to have the deduction taken on payroll in a timely manner.

Termination of Employment: Employees enrolled in CSP who terminate employment should be directed to log onto the plan administrator's website to cancel enrollment in the program. Once the enrollment has been cancelled, the employee will show on the monthly CSP report as a cancellation. Deductions should be taken for the entire monthly amount during the last month of employment. For example, a participant enrolled in the parking program terminates employment June 5th. Since the parking provider received payment for the entire month of June (payment is mailed the end of the prior month) for the participant's parking expenses, the entire monthly amount must be deducted from the employee's final paycheck.

10.0 Premiums

The State of Illinois covers most of the health insurance costs of members; however, employees are required to make a monthly salary-based contribution (see section 10 "Health Codes" to determine the codes used for salary-based contributions).

Salary-based contributions do not apply to retirees, annuitants, or survivors. However, retirees on or after January 1st, 1998 (or State Group members under TRS who retired on or after July 1st, 1998) enrolled in the State Group Insurance Program who have less than 20 years of State service, are required to pay a percentage of the cost of basic health coverage. The percentage of the cost is based upon the member's years of service. The GIR/P should contact the appropriate retirement system for rates.

A. Dependent Premiums

Monthly dependent premiums are in addition to the employee's monthly salary-based contribution. Dependents must be enrolled in the same plan as the member under whom they are enrolled. Dependent premiums may be found in either the current plan year's Benefit Choice Booklet or the rate tables.

B. Part-time Employee Premiums

A part-time employee who is eligible for state insurance coverage and elects to participate in health and dental must pay a percentage of the State's cost for coverage. The percentage the State pays is equal to the percentage of time worked. The employee must pay the remaining balance of the cost.

The GIR/P should use the employee's work hours from the previous 12 months to calculate the upcoming year's part-time percentage.

Example (does not apply to part-time faculty – see 'Eligibility - Part-time faculty' section for example): Member worked a full-time schedule from March 1st – November 30th, and was on seasonal leave December 1st – April 30th. The calculation would be 39 work weeks x 37.5 hours/week = 1462.50 hours in the 12-month period.

Since full-time employees work 1950 hours in a 12-month period, the GIR/P would divide the hours worked by 1950: Therefore, 1462.50 ÷ 1950 = .75 or 75%.

The employee in this example will have 75% of the basic health and dental costs paid by the State. The employee is liable for the remaining 25% of the costs.

C. Calculation of Premium

1. **Deduction Calculation Screen: GIR/P's with online access** to the Membership System can use the Deduction Calculation Screen (screen 5C) to calculate premiums of new members. This is especially helpful when calculating premiums for members who are not yet in the system (see section 11). The Calculation Screen may also be used to calculate premiums for current full-time or part-time members who are considering a change to their health, dental and/or life plan elections.

2. **Rate Charts: GIR/P's without online access** may use the formulas below to calculate life/dental/health premiums. The formulas below use information from the health, dental, and life rate charts which are sent to the agencies each year. The charts (effective the first day of the upcoming fiscal year) list the member and state portion of premiums. The state portion is provided for GIR/P's to use when calculating premium due for part-time employees responsible for a portion of the state rate and employees going on leave of absence. ***Note***: the Analysis and Resolution Unit may also be contacted to help calculate premium. *The rate charts are confidential and are not to be distributed to members.*

a) BASIC LIFE PREMIUM CALCULATION

Monthly Basic Life
Basic Life Units x Basic Life Rate + .0099 = State Basic Life Premium (drop last two digits).

Example: Basic Life rates for a monthly employee.

Basic Life Units	**x**	**Basic Life Rate**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped)
343	x	.036	=	12.348	+	.0099	=	12.3579 = 12.35

(Based on FY'02 rates)

Semi-Monthly Basic Life
Basic Life Units x Basic Life Rate x (.5) + .0099 = State Basic Life Premium (drop last two digits).

Example: Basic Life rates for a semi-monthly employee.

Basic Life Units	**x**	**Basic Life Rate**	**x**	**.5**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped)
343	x	.036	x	.5	=	6.174	+	.0099	=	6.1839 = 6.18

(Based on FY'02 rates)

b) OPTIONAL LIFE PREMIUM CALCULATION

Monthly Optional Life

Basic Life Units x Multiple x Optional Life Rate + .0099 = Optional Life Premium (drop last two digits).

Example: Optional life rates for a 42 year old employee paid monthly with 386 basic life units and 4 times optional life coverage.

Basic Life Units	**x**	**Multiple** (optional life)	**x**	**Optional Life Rate** (use rate chart and member's age)	**=**		**+**	**.0099**	**=**	***Optional Life Premium*** (last 2 digits dropped)
386	x	4	x	.010	=	15.44	+	.0099	=	15.4499 = 15.44

(Based on FY'02 rates)

Semi-Monthly Optional Life

Basic Life Units x Multiple x Optional Life Rate x (.5) + .0099 = Optional Life Premium (drop last two digits).

Example: Optional Life rates for a 50 year old employee paid semi-monthly with 469 basic life units and 3 times optional life coverage.

Basic Life Units	**x**	**Multiple** (optional life)	**x**	**Optional Life Rate** (use rate chart and member's age)	**x**	**.5**	**=**		**+**	**.0099**	**=**	***Optional Life Premium*** (last 2 digits dropped)
469	x	3	x	.026	x	.5	=	18.291	+	.0099	=	18.3009 = 18.30

(Based on FY'02 rates)

c) AD&D LIFE PREMIUM CALCULATION

Monthly AD&D Basic

Basic Life Units x AD&D Rate + .0099 = Member Paid AD&D Basic Premium (drop last two digits).

Example: AD&D Basic life rates for an employee paid monthly with 277 basic life units.

Basic Life Units	**x**	**AD&D Basic Rate**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped)
277	x	.002	=	.554	+	.0099	=	.5639 = .56

(Based on FY'02 rates)

Semi-Monthly AD&D Life

Basic Life Units x AD&D Rate x (.5) + .0099 = Member Paid AD&D Basic Premium (drop last two digits).

Example: AD&D Basic life rates for an employee paid semi- monthly with 277 basic life units.

Basic Life Units	**x**	**AD&D Basic Rate**	**x**	**.5**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped)
277	x	.002	x	.5	=	.277	+	.0099	=	.2869 = .28

(Based on FY'02 rates)

d) AD&D COMBINED LIFE PREMIUM CALCULATION

Monthly AD&D Combined

Basic Life Units x AD&D Rate + .0099 = Member Paid AD&D Basic Premium (drop last two digits).

Example: AD&D Combined life rates for an employee paid monthly with 499 basic life units and 2 times optional life coverage.

Basic Life Units	**x**	**Multiple + 1** (optional life)	**x**	**AD&D Basic Rate**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped
499	x	3	x	.002	=	2.994	+	.0099	=	3.0039 = 3.00

(Based on FY'02 rates)

Semi-Monthly AD&D Combined

Basic Life Units x AD&D Rate x (.5) + .0099 = Member Paid AD&D Basic Premium (drop last two digits).

Example: AD&D Combined life rates for an employee paid semi-monthly with 499 basic life units and 2 times optional life coverage.

Basic Life Units	**x**	**Multiple + 1** (optional life)	**x**	**AD&D Basic Rate**	**x**	**.5**	**=**		**+**	**.0099**	**=**	***Basic Life Premium*** (last 2 digits dropped)
499	x	3	x	.002	x	.5	=	1.497	+	.0099	=	1.5069 = 1.50

(Based on FY'02 rates)

e) PART-TIME EMPLOYEE HEALTH PREMIUMS

When calculating premiums for members who are paid monthly, use the monthly section of the health rate charts. When calculating premiums for members who are paid semi-monthly, use the semi-monthly section of the health rate charts.

– Members without dependents need only follow the "Member Portion" directions. The total derived by the calculation is the premium the member is responsible for.

– Members with dependents must follow both the "Member Portion" and "Dependent Portion" directions. Both totals must be added together to arrive at the total premium amount.

Basic and Dependent Health

Member Portion

(1) Basic Health Rate* x Part-time percentage + .009 = State Paid Basic Health (drop last two digits).
(2) Basic Health Rate* – State Paid Basic Health = Member Basic Health + Member Portion** = **Total Member Paid Basic**

* **Basic Health Rate –** Amount the state contributes for Member Only coverage for the salary bracket the member is coded. Ex. Member is coded 4M, the amount used would be the amount the state contributes for 4K ($356.46).

** **Member Portion -** Monthly (semi-monthly) amount of the member's contribution. Ex. Member is coded 4M, the premium used would be the monthly Member contribution amount for 4K ($40.00).

Dependent Portion

(1) State Dependent Rate* x Part-time % + .009 = State Dependent Health (drop last two digits)
(2) State Dependent Rate* – State Dependent Health + Dependent Premium** = **Total Member Dependent**

* **State Dependent Rate** = Difference between the State Paid Portion of the dependent premium (either 'L' or 'M') and the member only State Paid premium ('K'). Example: Monthly member is coded D3/4M, the State Paid amount for dependent premiums is $701.00. The member only premium is the amount associated with 4K, which is $356.46. The difference would be $344.54.

** **Dependent Premium** = Difference between the Member Paid Portion of the dependent premium (either 'L' or 'M') and the member only premium ('K'). Example: Monthly member is coded D3/4M, the Member Paid amount for dependent premiums is $199.00. The member only premium is the amount associated with 4K, which is $40.00. The difference would be $159.00.

Member Plus Dependent Portion
Total Member Paid Basic Health + Total Member Dependent = **Total Member Paid Health**
Note: See examples on next page for calculating part-time health premiums.

HEALTH PREMIUM EXAMPLE*: D3/4M for a 75% Part-time employee paid monthly.*

Calculation Part 1 (Member Portion)

Step 1	Basic Health Rate	x	Part-time Percentage	=		+	.009	=	*State Paid Basic Health* (last 2 digits dropped)
	356.46	x	.75 (75%)	=	267.345	+	.009	=	267.3540 = 267.35

Step 2	Basic Health Rate	-	*State Paid Basic Health*	=	*Member Paid Basic Health*	+	Member Portion	=	*Total Member Paid Basic*
	356.46	-	267.35	=	89.11	+	40.00	=	**129.11**

(Based on FY'02 rates)

* **Basic Health Rate –** State Paid amount for member only coverage for the salary bracket the member is coded. Ex. Member is coded 4M, the premium used would be the monthly State Paid amount for 4K ($356.46).

** **Member Portion -** Monthly (semi-monthly) amount of the member's contribution. Ex. Member is coded 4M, the premium used would be the monthly Member contribution amount for 4K ($40.00).

Calculation Part 2 (Dependent Portion)

Step 1	State Dependent Rate *	x	Part-time Percentage	=		+	.009	=	*State Dependent Health* (last 2 digits dropped)
	344.54	x	.75 (75%)	=	258.405	+	.009	=	258.4140 = 258.41

Step 2	State Dependent Rate *	-	*State Dependent Health*	=		+	Dependent Premium **	=	*Total Member Dependent*
	344.54	-	258.41	=	86.13	+	159.00	=	**245.13**

(Based on FY'02 rates)

* **State Dependent Rate** = Difference between the State Paid Portion of the dependent premium (either 'L' or 'M') and the member only State Paid premium ('K'). Example: Monthly member is coded D3/4M, the State Paid amount for dependent premiums is $701.00. The member only premium is the amount associated with 4K, which is $356.46. The difference would be $344.54.

** **Dependent Premium** = Difference between the Member Paid Portion of the dependent premium (either 'L' or 'M') and the member only premium ('K'). Example: Monthly member is coded D3/4M, the Member Paid amount for dependent premiums is $199.00. The member only premium is the amount associated with 4K, which is $40.00. The difference would be $159.00.

Calculation Part 3 (Total Premium)

Total Member Paid Basic (Part 1 total)	+	*Total Member Dependent (Part 2 total)*	=	Total Member Paid Health
129.11	+	245.13	=	**374.24**

(Based on FY'02 rates)

f) PART-TIME EMPLOYEE DENTAL PREMIUMS

When calculating premiums for members who are paid monthly, use the monthly section of the dental rate charts. When calculating premiums for members who are paid semi-monthly, use the semi-monthly section of the dental rate charts.

- Members without dependents need only follow the "Member Portion" directions.

- Members with dependents must follow both the "Member Portion" and "Dependent Portion" directions. Both totals must be added together to arrive at the total premium amount.

Member Portion

(1) Basic Dental Rate* x Part-time % + .009 = State Paid Basic Dental (drop last two digits).
(2) Basic Dental Rate* - State Paid Basic Dental + Member Portion Basic** = **Total Member Paid Basic**

* **Basic Dental Rate** – State Paid amount for member only coverage. Example: Semi-monthly member is coded X1, the premium used would be the State Paid amount for W1 ($4.51).

** **Member Portion Basic -** Monthly (semi-monthly) amount of the member's contribution. Example: Semi-monthly member is coded X1, the premium used would be the Member contribution amount ($6.25).

Dependent Portion

(1) State Dependent Rate* x Part-time % + .009 = State Paid Dependent Dental (drop last two digits).
(2) State Dependent Rate* - State Paid Dependent Dental + Member Dependent Premium** = **Total Dependent Dental**

* **State Dependent Rate** = Difference between the State Portion of the applicable dependent premium (either 'X1' or 'X2') and the member only premium ('W1'). Example: Semi-monthly member is coded D6/X1, the State Paid amount for dependent premiums is $9.74. The member only premium is the amount associated with W1, which is $4.51. The difference would be $5.23.

** **Member Dependent Premium** = Difference between the Member Portion of the applicable dependent premium (either 'X1' or 'X2') and the member only premium ('W1'). Example: Semi-monthly member is coded D6/X1, the Member Paid amount for dependent premiums is $6.25. The member only premium is the amount associated with W1, which is $3.75. The difference would be $2.50.

Member Plus Dependent Portion
Total Member Paid Basic + Total Dependent Dental = Total Member Paid Dental
Note: See examples on next page for calculating part-time dental premiums.

DENTAL PREMIUM EX.: *D6/X1 for a 75% Part-time employee paid semi-monthly.*

Calculation Part 1 (Member Portion)

Step 1	Basic Dental Rate *	x	Part-time Percentage	=		+	.009	=	*State Paid Basic Dental* (last 2 digits dropped)
	4.51	x	.75 (75%)	=	3.3825	+	.009	=	3.3915 = 3.39

Step 2	Basic Dental Rate *	-	*State Paid Basic Dental*	+	Member Portion Basic (not applicable for D7)	=	*Total Member Paid Basic*
	4.51	-	3.39	+	6.25	=	**7.37**

(Based on FY'02 rates)

* **Basic Dental Rate** – State Paid amount for member only coverage. Example: Semi-monthly member is coded X1, the premium used would be the State Paid amount for W1 ($4.51).

** **Member Portion Basic -** Monthly (semi-monthly) amount of the member's contribution. Example: Semi-monthly member is coded X1, the premium used would be the Member contribution amount ($6.25).

Calculation Part 2 (Dependent Portion)

Step 1	State Dependent Rate *	x	Part-time Percentage	=		+	.009	=	*State Paid Dependent Dental* (last 2 digits dropped)
	5.23	x	.75 (75%)	=	3.9225	+	.009	=	3.9315 = 3.93

Step 2	State Dependent Rate *	-	*State Paid Dependent Dental*	+	Member Dependent Premium ** (not applicable for D7)	=	*Total Dependent Dental*
	5.23	-	3.93	+	2.50	=	**3.80**

(Based on FY'02 rates)

* **State Dependent Rate** = Difference between the State Portion of the applicable dependent premium (either 'X1' or 'X2') and the member only premium ('W1'). Example: Semi-monthly member is coded D6/X1, the State Paid amount for dependent premiums is $9.74. The member only premium is the amount associated with W1, which is $4.51. The difference would be $5.23.

****Dependent Premium** = Difference between the Member Portion of the applicable dependent premium (either 'X1' or 'X2') and the member only premium ('W1'). Example: Semi-monthly member is coded D6/X1, the Member Paid amount for dependent premiums is $6.25. The member only premium is the amount associated with W1, which is $3.75. The difference would be $2.50.

Calculation Part 3 (Total Premium)

Total Member Paid Basic (Part 1 total)	+	*Total Dependent Dental (Part 2 total)*	=	**Total Member Paid Dental**
7.37	+	3.80	=	**11.17**

(Based on FY'02 rates)

10.1 Health Coding

A. Estimated Annual Salary

The Estimated Annual Salary (EAS) amount is the employee's base salary as indicated on the April 1st payroll voucher. The Membership System uses the EAS to calculate the employee's monthly contribution for health premiums effective July 1st of the upcoming fiscal year. The EAS also establishes the plan year deductible for employees enrolled in the Quality Care Health Plan (QCHP).

The EAS does **not** include such items as temporary assignment pay, bilingual pay, longevity pay, shift differential, overtime, summer contracts, etc.

CMS reviews each employee's April 1st pay record during the month of June to determine base salary. This base salary is used to update the EAS field on each employee's health plan record effective July 1st. Agencies will receive notification of those employee's whose EAS has been updated in order to ensure the correct deductions are taken for the July payroll.

The July 1st EAS will remain in effect the entire fiscal year unless one of the following occurs:

- the employee retires,
- the employee accepts a voluntary salary reduction, or
- the employee terminates State employment for a period of 10 days or more, then returns to State employment at a different salary (does not include employees who have been terminated while on a leave of absence).

If any of the three events listed above occurs after April 1st, the employee's EAS should be manually adjusted by the GIR/P to reflect the new salary. ***Note:*** For new members, the base salary at the time of hire determines EAS.

The example below indicates the Estimated Annual Salary on the Member Health screen on the Membership System.

```
PERMGAMR      DCMS - GROUP INSURANCE DIV - MEMBERSHIP SYSTEM      04/11/2002
PEOGAMI __                  MEMBER PLAN                    16:00:48

SSN: 333 44 5555                    TRAN (BEGIN) 04 08 2002        (END) 99 99 9999
GROUP: STATE            PLAN: HEALTH
NAME:(LAST) BONADUCCI          (FIRST) KAREN        (MIDDLE) JO
ACTIVE/TERM(A/T):  A       (EFDT) 04 08 2002
TERM/WAIVE REASON:                                    PRE-EXISTING MONTHS
CARRIER CODE: AH HEALTH ALLIANCE HMO    (BEGIN) 04 08 2002     (END) 99 99 9999
CARRIER CHNG REASON:    ** NOT FOUND **   PCP/PCD#: 111111         NO COB EXISTS
                                                                   GO TO COB (Y/N): _

EST ANNUAL SAL:  32599         (EFDT) 04 08 2002         CHNG REASON:

PF1-HELP  PF3-INQ MENU  PF4-GI MENU  PF7-NEWER  PF8-OLDER   PROC DT: 04 11 2002
```

B. Health Codes

The health plan coding structure consists of two codes, the health carrier code and the health deduct code. The carrier code is a two-digit code (e.g., AH) assigned to each health carrier. The health deduct code is an alpha-numeric two-digit code (e.g., 2K).

The health carrier code represents which health carrier the member has elected. For example, the code 'D3' represents the Quality Care Health Plan. (A complete list of carrier codes may be found in the current plan year's Benefit Choice Options booklet).

A member's health deduct code (e.g., 2K) is based upon 1) Estimated Annual Salary (EAS), 2) number of dependents, 3) Medicare status, and 4) member type (active or retired).

Together, the health carrier code and health deduct code determine the member contribution for each pay period. ***Note:*** There is an additional premium for dependent health. The GIR/P may derive the exact premium amount for which the member will be responsible by using either the current plan year's rate charts, or the Deduction Calculation Screen (5C) on the Membership System.

The highlighted area on the Membership System screen print below illustrates the health coding structure, as well as the costs associated with that code.

GROUP: STATE KAREN BONADUCCI BIRTHDATE: 04-01-1965
SSN: 333 44 5555 123 S. MAIN STREET AS OF AGE: 37 SEX: F
TEMP SSN: N CAHOKIA, IL 62206 1019 MARITAL STATUS: MARRIED

AGENCY: CENTRAL MANAGEMENT SERVICES

TYPE ENROLLEE: 1001 EMPLOYEE FULL TIME PT%:

MONTHLY COST AS OF 04 01 2002 ANNUAL

COVERAGE	CARRIER	MEMBER	DEPENDENT	TOTAL	COST
HLTH-AH-2M	HEALTH ALLIANCE HMO	28.00	99.00	127.00	1524.00
DNTL-D6-X2	QUALITY CARE DENTAL	7.50	7.50	15.00	180.00
LIFE-C9-P0	STATE LIFE INSUR.	0.00	3.66	3.66	43.92
VISN-VS-	VISION SERVICE PLAN	0.00	0.00	0.00	0.00
TOTAL MEMBER COST:		35.50	10.16	145.66	1747.92

PF1-HELP PF2-LIFE-COVERAGE PF3-INQ-MENU PF4-GI-MENU

The example below illustrates how to determine the health deduct code for a member by using the charts below and on the next page.

Example: An employee has an EAS of $29,722 and three non-Medicare dependents. Using the charts below, the annual salary $29,722 equates to the first digit of the code which would be ‘2’. This indicates the employee’s EAS is in the ‘2’ salary range. The second digit of the code indicates the type of coverage which would be an ‘M’ since the person is an active (non-retiree) member with two or more non-Medicare dependents.

The ‘2M’ health deduct code equates to a member monthly salary-based contribution of $35.00 if enrolled in the QCHP, or $28.00 if enrolled in a managed care plan. Dependent health has an additional premium.

Health Deduct Code	Employee Annual Salary	QCHP Monthly Employee Contribution	Managed Care / QCHP W/No Access Monthly Employee Contribution
1	$26, 300 or less	$30.00	$23.00
2	$26,301 - $39, 600	$35.00	$28.00
3	$39, 601 - $52, 700	$37.50	$30.50
4	$52, 701 - $66,000	$40.00	$33.00
5	$66, 001 and over	$42.50	$35.50
6	Retiree	$0	$0

Chart is based on FY’02 information; Salary ranges are adjusted each year by the Consumer Price Index.

Type of Coverage	Retiree Non-Med	Retiree Medicare	Non-Retiree (Active Member)	Retirees on or after 1/1/98 *	
				Non-Med	Medicare
Member Only	A	F	K	1	6
Member + 1 non-Medicare Dep	B	G	L	2	7
Member + 2 or more non-Med. Dep	C	H	M	3	8
Member + 1 Medicare Dep	D	I	N	4	9
Member + 2 or more Medicare Dep	E	J	O	5	0

* Or may be a TRS retiree on or after 7/1/98 (enrolled in the State Group Plan)

10.2 Dental Coding

The dental plan coding structure consists of two parts, carrier code and deduct code, each consisting of two alpha-numeric characters. The first two-digit code (e.g., D6) identifies the member's dental plan. The second two-digit code (e.g., X2), identifies whether the member is enrolled in member only coverage or includes dependent coverage. Together, these two codes determine the member's dental contribution, as well as coding for payroll.

A. Dental Plan Coding

The state offers two dental options, an indemnity plan and the option not to participate in the dental plan.

- The indemnity plan is called the **Quality Care Dental Plan (QCDP)** which has a carrier code of **D6**.
- Employees who **elect not to participate in the dental plan** must be coded on the Membership System with the carrier code **DD** (see section 10.5, 'No Dental Option Coding' for appropriate payroll codes).

Note: Effective July 1, 2004, the **Managed Care Dental Plan (MCDP)**, carrier code D7, is no longer offered.

Dental Accessibility: Prior to July 1, 2004, employees enrolled in the Quality Care Dental Plan (QCDP) were deemed accessible or non-accessible to a managed care dental provider depending on their residence. Employees enrolled in the QCDP who had access to a managed care plan were required to pay a premium for their dental coverage whereas an employee who did not have access was not charged the premium. Accessibility did not apply to retirees, annuitants, or survivors.

***Accessible Employees*:** All Illinois residents and some residents of bordering states were considered to **have access** to a managed care dental provider.

Non-Accessible Employees: Employees who lived in a state surrounding Illinois who were determined by the dental plan administrator **not to have access** to a managed care dental provider.

B. Category Coding

As indicated in the chart below, there are six dental deduct codes that describe the type of coverage in which the member, and applicable dependents, are enrolled (i.e., dental plan, number of dependents covered). These deduction codes are automatically derived and populated on the Membership System based upon the type enrollee code of the member and the number of dependents the member has enrolled in the Group Insurance Program.

Quality Care Dental (D6)		**Quality Care Dental (D6) - *Retirees/Survivors***	
W1	Member Only	S1	Member Only
X1	Member Plus 1 Dependent	T1	Member Plus 1 Dependent
X2	Member Plus 2 or more Dependents	T2	Member Plus 2 or more Dependents

- ***The first digit*** of the dental deduct code (i.e., W, X, S or T), is an alpha character which indicates whether the member is an active employee or retiree/survivor enrolled in the Quality Care Dental Plan.
  - **'W' or 'X' applies to:** Employees enrolled in the *Quality Care Dental Plan*
  - **'S' or 'T' applies to:** Retirees/Survivors enrolled in the *Quality Care Dental Plan*
- ***The second digit*** of the dental deduct code (i.e., 1 or 2), is a numeric character and indicates the number of enrolled dependents (i.e., member only, member +1, or member +2 or more).

The highlighted area on the Membership System screen print below illustrates the dental coding structure, as well as the costs associated with that code.

```
GROUP: STATE          KAREN BONADUCCI                BIRTHDATE: 04-01-1965
SSN: 333 44 5555      123 S. MAIN STREET             AS OF AGE:  37   SEX: F
TEMP SSN: N           CAHOKIA, IL 62206 1019         MARITAL STATUS: MARRIED

AGENCY: CENTRAL MANAGEMENT SERVICES

TYPE ENROLLEE: 1001        EMPLOYEE        FULL TIME        PT%:

                                   MONTHLY COST AS OF 04 01 2002    ANNUAL
COVERAGE       CARRIER                  MEMBER     DEPENDENT    TOTAL     COST
HLTH-AH-2M     HEALTH ALLIANCE HMO      28.00      99.00        127.00    1524.00
DNTL-D6-X2     QUALITY CARE DENTAL       7.50       7.50         15.00     180.00
LIFE-C9-P0     STATE LIFE INSUR.         0.00       3.66          3.66      43.92
VISN-VS-       VISION SERVICE PLAN       0.00       0.00          0.00       0.00

      TOTAL MEMBER COST:                35.50      10.16        145.66    1747.92
PF1-HELP  PF2-LIFE-COVERAGE  PF3-INQ-MENU     PF4-GI-MENU
```

Examples:

D6/X2 represents a member with Quality Care Dental who has coverage for two or more dependents.

'##' represents a member who has elected not to participate in the dental plan or has their dental coverage terminated.

D6/S1 represents a retiree or survivor with Quality Care Dental and no dependent coverage.

D6/W1 represents a member with Quality Care Dental and no dependent coverage.

10.3 Life Coding

A. Basic Life Units (BLU)

Basic life units (BLU) represent the annual basic salary of both full-time and part-time members. Each BLU represents $100 worth of Basic Life coverage. BLUs of part-time members must reflect the current gross pay - *not what the salary would be if the member were full-time*.

BLUs determine member Optional Life premium and AD&D premium for full-time and part-time members. Additionally, BLUs are used to determine a member's accelerated benefit and death benefit.

BLUs are also used to determine a member's Estimated Annual Salary (see "Health Coding - Estimated Annual Salary" in this section).

BLUs may be found on the 'Member Life Plan' screen on the Membership System.

1. **Calculating BLU's:** When calculating BLUs, the GIR/P must multiply the current monthly salary by the number of months worked* in a 12-month period to determine the annual base salary. The annual base salary is then divided by 100 and rounded up to the next whole number (do not include, temporary pay, bilingual pay, overtime pay, shift differential, summer contracts, longevity, etc.).

* Number of months worked includes months the member was on leave of absence, with the exception of a seasonal leave of absence or a summer break period.

Special Note on University Employees:

- If the member is a university employee paid over 12 months, calculate the annual base salary by multiplying the monthly salary by 12.

- If the university employee is paid over 9 months, calculate the annual base salary by multiplying the monthly salary by 9. (Summer break periods are **not** included in the number of months when calculating the annual base salary.)

- If the university employee is contracted to work over the summer break period, do **not** use the salary earned for these months when calculating the annual base salary.

step 1: Monthly Salary x months worked = Annual Base Salary
step 2: Annual Base Salary ÷ 100 = BLU
step 3: Round up to next whole number

Examples:
A full-time (regular state or non-academic year university) member working 12 months at $2436/month would have 293 basic life units (e.g., administrative staff, year-around groundskeeper):

step 1: 2436 x 12 = 29,232
step 2: 29,232 ÷ 100 = 292.32
step 3: **293**

A part-time (regular state or non-academic year university) member working 12 months at $1918/month would have 231 basic life units (e.g., groundskeeper working 5 ½ hours per day):

step 1: 1918 x 12 = 23,016
step 2: 23,016 ÷ 100 = 230.16
step 3: **231**

A full-time (academic year university) member paid over 12 months with a monthly salary of $2436 would have 293 basic life units (e.g., faculty, food service):

step 1: 2436 x 12 = 29,232
step 2: 29,232 ÷ 100 = 292.32
step 3: **293**

A full-time (academic year university) member paid over 9 months with a monthly salary of $2436 would have 220 basic life units (e.g., faculty, food service):

step 1: 2436 x 9 = 21,924
step 2: 21,924 ÷ 100 = 219.24
step 3: **220**

A part-time (academic year university) member working 9 months at $1918/month would have 173 basic life units (e.g., food service working 5 ½ hours per day):

step 1: 1918 x 9 = 17,262
step 2: 17,262 ÷ 100 = 172.62
step 3: **173**

2. **Retired Members** who are**:**
   - **under 60** years of age keep the same BLUs as of the last pay period of when they were actively employed.
   - **60 years and over** will have BLUs reduced to 0050 (which is $5000 of Basic Life coverage).

3. **Automatic Update of Basic Life Units:** Agency and university payroll files are received by CMS on a weekly basis. The basic life unit field on the Membership System is automatically updated based on the pay records loaded for the week. The effective date of the updated units will be the first day of the pay period.

4. **Basic Life Unit Maintenance:** Unlike the Estimated Annual Salary (EAS), basic life units must be updated on payroll whenever a member's base salary goes up <u>or</u> down. If the basic life unit field is left blank on payroll, the basic life units field will default to 0050 on the payroll record and the Membership System.

   - ♦ The BLUs of members off payroll (i.e., on a leave of absence, in a dock/suspension status, etc.) must not be changed until the member returns to payroll.
   - ♦ GIR/Ps must not retroactively adjust BLUs due to retroactive changes in salary, such as late filing of annual increases or union negotiated changes. Agencies are required, however, to adjust BLUs when there has been an error on the number of BLUs reported.
   - ♦ Although salary may be reduced by dock time, the member's BLUs must remain the same.

5. **Member Employed by Two State Agencies/Universities:** Occasionally a member is employed by two state entities. When this occurs, special procedures must be followed. See "Member Employed by Two State Agencies/Universities" in section 7 for details.

6. **Members Opting Out of Health/Dental/Vision:** Members who elect to opt out of health, dental, and vision coverage must continue enrollment in Basic Life. These members must be coded 'R' on payroll for 'life only' (or the code used on payroll by the agency that denotes life only coverage).

B. Life Deduct Code

The life plan coding structure consists of two parts, carrier code and deduct code, each consisting of two characters. The carrier code is the alpha-numeric code 'C9', which identifies the life plan. The life deduct code is based upon the member's optional life elections. These factors determine a member's life contribution amount, as well as payroll coding.

- ***The first digit*** of the life deduct code (i.e., 'A' – 'X') indicates the types of life coverage elected (member Optional Life, Spouse Life, Child Life, etc.).

- ***The second digit*** of the life deduct code indicates the member Optional Life elected (i.e., 0 - 8).

The chart below lists either an '*' or a '0' as the second digit of the code.

An '*' indicates the member has elected Optional Life coverage of 1 - 8 times the annual salary. The first digit of the deduct code for members electing member Optional Life coverage is a letter 'A' through 'M'.

A '0' indicates the member has zero times member Optional Life coverage (i.e., no Optional Life). The first digit of the deduct code for members electing no Optional Life coverage is a letter from 'N' through 'X'.

OPTIONAL LIFE MATRIX

Member Optional Life	X	X	X	X	X	X	X	X	X	X	X	X								
Dependent Life - Spouse		X	X	X	X	X	X						X	X	X	X				
Dependent Life - Children			X	X	X			X	X	X				X	X		X	X		
AD & D - Basic				X		X			X		X				X	X		X	X	
AD & D – Combined					X		X			X		X								
Life Deduct Code for Payroll	**A***	**B***	**C***	**D***	**E***	**F***	**G***	**H***	**J***	**K***	**L***	**M***	**N0**	**P0**	**R0**	**S0**	**T0**	**W0**	**X0**	**O0**

'*' indicates 1 - 8 times of Member Optional Life

The matrix above outlines the optional life coding structure for payroll.

The highlighted area on the Membership System screen 5 printed below illustrates the life coding structure, as well as the costs associated with that code.

GROUP: STATE KAREN BONADUCCI BIRTHDATE: 04-01-1965
SSN: 333 44 5555 123 S. MAIN STREET AS OF AGE: 37 SEX: F
TEMP SSN: N CAHOKIA, IL 62206 1019 MARITAL STATUS: MARRIED

AGENCY: CENTRAL MANAGEMENT SERVICES

TYPE ENROLLEE: 1001 EMPLOYEE FULL TIME PT%:

MONTHLY COST AS OF 04 01 2002 ANNUAL

COVERAGE	CARRIER	MEMBER	DEPENDENT	TOTAL	COST
HLTH-AH-2M	HEALTH ALLIANCE HMO	28.00	99.00	127.00	1524.00
DNTL-D6-X2	QUALITY CARE DENTAL	7.50	7.50	15.00	180.00
LIFE-C9-P0	STATE LIFE INSUR.	0.00	3.66	3.66	43.92
VISN-VS-	VISION SERVICE PLAN	0.00	0.00	0.00	0.00
TOTAL MEMBER COST:		35.50	10.16	145.66	1747.92

PF1-HELP PF2-LIFE-COVERAGE PF3-INQ-MENU PF4-GI-MENU

Examples:
C9/A4 represents a member with four times member Optional Life (also includes Basic Life).

C9/G3 represents a member with three times member Optional Life, Spouse Life, and AD&D Combined (also includes Basic Life).

C9/R0 represents a member with Spouse Life, Child Life, and AD&D Basic (also includes Basic Life).

C9/O0 represents a member with Basic Life coverage only.

10.4 Opt Out Coding

Members who elect to opt out of health/dental/vision coverage must be correctly coded on the Membership and Payroll systems. The GIR/P must code the member on the Membership System with the appropriate type enrollee code (see chart A for Membership codes; see Section 12 for opt out processing instructions). The GIR/P must also inform their agency's payroll department of the correct opt out coding (see chart B for Payroll codes) for the member's payroll file. Correct coding will ensure health and dental premiums are not deducted from the member's payroll check and that records loading into GIFCS will not have coding discrepancies. ***Note:*** See section 10.5, 'No Dental Option Coding' to determine the correct coding structure for members who elect not to participate in the dental plan, but continue to participate in the health and vision plans.

Chart A: The following codes are used on the Membership System for members who have elected to Opt Out:

Membership Type/Subtype Codes		Membership Reason Codes		Membership Leave Codes For Opt Out Members	
1051	Opt Out code for active members	**34**	Opt Out with life only coverage	**6051**	Non-Occupational Disability With Retirement Benefits (FT)
				6052	Non-Occupational Disability No Retirement Benefits (FT)
1053	Opt Out code for public officials	**33**	Opt Out with no life coverage	**6053**	Occupational Disability (FT) *(Workers' Compensation)*
				6056	Educational/Sabbatical (FT)
				6058	Permanent Layoff w/State Paid
				6059	Personal Leave (FT)
1056	Opt Out code for U of I Foundation members (Urbana only)			**6060**	Family Responsibility Leave (FMLA) (FT)
				6061	Dock/Suspension <= 30 Days (FT)
				6062	Dock/Suspension > 30 Days (FT)
8008	Termination code for members enrolled with life coverage who had opted out prior to terminating employment			**6064**	FMLA RTW Part-time Direct Pay (FT)
				6068	Furlough *(ISD, ISVI only)*
				6069	Military Call up – Payroll
				6070	Military Call up – Direct Pay
8033	Termination code for members who either are not eligible for life coverage or waived life coverage and are electing to opt out of health and dental (only applies to certain survivors and retiree codes)			**6071**	Occupational Disability – Previously Part-time
				6072	University Paid Academic Yr Break *(SIU-C only)*
				6073	Univ. FT Faculty and "Academic Yr" Non-Faculty Annual Break *(Universities only)*
				6089	Military Leave Opt Out

Chart B: Payroll must code members who Opt Out:

Plan	Payroll Carrier Code	Payroll Deduct Code	Eligibility Code
Health	NH	00	'R' – Life Only * * Or the code used by the agency payroll system to denote life-only coverage
Dental	ND	00	
Vision	(do not need to code as there is no payroll code for vision)	(do not need to code as there is no payroll code for vision)	
Life	C9 (full-time members must be coded with at least basic life)	Use Life Chart to determine applicable deduct code (see Appendix F, page 3)	

10.5 No Dental Option Coding

Members who elect not to participate in the dental plan must be correctly coded on the Membership and Payroll systems. The GIR/P must code the member on the Membership System with the dental carrier code 'DD'. The GIR/P must inform the agency's payroll department of the correct coding for the member's payroll file (see chart below). Correct coding will ensure dental premiums are not deducted from the member's payroll check and that records loading into GIFCS will not have coding discrepancies.

Payroll must code members who elect not to participate in the dental plan:

Plan	Membership Carrier Code	Payroll Carrier Code	Payroll Deduct Code
Dental	DD	ND	O0 (alpha, numeric)

11.0 Group Insurance System

A. General Information

The Group Insurance Division (GID) has three main databases that allow the Group Insurance Representative and/or Preparer (GIR/P) to do a variety of insurance related transactions. The databases include the Membership System, the Group Insurance Financial Control System (GIFCS) and the Flexible Spending Accounts (FSA) System. All three systems are accessible through the online system's main menu.

Transactions GIR/P's may process on the Membership System include:

- add new member/dependent;
- inquire and/or change member/dependent coverage and biographical information;
- view a list of Group Insurance Representatives and Preparers, which includes the GIR/P's agency, organizational processing codes, phone numbers, and addresses;
- retrieve system messages regarding policy, system changes and updates; and
- print forms and other insurance related information;
- calculate member premium using the "what if" Membership screens.

Transactions GIR/P's may process on GIFCS include:

- request premium refunds;
- correct payroll code discrepancies;
- transfer member-paid premium; and
- research premium discrepancies.

Transactions GIR/P's may process on the FSA System include:

- determine eligibility start/end dates and payroll deduction amounts;
- view deposit history;
- research payroll discrepancies.

B. Requesting System Access

A written request must be provided to GID to 1) establish a mailing address and security clearance for new GIRs and GIP's, 2) remove a person as a GIR/P from the database, or 3) change work information for an existing GIR/P (such as address, phone number, email address, etc.). The Benefits Systems Division has developed an "Agency Organizational Processing Code File Set-Up Form" (CMS-139) for this purpose. (See Appendix C, 'Agency Completed Forms' for a sample of the CMS-139.) The form should be completed by the GIR and sent to the Benefits Systems Division at the address indicated on the form.

The GIR/P must request which systems (Membership, GIFCS and/or FSA) they will need to access. The Benefits Systems Division will set-up the GIR/P for the requested system access, if approved. The Benefits Systems Division will then contact the Program Liaisons and/or the Analysis and Resolution Unit to inform them of the need for training. At that time, the staff will contact the GIR/P directly and schedule training on the requested system(s).

In order to access the Group Insurance Division systems, a new GIR/P must do the following:

1. Contact the CMS Benefits Systems Division to request an "Agency Organizational Processing Code File Set-Up Form" (CMS-139), or copy the form in the 'Agency Completed Forms' Appendix C.

2. Complete the required information on the form and return to the Benefits Systems Division.

3. Successfully complete Membership and/or GIFCS training. Upon completion of training, access to the Group Insurance System will be granted.

C. GIP Leaving Agency

If a GIP is leaving your agency and is not being replaced, the "Number of Active Members by Organizational Processing Code" option may be used to determine how many members are on the Membership System under the org proc code of the person leaving. Each member's record will need to be updated with a new org proc code. If there are a significant number of members under the code of the person leaving (approximately 20 or more), CMS can mass update the member records for you. You will need to notify the Benefits Systems Division to terminate the org proc code of the person leaving and designate the new org proc code and effective date for the members whose records need to be updated. If there are only a few members whose code needs to be updated, the agency should process the update. Once GID has terminated the org proc code, a report will be sent to the agency listing the members whose records need to be updated.

D. Accessing the System

To maintain system security, GIR/P's are assigned a user RACF ID and an Organizational Processing Code (org proc code).

1. **System Identification Codes**

   a. **RACF ID #** (e.g., pergi99): GIR/P's are assigned a RACF ID for use when signing onto the Group Insurance System. If the GIR/P does not have a RACF ID, the agency system administrator, or Benefits Systems Division, should be contacted.

   The GIR/P **must have approved access** from CMS in order to log onto the Membership and GIFCS Systems. Both systems will display the RACF ID's on each transaction processed.

   b. **Organizational Processing Code** (e.g., 416-000-005): A nine-digit org proc code is assigned to new GIR/P's by the Benefits Systems Division. ***Group Insurance Representatives*** have access to all employees within the agency. ***Group Insurance Preparers*** access may be limited to a certain group of employees within the agency per the Group Insurance Representative's request.

   The org proc code consists of three sets of three-digit codes described below:

   - The first set of digits is the **CUSAS code** which identifies the agency. In the example 416-000-005, the cusas code is '416' (i.e., CMS).

   - The second set of digits is the **facility code** which represents a specific facility within an agency. For example, the Department of Transportation, may have 15 facilities in various locations throughout the state. Each facility will be assigned a unique facility number (e.g., 494-001: Highway Div. District 1, 494-002: Highway Div. District 2, etc.); however, all facilities would have the same CUSAS code (e.g., 494 for the Department of Transportation). ***Note:*** The second set of digits in the org proc code will be zeros if the agency does not have separate facilities.

   - The final set of digits **identifies the Group Insurance Representative and/or Group Insurance Preparer**. In the example 416-000-005, the GIP's identification code is '005'. GIR's have an identification code of '000'. In general, there should be only one GIR per agency.

2. **System Logon Procedure**

   a. **Logging on the Group Insurance System:** The following are instructions for logging on the Group Insurance System:

   - Connect with the State of Illinois Central Computer Facility.

   - The message "**TERMINAL *XXXXNNNN* ACTIVE WAITING FOR LOGON**" will appear at the top of the screen.

   - Key in the following: **IMS_**
     - Fill the blank in with the system identifier associated with your installation. This will be either an A, K, or H.

   - Press the **ENTER** key. The following message will be displayed:
     - "***DFS3650I* SESSION STATUS FOR IMS IMS_**"
     - (The blank will be filled in with the system identifier)

   - Key the following: **/FOR SIGNRACF**

   - Press the **ENTER** key. The following message will be displayed:

     IMS/VS RACF SIGN ON SCREEN

     USERID ====> (RACF ID)
     PASSWORD ====>

   - Key the RACF ID and password.

   - Press the **ENTER** key. If the RACF ID and password clear security, the following message will be displayed:

     ***DFS3650I* SESSION STATUS FOR IMS IMS_** (System identifier – A, K, or H)

   - Key the following: **/FOR PEOGI0M**

   - Press the **ENTER** key. The Group Insurance Main Menu will be displayed.

b. **Log Off Procedure**

- Return to the Group Insurance Main Menu.
- Key a '6' in the **OPTION** field to select exit.
- Press the **ENTER** key. The screen will display the following:

  PRESS ENTER TO EXIT SYSTEM

- Press the ENTER key. The screen will display the following:

  TERMINAL *XXXXNNNN* ACTIVE WAITING FOR LOGON

c. **Changing the Password:** The command to change a RACF password is as follows:

- Press the '**CLEAR' or 'PAUSE/BREAK'** key**.**
- Key the following: **/FOR SIGNCPWD**
- Key in the RACF ID, old password, and new password.
- Press the **ENTER** key. The following message will appear:

  PLEASE RE-ENTER NEW PASSWORD:

- Re-enter the password. Press the **ENTER** key. The user will be returned to the signon delete screen.

d. **Revoked Password:** If the user does not log onto the system within 30 days, the RACF ID will be revoked based upon lack of usage. Attempting to log on with an incorrect or expired password more than three (3) times will also revoke the RACF ID. If the RACF ID has been revoked, the user must contact their agency technical support person.

e. **Other Password Information:** When assigning a password, keep the following in mind:

- The password will automatically expire every 35 days.
- The system will prompt you to change your password when it has expired.
- You may change your password more frequently than every 35 days (reference above).
- The password can be 6 to 11 characters consisting of any combinations of letters and numbers.
- The last twelve (12) passwords are remembered by RACF and cannot be reused.
- Avoid using passwords easily identifiable such as kids names, birth date, etc.

E. Main Menu Options

Once logged on the Group Insurance System, the main menu is displayed. The options available to the GIR/P from the main menu are the: Membership System, Group Insurance Financial Control System (GIFCS), Group Insurance Division (GID) Notices, Insurance Representative Listing and Flexible Spending System. (Option 2 - "BSD Support Systems" is not available to GIR/P's).

Below is a brief description of each option:

1. **Membership System:** The Membership System is a database which stores all insurance related member and dependent information. Member premium can be easily calculated by using the "What If" Deduction Calculation screen of this system. (See section 11.1, "Membership System" for details regarding use of this system.)

   GIR/P's will be given one of the following levels of access to the Membership System, as determined by their agency:

   - *Full online update capability* allows GIR/P's to process new member/dependent enrollments, as well as, process change requests.
   - *Limited online update capability* allows GIR/P's to process certain changes to member enrollment information, such as changes in marital status, address changes, PT% changes, type enrollee changes, and organizational processing code changes.
   - *Inquiry only access* allows GIR/P's to view member enrollment information only and does not allow the GIR/P to process transactions. The GIR/P must send copies of Change, Correction, or Enrollment forms to the Membership Unit for processing.

2. **BSD Support Systems:** This option is for CMS internal use only.

3. **Group Insurance Financial Control System (GIFCS):** The Group Insurance Financial Control System (GIFCS) is a database that compares payroll coding and deductions against Membership liability. Discrepancies are located and corrected using this system. See the GIFCS section of the manual for details regarding use of this system.

4. **Group Insurance Division (GID) Notices:** The Group Insurance Division periodically sends GIR/P's insurance related messages via the Online System. The date of the latest message is displayed on the main menu. All messages are retained on the system and may be viewed at any time. (See 'GID Notices' in this section for step-by-step instructions for using this option.)

5. **Insurance Representative Listing:** All State agency and university GIR/P information (i.e., name, facility, org proc code, phone number, etc.) may be located using the "Insurance Representative Listing". (See 'Insurance Representative Listing' in this section for step-by-step instructions for using this option.)

6. **Flexible Spending System:** The Flexible Spending System is a database that stores all MCAP and DCAP related information. All GIR/Ps are given Inquiry Only access to the system. Full Online Update and Limited Online Update capabilities will be given to GIR/Ps at a future time. Each access level is described below:

   - *Full Online Update capability:* This access level will allow GIR/Ps to process new member enrollments, as well as process change in status requests.

   - *Limited Online Update capability:* This access level will allow GIR/Ps to process Benefit Choice enrollments, as well as mid-year enrollments, pay code and organizational code changes.

   - *Inquiry Only:* This access level allows GIR/Ps to view participant enrollment and account information only and does not allow the GIR/P to process transactions.

7. **Exit – Enter "X" in Option to Exit System:** GIR/Ps must enter an "X" in the "Option" field to exit the system.

11.1 Membership System

A. Membership Access

In order to obtain Membership System access the GIR/P must complete a training class. See 'Requesting System Access' in this section for instructions on receiving system training.

B. Membership Screens

The Membership System database is comprised of the following four main components for each member and dependent. A description of each is outlined below:

- **Biographical:** The Biographical screen contains pertinent member information. Information such as name, sex, birthdate, Social Security Number, and Medicare status.

- **Group:** The Group screen contains information pertinent to the group in which a member is enrolled (i.e., State, CIP, TRIP, LGHP). (Not all groups have the same coverage or rules.) Information such as type enrollee code, part-time percentage, deduction frequency, work county, org proc code, qualifying change reason, etc., are located on this screen.

- **Plan:** The Plan screens indicate the health, dental, life, and vision coverage elections of the member.

- **Address:** Two address records may be maintained for each person enrolled: a residential address record and an 'Other' address record. The 'Other' address record is used to document custodial parent, legal guardian, power of attorney, or trustee information. A member may designate that mail be sent to one or both addresses on file.

C. Membership Inquiry Menu

GIR/P's have access to Membership screens 1 through 12. Screen 13 is available for GID use only. Screen 9 ('View Messages') is not available. A description of each menu option is indicated below:

Membership Inquiry Screens

1	Name/SSN Cross Reference	This option may be used to locate the SSN of either a member or a dependent. The GIR/P need only type the last name and first name (if known) of the desired member and press ENTER. The search automatically defaults to locate a member's SSN. In order to locate a dependent's SSN, the GIR/P should type the desired name, enter an 'X' in the 'DEPENDENT' field, and press ENTER. The dependent's SSN will appear next to the member's SSN.
2	Member Current Profile	This option is used to display the member's name, address, birth date, age, sex, marital status, group enrolled, SSN, agency, GIR name and phone number, county, dental accessibility, type enrollee status, part-time percentage, effective date of type enrollee, and coverage elections specified by carrier name and effective date, as well as number of active dependents covered by the plan.
3	Member Type Enrollee	This option is used to display in chronological order, the changes in type enrollee status. Other information on this screen includes the member's name, address, birth date, age, marital status, group enrolled, SSN, agency, part-time percentage, and effective date of coverage.
4A	Current Medicare Status	This option is used to display the current Medicare status of the member and their enrolled dependents according to information entered on the Membership System. The screen also includes the effective date of coverage, member/dependent name, SSN, birth date, Medicare number and age.
4B	Detail Medicare Status	This option is used to display the Medicare status of the selected member or dependent. This screen displays the member/ dependent SSN, name, birth date, age, group enrolled, coverage effective date, begin and end dates of Medicare Part A and B. There is also an indicator to reflect whether the member/ dependent has free Medicare Part A. The lower portion of the screen displays whether Medicare or the member/dependent's employer (the State) is Primary payer for Parts A and B, the effective dates of the Primary payer status, and whether or not Part B is reduced. See Medicare Reduced section of the 2004 Member Handbook page 82. In order to view a dependent's information, the dependent must be selected from screen 4A by entering a 'S' in the 'SEL' field.

Membership Inquiry Screens (cont')

5A	Benefit Statement - Summary	This option is used to display the member's coverage elections and the calculated monthly and annual premium for the elected coverage. The screen also displays member name, address, group enrolled, SSN, birth date, age, sex, marital status, agency, type enrollee status, part-time percentage. The GIR/P may enter either a past or future date in the 'Monthly Cost As of XX XX XXXX' field to view the cost of coverage for the date entered.
5B	Benefit Statement – Life Summary	This option is used to display the member's life coverage elections in detail. The screen also displays member name, address, group enrolled, SSN, birth date, age, sex, marital status, agency, type enrollee status, part-time percentage, and monthly cost of member and dependent life coverage. The 'Life Insurance Benefits Based on Information As of XX XX XXXX' field may be typed over by the GIR/P with either a past or future date to view the cost of life coverage for the date entered.
5C	Deduction Calculation ("What If" screens)	This option may be used to calculate various full and part-time insurance cost scenarios. This screen is also referred to as the 'What If' screen. The GIR/P may use this screen for a current employee by entering the employee's SSN and altering the fields, or the GIR/P may leave the SSN field blank for a new employee not yet on the Membership System. The GIR/P must enter information in each field, with the exception of the PT% field, which does not need completed for full-time employees. ***Note:*** The 'ACCS' field indicates dental accessibility and automatically defaults to 'Y', as all members are considered to have access to a dental provider. Past or future calculation dates may be entered in the 'Calc Date' field. ***Note:*** If a member is currently terminated and you want to calculate a deduction for the person, leave the SSN field blank, enter the appropriate carrier codes, BLUs, etc. and press ENTER.
6	Dependent Benefit Statement	This option displays the coverage elections for each dependent. Also displayed is the member's name, SSN, group enrolled, dependent's name, SSN, birth date, age, sex, and dependent's relationship to the member.
7	COBRA Member Information	Not accessible to GIR/P's.
8A	Coverage Summary	This option is used to display the member and dependent's name, SSN, birth date, age, sex, dependent's relationship to member, and effective date of coverage. From this screen the GIR/P may enter an 'X' in any of the 'Plan' fields to list either all plans or specific health, dental, life, or vision carrier information. A 'C' may be entered in the 'SEL' field to display 'Carrier History' (8B). Or, the GIR/P may enter a 'R' in the 'SEL' field to view 'Relationship and Recertification History' (8C).

Membership Inquiry Screens (cont')

8B	Carrier History	This option is used to display a history of the carriers in which a member or dependent has been enrolled. Also displayed are the member/dependent's name, SSN, group enrolled, plan name, coverage effective dates, and whether or not there is a COB listed on the Membership System for the member/dependent.
8C	Dependent Relation/Recert	This option is used to display both the dependent's relationship to the member and the recertification type and effective date. Also included on this screen is the member and dependent's name, SSN, dependent birth date, age, sex, coverage begin and end dates, as well as relationship begin and end dates.
9	View Messages	Not currently being utilized.
10	GIFCS Menu	This option will transfer the GIR/P to the GIFCS menu.
11	Detail Information	This option provides a historical view of changes to member or dependent group, plan, address, or biographical information. This screen displays the date transactions were processed on the system, who processed the transaction, and the effective dates of each information change. This screen uses the "smart-user" function which allows the GIR/P to press the HOME key and the smart-user code designated for the requested screen (e.g., to access the Member Group screen, the GIR/P should enter MG and press ENTER. Smart User codes begin with either an 'M' for member or a 'D' for Dependent.) The *'Biography'* (*smartuser: MB or DB*) screen indicates the member/ dependent's name, SSN, previous SSN, effective date of coverage, marital status, sex, birth date, date of death, and Medicare status. The *'Group'* (*smartuser: MG or DG*) screen indicates the member/ dependent's SSN, name, group enrolled, effective date of coverage, type enrollee code, part-time percentage, deduction frequency, GIR/P name, phone number, and org proc code, effective date of displayed org proc code, agency name, work county and distribution code. The GIR/P can press the F5 (PF5) key from this screen to view the date and type(s) of letters that have been sent to the member automatically by the Membership System.

Membership Inquiry Screens (cont')

11	Detail Information (cont')	The *'Health'* (*smartuser: MH or DH*) screen indicates the member/dependent's SSN, name, group enrolled, effective date of coverage, active/term status code, term/waive reason, number of pre-existing months, carrier code and name, effective date(s) of carrier coverage, carrier change reason, PCP#, whether COB exists or not, alterable field "GO to COB (Y/N)" for viewing COB information screen, estimated annual salary (EAS), effective date of EAS, and change reason of last entry. The *'Life'* (*smartuser: ML or DL*) screen indicates the member/ dependent's SSN, name, effective date of coverage, active/term status code, term/waive reason, carrier code and name, effective date(s) of carrier coverage, carrier change reason, and health certificate approval date. The following information is listed on the Member Life screen only: basic life units (BLU), effective date of the latest BLU change, number of times Optional Life coverage, survivor's optional life election, AD&D coverage option, Spouse and Child Life coverage option. The *'Dental'* (*smartuser: MD or DD*) screen indicates the member/dependent's SSN, name, effective date of coverage, active/term status code, term/waive reason, carrier code and name, effective date(s) of carrier coverage, carrier change reason, PCD#, dental accessibility status, whether COB exists or not, and alterable field "GO to COB (Y/N)" for viewing COB information screen. The *'Vision'* (*smartuser: MV or DV*) screen indicates the member/dependent's SSN, name, effective date of coverage, active/term status code, term/waive reason, carrier code and name, effective date(s) of carrier coverage, carrier change reason, whether COB exists or not, and alterable field "GO to COB (Y/N)" for viewing COB information screen. The *'Address'* (*smartuser: MA or DA*) screen indicates the member/ dependent's SSN, name, address, resident county, zip code effective date, indicates whether or not mail should be sent to the indicated address.
12	SSN Search	This option allows the GIR/P to enter a SSN to determine the name of the person associated with the SSN. This screen also indicates group enrolled, effective date of coverage, org proc code, and birth date of member/dependent. Please note that only members/dependents listed under the GIR/P's org proc code may be viewed using this option.
13	GID Inquiry	(CMS GID use only)

D. General Screen Information

The Membership System 'inquiry' screens have several different date fields. A '99 99 9999' in a date field is referred to as the "high date." The "high date" indicates the information on the screen is currently in effect.

Below is an explanation of each field.

TRAN (Begin/End): Information displayed on this screen is applicable for the range of dates specified.

GROUP (Begin/End): Employee's starting and ending date as a member in the Group Insurance Program.

EFDT (effective date): This field may be found on several different screens. The 'EFDT' indicates the effective date of the information to the left of the 'EFDT' field.

Example: On the Member Group screen, the 'EFDT' date is next to 'FT/PT %' which indicates the date the full-time or part-time percentage became effective.

INVALID: Date a correction was processed for the displayed information. If the 'INVLD' date field is blank, the information displayed has not been corrected.

ORIG DT: Date the transaction was originally processed.

PROC DT: Processing date of a change. If the date is the same as the 'ORIG DT', the information on the screen has not been altered. If the date is different from the 'ORIG DT' field, something on the screen has been changed.

E. Membership Source Codes

The source code for each transaction on the Membership System is a "tracking stamp" used to identify by whom and when changes were processed. Each group allowed access to the Membership System has a source code identifying them. Below is a list of source codes:

- 10 – Group Insurance Division personnel
- 11 – Analysis and Resolution Unit
- 12 – Premium Collection Unit
- 13 – CMS Management Directive
- 14 – CMS Report
- 20 – Agency personnel
- 30 – COBRA personnel
- 70 – System mass update

F. Type Enrollee Codes

Members enrolled on the Membership System must be assigned a four-digit "type enrollee code." Type enrollee codes identify the type of coverage (health, life, vision, dental) available to the member.

- The first two-digits of the type enrollee code describe which main group the member is categorized (type). The list below describes the various 'type' codes.

Type Code	Description
10**	Employees
20**	Survivors (Used by retirement system and U of I Urbana only)
30**	Pending Survivors (Used by retirement system only)
40**	COBRA (Used by CMS GID only)
50**	Retirees (Used by retirement systems and U of I Urbana only)
60**	Leave of Absence
80**	Terminated

- The second two-digits of the type enrollee code further define the member within the above type categories (e.g., 1001 Full-time Employee, 1016 Part-time Employee, etc.).

A complete list of type enrollee codes may be found in Appendix J, 'Type/Subtype Chart'.

G. Membership System Help Messages

There are two levels of 'help' which may be accessed on the Membership System: ***screen level help*** and ***field level help***.

- **Screen level help** messages describe the screen, the screen's purpose, how to use the screen, etc. To access screen level help, press F1 once the screen is displayed.

- **Field level help** messages give information specific to a particular field on the screen, such as a description of the field and valid entries for the field. To access field level help message the GIR/P must:

  1. Position the cursor in any enterable field,

  2. Enter a question mark (?),

  3. Press F1.

11.2 Group Insurance Financial Control System (GIFCS)

A. GIFCS Access

In order to obtain GIFCS access, the GIR/P must complete a training class given by the Analysis and Resolution Unit staff. See 'Requesting System Access' in this section for instructions on receiving system training.

B. GIFCS Menu Information

GIR/P's have access to GIFCS screens 1 through 9, and screen 50. Screens 20 through 40 are available for GID use only. A description of each menu option available to the GIR/P is indicated below:

Agency Screens

Screen #	Name of Screen	Description
01	Discrepant Account List	This screen displays all members with either a coding discrepancy or a payment discrepancy of $3.50 or more, and identifies CFT and Priority members.
02	Pay Period Summary Inquiry	This screen allows the GIR/P to view payroll records and Membership liability side-by-side. A 'discrepant indicator' displays a 'Y' or 'N' to indicate whether the coding for the displayed pay period is discrepant.
03	Pay Record Update / Inquiry	This screen allows the GIR/P to correct pay record coding for individual pay periods.
04	Pay Record History / Inquiry	This screen allows the GIR/P to view all pay records for a specific member.
05	Membership Liability History Inquiry	This screen allows the GIR/P to view all Membership liability for a specific member.
06	Member Paid Premium Transfer	This screen allows the GIR/P to transfer member paid premiums between fiscal years, pay periods, and/or carriers.
07	Pay Record Audit History Inquiry	This screen allows the GIR/P to view a changed pay record. The user who altered the pay record, along with the date, time, original coding, and new coding will be displayed.
08	Refund Request	This screen allows the GIR/P to request member paid premium refunds which cannot be processed via payroll.

Agency Screens (cont')

Screen #	Name of Screen	Description
09	Change SSN / Pay Period on Pay Record	This screen allows the GIR/P to correct the Social Security number of a member whose pay record loaded with an incorrect SSN. A pay record end date may also be changed to a new pay period end date.
50	Return to Agency Inquiry	This screen allows the GIR/P who has access to toggle to the Membership System.

C. General Screen Information

- Highlighted fields, such as pay ending date or SSN, may be typed over to call-up new information.

- Most recent pay period information will be displayed if a specific pay period is not entered. Deleting the information in the pay period fields and pressing **ENTER** will also display the most recent pay period information.

- The 'Carrier Balances to Date' section appears on screens 2, 3, 6, and 8. The date displayed in this section is the last date the balances were updated. Balances are updated at the time of the monthly run, upon receipt of a pay record, or when a Membership or payroll adjustment is processed.

- GIR/P's are allowed to access GIFCS to review member payroll and liability history within the agency's organizational processing code on the Membership file. However, when no corresponding Membership record exists, the payroll code from the pay record is used to determine access to the member's account.

- A member's file may be viewed at any time, regardless of whether or not the account is discrepant.

- The GIR/P can transfer from one GIFCS screen to another by entering the screen number in the SCREEN# field and pressing the ENTER key. When this is done, the member's name, SSN, and pay period(s) will transfer from the previous screen.

- GIR/P's having access can transfer to the Membership System by inputting '50' in the SCREEN# field of any screen and pressing the ENTER key.

- If any error conditions exist when inquiring or updating on a screen, the screen will be displayed with the fields in error highlighted and the appropriate error message displayed at the bottom of the screen.

- When an update is processed, a message will appear at the bottom of the screen stating the transaction has been entered.

- When a clock is displayed at the bottom of the screen, DO NOT press the ENTER key. The system is processing the transaction. The clock will disappear when the transaction is complete.

- Codes can be input in the fields in either upper or lower case.

- GIR/P's may transfer to the GIFCS Main Menu from any screen using the F3 (or PF3) key.

- GIR/P's may transfer to the Group Insurance System Main Menu from any screen using the F4 (or PF4) key.

11.3 Group Insurance Division (GID) Notices

A. GID Notices General Information

GID periodically broadcasts messages to GIR/Ps via the GID Notices screen. The messages provide information regarding mailings going to agencies, problems or concerns the GIR/P should be aware of, changes in procedure, etc. The GID Notices System maintains a historical log of all messages broadcast that may be viewed by GIR/Ps at anytime. ***Note:*** System messages are also sent to GIR/Ps via email.

B. GID Notice Procedure

The GIR/P should follow the procedures below to utilize this option:

1. Select option 4 (GID Notices) from the GID Main Menu. Press ENTER. The date of the most recent notice will appear. Press ENTER again to display a list of system messages beginning with the most recent.

2. Enter either a specific date in the highlighted field next to "Enter date to start the list at a specific field," or enter a topic in the highlighted field next to "Enter topic selection to filter list."

> ***Note:*** If entering a topic, the characters entered must match the first word of the topic exactly. Most topics are divided into the following categories:
>
> - System Status
> - System Enhancements
> - System Problem
> - Admin Issue
> - Mailing
> - Dep (i.e., Dependent Recertification)
> - BCP (i.e., Benefit Choice Period)

3. Press ENTER.

4. Place an 'S' in the 'SEL' field next to the desired message and press ENTER.

5. The 'Notice Text' screen will appear. This screen shows the date, time, page number, topic description summary, and topic description in detail. The GIR/P may view previous ("older") notices by pressing the F6 (PF6) key, or newer notices by pressing the F5 (PF5) key. If the message "More Pages" is listed in the lower right corner, the user should press the F8 (PF8) key to display the additional pages.

11.4 Insurance Representative Listing

A. Insurance Representative Listing Menu (Main Menu Option 5)

GIR/P's may need to contact other Group Insurance Representatives or Preparers. The Insurance Representative Listing provides the name, address, phone number, and email address of each GIR/P. The GIR/P has five options when looking up another GIR/P.

The following options are available on the Insurance Representative Listing Menu:

- List of Agencies (Option 1) – this option displays the complete name of all agencies matching the criteria entered, as well as the agency and facility number of the agency. Furthermore, the user may choose to either view a general list of GIR/P's in organizational processing code order, or view all detail information pertaining to each GIR/P of the desired agency.

- List of Organizational Processing Codes (Option 2) – this option displays a general list of all GIR/P's in organizational processing code order for the specified agency. Furthermore, the user may choose to view each GIR/P's detailed information.

- Insurance Representative Detail Listing of Name, Address, and Phone Number (Option 3) – this option displays all GIR/P detail information for the GIR/P's of the desired agency.

- Insurance Representative Name Search (Option 4) – this option displays the detail information of all GIR/P's matching the name criteria entered.

- Number of Active Members By Organizational Processing Codes (Option 5) - this option lists the number of active members for each facility within an agency, along with the total number of active members for the agency. A specific organizational processing code may be entered on this screen to view the number of active members for a specific agency. The number of active members is updated each Friday.

B. Insurance Representative Listing Procedures

The GIR/P should follow the procedures below to utilize the Insurance Representative option:

1. **List of Agencies**

   a. Select option 5 (Insurance Representative Listing) from the GID Main Menu. Press ENTER.

   b. Leave the 'Group' field 'S' (State). Tab to the 'Option' field. Enter option '1'. Tab to either the highlighted 'Org Proc Code' field or highlighted 'Agency Name' field and do one of the following:

      - Enter the org proc code (the user must enter at least the first three digits of the code.) Press ENTER.

      ~ OR ~

      - Enter the agency name (the user must enter at least the first two characters of the agency name.) Press ENTER.

   c. The 'List of Agencies' screen will be displayed. The cursor will appear in the 'SEL' field. Tab down to the field next to the desired agency/facility/facility name and do the following:

      - *To display all GIR/P's within the desired agency, along with the org proc code of the GIR/P*, enter a '2' in this field. Press ENTER. The 'List of Org Proc Codes' screen will appear. At this point the user may either place an 'X' in the field next to the org proc code of the desired GIR/P (in the 'SEL' column) and press ENTER to display the GIR/P's detail information, or the user may view a different agency by entering a different org proc code in the highlighted 'Org Proc Code' field and pressing ENTER.

      - *To display the detail information for all GIR/P's listed within the desired agency*, enter a '3' in this field. Press ENTER. The 'Insurance Rep. Detail Listing' screen will appear. The user may press the F8 (PF8) key if the word "More" is listed in the lower right corner of the screen to view the remaining GIR/P's for the selected agency.

2. **List of Organizational Processing Codes**

   a. Select option 5 (Insurance Representative Listing) from the GID Main Menu. Press ENTER.

   b. Leave the 'Group' field 'S' (State). Tab to the 'Option' field. Enter option '2'. Tab to the 'Org Proc Code' field and enter the organizational processing code of the desired agency (the user must enter at least the first three digits of the code). Press ENTER.

   c. The 'List of Org Proc Codes' screen will be displayed. All GIR/P's of the desired agency are listed on this screen, along with the organizational processing code and agency name. The user may either:

      - Tab down to the blank field next to the desired organizational processing code/agency name/GIR/P name, and place an 'X' in the field and press ENTER. The GIR/P's detail information will be displayed.

      - Tab to the highlighted 'Org Proc Code' field, enter a new organizational processing code and press ENTER to view a different agency. Once the new agency is displayed, the user may either enter a different organizational processing code, or select a displayed GIR/P by placing an 'X' in the 'SEL' column next to the desired org proc code/agency name/GIR/P name, and pressing ENTER.

3. **Insurance Representative Detail Listing of Name, Address and Phone Number**

   a. Select option 5 (Insurance Representative Listing) from the GID Main Menu. Press ENTER.

   b. Leave the 'Group' field 'S' (State). Tab to the 'Option' field. Enter option '3'. The cursor will automatically go to the 'Org Proc Code' field. Enter the desired organizational processing code (the user must enter at least the first three digits of the code). Press ENTER.

   c. The 'Insurance Rep. Detail Listing' screen will be displayed. All detail information for the GIR/P's of the selected agency is listed on this screen. The user may press the F8 (PF8) key if the word "More" is listed in the lower right corner of the screen to view the remaining GIR/P's for the desired agency.

4. **Insurance Representative Name Search**

   a. Select option 5 (Insurance Representative Listing) from the GID Main Menu. Press ENTER.

   b. Leave the 'Group' field 'S' (State). Tab to the 'Option' field. Enter option '4'. Press ENTER.

   c. The 'Insurance Representative Name Search' screen will be displayed. The user must enter at least the first two characters of the desired GIR/P's last name. Press ENTER.

   d. All detail information of the GIR/P's matching the name criteria entered is listed. The user must press the F8 (PF8) key if the word "More" is listed in the lower right corner of the screen to view additional GIR/P's with matching criteria.

5. **Number of Active Members By Organizational Processing Code**

This option identifies the number of members assigned to a particular organizational processing code.

a. Select option 5 (Insurance Representative Listing) from the GID Main Menu. Press ENTER.

b. Leave the 'Group' field 'S' (State). Tab to the 'Option' field. Enter option '5'. The user may either:

- Press ENTER to view a list of all agencies in organizational processing code order, beginning with '101 000 000'. This option will display the number of active members for each org proc code, broken down by facility, if applicable. The user may press the F8 (PF8) key to view additional agencies if the word "More" is displayed in the lower right corner of the screen.

- Enter an org proc code (the first three or six digits) in the highlighted 'Org Proc Code' field and press ENTER. This option will display the number of active members for the requested org proc code only, broken down by facility, if applicable.

11.5 Flexible Spending Accounts (FSA) System

A. Flexible Spending Accounts (FSA) System Access

FSA System access will be granted once the GIR/P completes Membership training. See 'Requesting System Access' in this section for instructions on receiving Membership system training.

B. Flexible Spending Accounts (FSA) System Main Menu

The FSA System Main Menu is comprised of the following four main components. A description of each is outlined below:

- **Add/Update Menu:** The Add/Update Menu is used by the FSA Unit to process MCAP and DCAP enrollments, terminations, refunds, MCAP COBRA deposits, university payroll deposits, as well as changes in status.

- **Inquiry Menu:** The Inquiry Menu is for GIR/P use. GIR/Ps may use the 'Deduction - What If' screens to determine eligibility start and end dates, as well as payroll deduction start and end dates and amounts. The GIR/P may also use the screens to view currently enrolled MCAP and DCAP participants, as well as participants enrolled for previous plan years, by org proc code for each agency. The deposit history of each participant may be viewed for both MCAP and DCAP accounts and any person enrolled on the Group Insurance Membership System may be searched by name for an SSN using these screens.

- **Claims Administrator Inquiry Menu:** The Claims Administrator Inquiry Menu allows the plan administrator's to look up State of Illinois MCAP and DCAP participants to view whether they have an HMO or the Quality Care Health Plan and whether or not they are enrolled in the dental plan.

- **Corrections Menu:** The Corrections Menu is used by the FSA Unit to correct active MCAP and DCAP accounts.

C. Flexible Spending Accounts (FSA) System Inquiry Menu

GIR/P's have access to FSA Inquiry screens 1 through 12. Option 10 is hidden from view and is not currently in use; option 13 (Manual Refund Inquiry) is available for GID use only. A description of each menu option is indicated below:

Flexible Spending System Inquiry Screens

Screen #	Option Name	Description of Option
1	Deduction What If Screen – Benefits Choice Enrollment	This option should be used to determine deductions per pay period, deduction start date and deduction end date for benefit choice enrollments. The user must enter paycode and either deduction amount per pay period or an annual expense (deduction) amount. The social security number field is optional.
2	Deduction What If Screen – Mid Year Enrollment	This option should be used to determine deductions per pay period, deduction start date and deduction end date for mid year enrollments. The user must enter paycode, change in status event date, enrollment form signature date, and either deduction amount per pay period or an annual expense (deduction) amount. The social security number field is optional.
3	Deduction What If Screen – Change in Status	This option should be used to determine deductions per pay period, deduction start date and deduction end date for qualifying change in status changes for an active participant. The user must enter the social security number for an active participant. The change in status qualifying event code should be obtained from the Change In Status Form (CMS 330M or CMS 330D). The change in status event date, Enrollment Form signature date, and either deduction amount per pay period or an annual expense (deduction) amount must also be entered.
4	Participant/Plan Summary	This option is used to display a participant's name, address, work and home phone numbers, GIR and payroll rep names and phone numbers, a debit card indicator, per pay and annual deduct amounts, paid through date, discrepant indicator, total expected deposits, total deposits received, eligibility begin and end dates, deduction start date and (most recent) transaction date.
5	Participant Listing By Org Proc	This option is used to list all MCAP and DCAP participants for each Org Proc code. The participants can be listed by agency (cusas) code, facility code or org proc code. The participants can be sorted by plan type (M or D), plan year and discrepant accounts only or all accounts. Both active and terminated accounts will be listed and identified.

Screen #	Option Name	Description of Option
6	Deposit History Inquiry	This option is used to display a participant's name, GIR and payroll rep names and phone numbers, eligibility begin and end dates, expected and actual deposits year to date, paid through date, discrepant amount (if any), paycode and type payroll (Ex Delayed/Semimonthly). All deposits received are listed on the bottom of the screen beginning with the most recent deposit received. This list includes the pay period end dates as well as the date the money was sent to the vendor via electronic file, the amount of the deposit and type (Ex P=payroll).
7	Claims/Reimbursement Inquiry (Claims Until 09/30/04)	This option displays claims and reimbursements prior to 10/01/2004, which is the date the claims payment was turned over to the vendor.
8	Discrepancy List	This option will display all discrepant accounts by agency (cusas), facility and org proc code. Both active and terminated accounts will be displayed as well as both MCAP and DCAP.
9	Suspense List	This option will display all accounts in suspense by agency (cusas), facility and org proc code. Both active and terminated accounts will be displayed as well as both MCAP and DCAP. Note: The two types of suspense accounts are Deposit Suspense and Payroll Suspense. 'Deposit Suspense' occurs when deposits are received for an MCAP or DCAP account, however, there is no enrollment for that individual. 'Payroll Suspense' occurs if a deposit is received under a different paycode that has a different frequency or type (delayed or anticipated) than the paycode entered at time of enrollment.
10	Not in Use – Hidden	This option is not currently programmed and is hidden from view.
11	Log Information Inquiry	This option will display log entries, both manual and system generated, for a specific MCAP or DCAP account. The date of entry as well as the RACF ID of the user will be displayed.
12	Name Search	This option can be used to find a Social Security number by entering a last name (at least two characters required) and first name (optional). The user can request a search for flex participants only or search the entire membership system.
13	Manual Refund Inquiry	This option will display manual refunds that are processed by the Flexible Spending Unit (for GID use only).

12.0 General Information

This section has step-by-step instructions for processing each Membership procedure necessary to complete on the Membership System. The GIR/P must sign on to the Membership System (see section 11) and then follow the steps detailed for each procedure.

The GIR/P should verify that the PCP field is completed on the Enrollment forms before beginning entry of the form data on the Membership System. This only applies to forms of members who are enrolling in a managed care health plan.

For information regarding the Membership inquiry screens, refer to section 11, 'Group Insurance System Administration.'

12.1 Processing Enrollment Transactions

A. Completion of Forms

All forms must be:

- typed or printed with black ink.
- completed by the Group Insurance Representative (GIR) or Group Insurance Preparer (GIP) only.
- signed by the GIR/P and the member at all times - **"Signature on file"** is not acceptable.
- maintained at the agency (see Appendix B, 'Insurance File Recordkeeping Requirements').

B. Transaction Types

There are two types of transactions which GIR/P's *with online access* may process on the Membership System: adds and changes. Corrections may only be processed by GID.

GIR/P's without online access must submit the proper forms and back-up documentation (see Appendix B, 'Documentation Requirements' for specific documentation criteria) to the Membership Unit for processing.

- ***'Add' transactions*** are used to create a member's online file of biographical, plan, and group information. 'Adds' are typically used for Initial Enrollment.

- ***'Change' transactions*** are used to change member/dependent online information, or add/drop dependent coverage. A 'change' is any transaction which has an effective date later than the latest effective date currently on the member's online file. 'Changes' are typically used for Benefit Choice or Qualifying Changes in Status processes.

> ***Example:*** A member's file shows a new health carrier effective October 1st. The only changes allowed to be processed by the GIR/P are changes with an effective date of October 2nd or later. Any changes to the member's file with an effective date of October 1st or before must be processed by CMS as a correction.

- ***'Correction' transactions*** are used for any changes to a member's online file which have an effective date earlier than, or equal to, the latest effective date. Corrections may only be processed by the Membership Unit. Documentation indicating the reason for the correction is required before the Membership Unit can process the transaction.

> ***Example:*** Member's health carrier (XX) has an October 5th effective date. The GIR/P discovers the member's health carrier should have been (YY) effective September 30th. The GIR/P must send a correction to the Membership Unit to have this correction processed.

C. Membership Form Descriptions

GIR/P's must use the appropriate Membership form(s) to acquire member/dependent biographical and coverage election information. To streamline the data entry process, the Membership form design follows the layout of the Membership screens.

1. **Initial Enrollment Forms:** There are two enrollment forms the GIR/P must use when adding a new member and/or dependent.

- ***Initial Enrollment Form – Member Information (CMS-310):*** The Initial Enrollment Form must be used for new enrollees only. This form provides the necessary information to establish an insurance file.

- ***Initial Enrollment Form – Dependent Information (CMS-311):*** The dependent page of the Initial Enrollment form must be used to enroll a new dependent with a new member. The Initial Enrollment form with the member's signature must accompany the dependent page as proof of election of coverage.

  A copy of the Initial Enrollment forms must be distributed to the agency payroll office. The original form must be retained by the agency in the insurance file.

2. **Change Forms:** The GIR/P must use 'Change' forms when processing changes to member/dependent coverage, member/dependent address or when adding/dropping dependents.

- ***Member Change Form (CMS-312)***: The Member Change form must be used to process changes to member biographical, plan and group information.

- ***Dependent Change Form (CMS-313)***: The Dependent Change form must be used to process changes to dependent biographical information, as well as when adding or dropping dependent coverage.

- ***Member and/or Dependent Address Change Form (CMS-314)***: The Member/Dependent Address Change form must be used when a member and/or dependent's address changes.

Special Notes on 'Change' Transactions:

- The GIR/P must complete **only** the information on the form **that has changed**. Completing sections of the form which have not changed will slow processing.
- Form instructions are printed on the back of each form. Change forms are to be used for changes, terminations and corrections only (do not use for initial enrollment).
- Multiple changes affecting the same member and/or dependent may be submitted on the same Member or Dependent Change form.
- When processing changes online, multiple changes should be processed in date order. Changes processed out of date order will prevent changes with an earlier effective date from being allowed to be processed by the GIR/P.

3. **Correction Form:** There are two types of forms which must be used for corrections. Documentation explaining the reason for the correction must accompany the correction request (see Appendix B, 'Documentation Requirements' for specific documentation requirements).

♦ ***Correction Form (CMS-340)***: Agencies *with online access* must use the Correction Form (CMS-340) to request corrections. The CMS-340 must contain the GIR/P's signature and date. The GIR/P must attach documentation containing the member's signature to the correction form.

♦ ***Change Form (CMS 312, 313, 314)***: Agencies *without online access* may use CMS 'Change' forms when requesting a correction.

Special Note: Screen prints are not accepted for correction requests and, if received, will be returned to the GIR/P unprocessed.

D. Confirming Transactions

Once the member and dependent information has been entered on the Membership System, the GIR/P will be asked to 'confirm' the transactions. Once the transaction(s) have been 'confirmed', the system will allow changes with the same effective date to be processed until the end of the day. After that time, changes with the same effective date, or a prior effective date, must be sent to the Membership Unit as a correction.

Example: On December 1st, a GIR/P changes a member's address to be effective December 2nd and confirms the change. On December 2nd, the GIR/P needs to change the same member's health carrier effective December 2nd. The system will not allow the GIR/P to process this change. The change must be sent to the Membership Unit as a correction.

E. Disaster Recovery

The possibility of a system failure occurring on the Membership system exists, as with all computer systems. In situations of a system crash, data is lost and may need to be re-entered, depending on the severity of the crash.

Therefore, in order to guard against loss of data due to a system failure, the GIR/P must segregate all data entered on the Membership System (e.g., Membership forms) by process date. The forms must be kept separated for at least one day after they have been processed on the Membership System. By segregating the data entered, lost data can be quickly determined, and if necessary, re-entered in the event a system crash does occur.

F. Verification of Coverage Elections

The Membership System generates two copies of a verification form once an initial enrollment, change, or correction transaction has been processed; however, a verification form will only be automatically printed if information contained on the form has changed. One copy will be sent to the GIR/P, the other copy will be mailed to the member's address indicated on the Membership file. Additionally, the verification form will be available on MOBIUS (GIMBM108-01).

Example: Work county is not a printed field on the form; therefore, if a Membership transaction is processed changing only the work county of a member, no verification form will be printed. Additionally, no Verification form will be printed if the only change processed is the organizational processing code.

Information that has been added or changed will appear underlined on the form. Additionally, a message will print under the form title that reads, "Underlined Information Has Been Changed."

Verification forms requested by the agency with no change will have a message printed under the title which reads, "No Change Processed – Form Requested by Insurance Representative."

GIR/P's with online access may request a verification form to be printed at any time by utilizing the Forms Request screen on the Membership System (see section 12.23 'Requesting Forms to be Printed" for step-by-step instructions on printing a verification form).

12.2 Adding a New Member

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   ***Note**: If another member's biographical information appears after you enter the social security number**, STOP and immediately cancel the transaction**! Contact the Membership Unit so they can research and determine the correct owner of the social security number. Do not proceed to type over the information already in the system. Typing over the information already input for that social security number will overlay the new member's information over the current member's information causing the initial member with that SSN to cease existence in the system.*
   Field Group S(tate)
   Field Option 1 (Add member)
   Field GI Processing Organization (CUSAS Code, Facility Code, GIR/GIP code - total 9 digits)
   Field Effective Date MMDDYYYY = Date of Hire
   Field Address U (sa) or F (oreign)
   Field "Other address" is used when information regarding group insurance issues is to be sent to another individual, in addition to, or instead of, the member.
   Other address (Y/N)
   If Yes, enter either (U or F).
   <Enter>

4. Member Biographical
   Field Temporary SSN. Default is N. If temporary, Y.
   Field Last Name, First Name, Middle Name or Initial
   Field Marital Status (M or S). Effective date is pre-filled.
   Field Handicapped (Y/N).
   Field Birthdate (MMDDYYYY)
   Field Sex (M/F)
   Field Medicare Status
   1 = Non-Medicare
   2 = Medicare eligible 65 and over
   3 = Medicare ineligible 65 and over *
   4 = Medicare disability
   5 = Medicare End Stage Renal Disease

* GIR/P's must submit documentation to GID from the member verifying Medicare ineligibility. GID will process the transaction to add the member to the system. See Section 3.3.F.1, 'Medicare' for documentation requirements.

If Medicare Status 1, press enter twice, go to step 5.
If Medicare Status 2, 4, or 5, continue.

Field Part A begin date - input the date listed on the member's Medicare ID card as first eligible for Part A.
Field Part A end date will be 99 99 9999
Field Part A Free "Y", if member receives Part A free.
If member must purchase Part A, "N".
Field Part B begin date - input the date listed on the member's Medicare ID card as first eligible for Part B.
Field Part B end date will be 99 99 9999
Field Phone Number: Home – enter home phone number
Field Work – enter work phone number
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Member Medicare Number History (Optional) – Screen will appear if 2, 4, or 5 was entered for the Medicare Status on the Member Biographical Screen.

Field SEL enter 'A' for Add
Field Medicare Number – enter the Medicare number from the member's Medicare ID card (the Medicare number is the member's SSN followed by either 1 or 2 alpha characters)
Field Begin Date – listed as Effective Date on Medicare card
Field End Date – enter 99 99 9999
Press <**enter**>: **No additional records** will appear on the bottom of screen.
Press <**enter**> again to proceed.

5. Member Address - This screen has special editing capabilities. After entering the information, the system will compare the address to standard post office address information. If there is a difference, the system will display recommended changes to the right of the data entered. Changes include street address, state, zip code (9 digits), and resident county. **Note**: The system will not let you exit the address screen until you accept the recommended changes.

Field Member address - 2 lines, if necessary
Field Member city
Field Member state
Field Member zip code; the zip+4 field will automatically update
Field Resident county
Field Country Code – only complete for foreign addresses
Field Country Name – only complete for foreign addresses
Field Mail to this address (Y/N)
If Yes, go to step 7.
If no, the "Other Addressee" information screen will appear in which the other address must be entered.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

6. Member Other Addressee Screen (This optional screen will appear only if you answered 'No' to "Mail to this address" on the Member Address screen).
   Field Name, Last Name, First Name, Middle Name ***or*** Organization
   Field Member address - 2 lines, if necessary
   Field Member city
   Field Member state/zip code; the zip+4 field will automatically update
   Field Country Code – only complete for foreign addresses
   Field Country Name – only complete for foreign addresses
   Field Type of Address
   1. Custodial Parent 2. Trustee
   3. Power Of Attorney 4. Legal Guardian
   5. Mailing Address 6. In Care Of (C/O)

   Field Mail to this address (Y/N)
   Must input Yes ***if*** answer to #5 "Mail to this address" was No.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Member Group Screen
   Field Type Enrollee
   1001 = FT Employee
   1016 = PT Employee
   1003 = Public Official
   1004 = Emergency Appointment
   1006 = U of I Foundation
   1009 = IL Development Finance Authority FT
   1010 = IL Development Finance Authority PT
   1017 = PT Direct Pay (Restricted to certain agencies)
   1051 = FT Employee electing to Opt Out
   1053 = Public Official electing to Opt Out
   1056 = U of I Foundation electing to Opt Out
   Field FT/PT % - If FT, enter 100. If PT,
   must be equal to or greater than 50, but less than 100.
   Field Deduction Frequency - defaulted to "S" (semi-monthly) or "M" (monthly), depending on the agency CUSAS code.
   Field Work county code (Refer to Residence Code/Work Code list)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

8. Member Plan - Health
   Field Active/Term - default is "A".
   Use "T" if full-time employee is electing to opt out, or if part-time employee is waiving coverage
   Field Term Reason -34 (full-time opt out, has life coverage)
   33 (full-time opt out without life coverage)
   13 (part-time waiving coverage)
   Note: If member waived health coverage, vision must also be waived.

Field Pre-existing months. Entry is required - if none, "0"
Field Carrier Code
Field PCP/PCD#: If managed care, must enter PCP#, cannot be "000000".
Field Go to COB (Y/N). Default is "N".
If "Y", additional screen will appear after Member Plan Health screen.
Field Estimated Annual Salary (not required if opting out or waiving)
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Member COB (Optional) – Screen will appear if "Y" was entered in COB field on the health plan screen.
Field A(dd)
Field Begin date – Effective date of the other group coverage.
Field End Date - may be 99 99 9999
Field Carrier Name – Insurance company name of other coverage.
<Enter> and process.

9. Member Plan - Dental
Field Active/Term - Default is "A".
Use "T" if full-time employee is electing to opt out, or if part-time employee is waiving coverage
Field Term Reason -34 (full-time opt out, has life coverage)
33 (full-time opt out without life coverage)
13 (part-time waiving coverage)
Note: If member waived health coverage, vision must also be waived.
Field Carrier Code D6 or DD if Dental is not elected.
Field PCP/PCD#: Leave Blank.
Field Accessible Y/N. Default is "Y" ("N" will revert back to "Y")
Field Go to COB (Y/N). Default is "N".
If "Y", additional screen will appear after Member Plan Dental screen.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Member COB (Optional) – Screen will appear if "Y" was entered in COB field on the dental plan screen.
Field A(dd)
Field Begin date – Effective date of the other group coverage.
Field End Date - may be 99 99 9999
Field Carrier Name – Insurance company name of other coverage.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

10. Member Plan - Life
    Field Active/Term - Default is "A".
    Field Carrier Code = C9
    Field Certificate approval date is required **only** when optional life is being added after the 10 day initial enrollment period.
    Field Basic Life Units (BLU). Field will be pre-filled.
    Note: Member basic life units are calculated by dividing the member's estimated annual salary by 100 and rounding up to the nearest 100.
    Field Optional Term Life - 1/2/3/4 times member salary. If member elects 5/6/7/8 times a Statement of Health is required. If member does not elect optional life coverage do not change the '0' default.
    Field AD & D: (N) = none, (B) = basic, (C)ombined = basic + optional (maximum of 4 times)
    Field Spouse life (Y/N). Default is "N".
    Field Child life (Y/N). Default is "N".
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

11. Member Plan - Vision
    Field Active/Term - Default is "A".
    Use "T" if full-time employee is electing to opt out, or if part-time employee is waiving coverage
    Field Term Reason - 34 (full-time opt out, has life coverage)
    33 (full-time opt out without life coverage)
    13 (part-time waiving coverage)
    Note: If member waived health coverage, vision must also be waived.
    Field Carrier Code 'VS' – **Pre-filled**
    Field Go to COB (Y/N). Default is "N".
    If "Y", additional screen will appear after Member Plan Vision screen.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

    Member COB (Optional) – Screen will appear if "Y" was entered in COB field on the vision plan screen.
    Field A(dd)
    Field Begin date – Effective date of the other group coverage.
    Field End Date - may be 99 99 9999
    Field Carrier Name – Insurance company name of other coverage.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

12. Dependent Add Menu
    - To add dependents, proceed to the next section **"Adding Dependent(s) – Initial Enrollment with Member".**
    - If there are no dependents to add at this time, proceed with confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

12.3 Adding Dependent Coverage
Initial Enrollment with Member

1. Dependent Add Menu
   - **Field** Dependent Social Security Number. If newborn dependent does not have a social security number, enter 808 00 0000.
     Note: The system will generate a temporary SSN.
     Do not attempt to enter a temporary SSN for the dependent.
   - **Field** Temporary SSN (Y/N)
   - **Field** Dependent address same as member (Y/N). Default is Y.
     If no, enter either U (sa) or F (oreign)
   - **Field** "Other address" is used when information regarding group insurance related issues is to be sent to another individual, in addition to, or other than the member.
     Other address (Y/N). Default is N.
     If Y, enter either U (sa) or F (oreign).

   <Enter>

2. Dependent Biographical
   - **Field** Last name, first name, middle initial
   - **Field** Date of birth (MMDDYYYY)
   - **Field** Birth Seq #. Enter a '01' for all dependents, except those born on the same day, month and year, in which case, enter the first born as '01', the second born as '02', etc.
   - **Field** Sex (M/F)
   - **Field** Retirement Date (leave blank unless dependent is retired)
   - **Field** Medicare Status
     1 = Non-Medicare
     2 = Medicare eligible 65 and over
     3 = Medicare ineligible 65 and over *
     4 = Medicare disability
     5 = Medicare End Stage Renal Disease

* GIR/P's must submit documentation to GID from the member verifying Medicare ineligibility. GID will process the transaction to add the member to the system. See Section 3.3.F.1, 'Medicare' for documentation requirements.

If Medicare Status 1, press <enter> twice; go to next step.
If Medicare Status 2, 4, or 5 - continue.

   - **Field** Part A begin date – input the date listed on the dependent's Medicare ID card.
   - **Field** Part A end date will be 99 99 9999
   - **Field** Part A Free "Y" if dependent receives Part A free. If dependent must purchase Part A, "N".
   - **Field** Part B begin date - input the date listed on the dependent's Medicare ID card.
   - **Field** Part B end date will be 99 99 9999
     Press <**enter**>: "Data Added, Pending Confirmation" will appear.
     Press <**enter**> again to proceed.

Dependent Medicare Number History (Optional) – Screen will appear if 2, 4, or 5 was entered for the Medicare Status on the Dependent Biographical Screen.

Field SEL enter 'A' for Add
Field Medicare Number – enter the Medicare number from the dependent's Medicare ID card (the Medicare number is the dependent's SSN followed by either 1 or 2 alpha characters)
Field Begin Date – listed as Effective Date on Medicare card
Field End Date – enter 99 99 9999
Press <**enter**>: **No additional records** will appear on the bottom of screen.
Press <**enter**> again to proceed.

3. Dependent Address – (This optional screen will appear only if you answered 'No' to "dependent address same as member" on the Dependent Add Menu).

Field Dependent street address
Field Dependent city
Field Dependent state
Field Dependent zip code; the zip+4 field will automatically update
Field Dependent resident county
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

4. Dependent Other Addressee – (This optional screen appears if you answered 'Yes' to "other address" on the Dependent Add Menu).

Field Name, Last Name, First Name, Middle Name ***or*** Organization
Field Street Address (2 line maximum)
Field City
Field State/Zip code; the zip+4 field will automatically update
Field Type of Address

1. Custodial Parent	2. Trustee
3. Power Of Attorney	4. Legal Guardian
5. Mailing Address	6. In Care Of (C/O)

Field Country Code – only complete for foreign addresses
Field Country Name – only complete for foreign addresses
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

The system will advise if corrections are recommended for the zip code; therefore, double-check the city name after you press enter to make sure it is correct.

5. Dependent Group

Field Dependent Type = Enter 10 (for Active) in the first field, leave second field blank (will look like 10 __ when input correctly).

Field Relationship
01 = Spouse
02 = Natural Child
03 = Adopted Child
04 = Stepchild
06 = Legal Guardian
07 = Adjudicated Child
08 = Student
09 = Handicapped **(GID entry only)**
10 = Other
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

6. Dependent Plan - Health
   Field Active/Term - default is "A".
   Use "T" if dependent is not to be covered for health.
   Note: If dependent health is waived, dental and vision coverage must also be waived - Term/Waive Reason 63.
   Field Pre-existing months. Entry is required - if none, "0"
   Field Carrier Code. **Pre-filled with same carrier as member.**
   Field PCP/PCD#: If managed care, must enter PCP#, cannot be "000000".
   Field Go to COB (Y/N). Default is "N".
   If "Y", additional screen will appear after Dependent Plan Health screen.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the health plan screen.
   Field A(dd)
   Field Begin date – Effective date of the other group coverage.
   Field End Date - may be 99 99 9999
   Field Carrier Name – Insurance company name of other coverage.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Dependent Plan - Dental
   Field Active/Term - Default is "A".
   Use "T" if dependent is not to be covered for dental.
   Note: If the dependent health was waived, dental coverage must also be waived - Term/Waive Reason 63.
   Field Carrier Code. **Pre-filled with same carrier as member.**
   Field PCP/PCD#: Leave blank.
   Field Accessible Y/N. Default is "Y" ("N" will revert back to "Y")

Field Go to COB (Y/N). Default is "N".
If "Y", additional screen will appear after Dependent Plan Dental screen.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the dental plan screen. **Instructions are the same as the COB portion of step 6**.

8. Dependent Plan - Life
   Field Active/Term - Default is "A".
   Use "T" if dependent is not to be covered for life insurance - Term/Waive Reason 63.
   Field Carrier Code = C9
   Field Certificate approval date **–*check the "Statement of Health" table to verify if a Health Certificate is required for the specific change being requested.**
   Field Life amount. Pre-filled with $10,000.00 dependent coverage limit.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.
   Note: If Spouse or Child Life is being added, the "Member Plan – Life" screen must be updated to reflect this change. If the member screen is not updated, the life premium will not calculate correctly. Instructions for updating the member life plan screen are given starting with step 10. MSG30-THERE ARE CROSS EDIT ERRORS ON THE DEPPLANRECORD will be displayed.

9. Dependent Plan - Vision
   Field Active/Term - Default is "A".
   Use "T" if dependent is not to be covered for vision.
   Note: If dependent health was waived, vision coverage must be also be waived - Term/Waive Reason 63.
   Field Carrier Code 'VS' – **Pre-filled**.
   Field Go to COB (Y/N). Default is "N".
   If "Y", additional screen will appear after Dependent Plan Vision screen.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the vision plan screen. **Instructions are the same as the COB portion of step 6**.

To add another dependent, repeat instructions for **"Adding Dependent Coverage – Initial Enrollment with Member"** beginning with step 1.

Once all dependents have been added:

- proceed with member life update (step 10) if Child or Spouse Life was added, or
- proceed with confirmation process (step 14) if dependent life was not added.

If Child or Spouse Life was added, the member life plan screen must be updated. If this step is not done, the system will not calculate the member's life premium correctly.

10. Dependent Add Menu
    Press F6 (Confirm)

11. Confirmation Screen
    Press F7 (Member Change Menu)

12. Member Change Menu
    Field Change date should be pre-filled from previous entry.
    Field Option 18 (Life Coverage)
    <Enter>

13. Member Plan - Life
    Field Spouse life (Y/N) = Y, or
    Child life (Y/N) = Y
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

Proceed with Confirmation Process.

14. Member Change Menu
    Press F6 to proceed to the confirmation screen.

15. Confirmation Screen
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.4 Terminating Member Coverage

Dependents are terminated automatically when member is terminated.
See the 'Member Death' procedure for terminating a member due to death.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is the day following the last day worked. (i.e., Member's last day of work is July 31st, the member will have coverage until midnight on the 31st. The effective date of termination status is August 1st.)
   Field Option 14 (Terminate Member In A Group)
   <Enter>

5. Member Group Screen
   Field Type Enrollee Code –
   It is important the correct type enrollee code be entered since this field determines whether a COBRA letter will be generated. COBRA codes include:
   8008 = Terminate employment
   8011 = Maximum leave of absence ends
   8014 = Change to less than 50% employment
   8015 = Permanent layoff without state-paid coverage
   (Applicable to employees of the Attorney General's Office, Office of the Comptroller, Secretary of State or the State Treasurer. Employees of these agencies should be terminated effective the date of the layoff.)

Type enrollee codes in which **no COBRA** letter is generated are:

8007 = Never eligible
8009 = Dependent of another member
8010 = Nonpayment of premium
8012 = Employment terminated due to gross misconduct
8016 = Non-state paid leave of absence waiver
8017 = Termination - no COBRA
8033 = Opt Out – employee does not have life coverage
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

12.5 Full-time Member Opting Out of Health, Dental and Vision

Note: All dependent coverage will be automatically terminated when the member's opt out election is processed if the dependents are enrolled in health, dental and vision coverage. If the dependent(s) are enrolled without life coverage, you will receive the following message, "MSG638 DEPS W/TRMED LIFE. TERM DEPGRP USING 8069 BEFORE ENTERING MBR OPT OUT" and you will need to terminate the dependent coverage before the member's opt out can be processed (refer to section 12.6 for the procedure to terminate dependent life coverage).

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is *the later of:*
   (a) the date the request was signed, or
   (b) the date of the event
   Field Option 15 (Multiple Group Fields)
   <Enter>

5. Member Group
   Field Type Enrollee 1051 = FT Employee opting out
   1053 = Public Official opting out
   1056 = U of I Foundation employee opting out

6. Member Group
   Field Qualifying Change Reason
   10 = Benefit Choice
   32 = Marriage of Employee
   46 = Spouse's employer offers insurance for the first time
   47 = Coordination of spouse's annual election period
   62 = Spouse gaining employment
   63 = Change Employment Status
   64 = Change in Public Aid or Medicare status
   65 = Dependent becomes eligible for coverage

Field Requested Date of Change (Date Opt Out Form was signed).
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed

7. Member Change Menu
   Field Option 21, enter an 'H' (health)
   <Enter>

8. Member Plan (Health)
   Field Active/Term (A/T) "T"
   Field Term Reason 34 (Term Reason 33 if member does not have life coverage)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.
   Repeat Step 9 for Dental and Vision

9. Member Change Menu
   "THERE ARE CROSS-EDIT ERRORS ON THE MEMBER PLAN RECORD" will appear.
   Field Option 21 for H, D and V (When you go to each screen "CROSS EDIT ERRORS ON THIS TABLE NO LONGER EXIST" will appear)

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

12.6 Terminating Dependent Coverage

See the 'Dependent Death' procedure for terminating a dependent due to death.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date)
   The day following:
   - the last day of the pay period in which the member requests termination of dependent coverage.

   The same day:
   - the dependent enters the military,
   - the dependent enrolls in the State's program as a member,
   - the dependent gets married,
   - the member's divorce (termination of the spouse) is date stamped by the circuit clerk.

   The first day of the month:
   - following the month in which the dependent child becomes 19 or 23 and is no longer eligible for state coverage, graduates or drops out of school.

   Field Option 12 (Family Status)
   <Enter>

5. Member Group Screen
   Field Qualifying Chg Reason
   Field Reqdt – enter the date the member signed the request
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change Date (effective date)
   Field Option 24 (Terminate Dependent Menu)
   Note: If terminating dependent due to divorce, marital status must be changed ***after*** processing the dependent termination. If the marital status is changed prior to the termination, a cross-edit error will occur.
   Field Dependent SSN (Leave blank if terminating all dependents)
   <Enter>

7. Terminate Dependent Menu
   * If the dependent SSN is not known, press F2 (Dependent List). The 'Dependent Selection Menu' will list all dependents. Place an 'X' next to the dependent who is being terminated. Press <Enter>.
   Field Termination Reason (Other than Death – see the 'Dependent Death' procedure for terminating a dependent due to death).
   It is important that the correct code be entered, since this field determines whether a COBRA letter will be generated.

   COBRA codes include:
   55 = Dependent marriage
   56 = Dependent spouse divorce
   57 = Failure to recertify (This code is used when the system automatically terminates dependent coverage, age 19 through age 23).
   58 = Dependent child turns 19
   59 = Dependent child turns 23
   66 = Dependent becomes ineligible (Loss of student status, etc.)

   No COBRA letter is generated when these codes are used:
   50 = Dependent voluntarily terminated
   51 = Transfer to another member
   53 = Military service
   54 = Enrolled as a member
   65 = Dependent never eligible
   69 = Opt Out dependent without life

   Field Select Term Option:
   1. Terminate All Plans
   2. Terminate H/D/V
   3. Terminate Life

   Field And Number of Dependents
   1. All Dependents
   2. One Dependent – SSN Required

   Press <enter>: '# of dependents termed at group and plan level" message will appear.
   Press <enter> again to proceed.

If Child Life coverage for all children, or Spouse Life coverage has been terminated, the "Member Plan – Life" screen must be updated to reflect this change. If the member life plan screen is not updated, life premium liability will not be calculated correctly.

Once the required dependent has been terminated:

- proceed with member life update (step 8) if Child or Spouse Life was dropped, or
- proceed with confirmation process (step 11) if dependent life was not changed.

8. Terminate Dependent Menu
   Press F3 (Member Change Menu)

9. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 18 (Life Coverage)
   <Enter>

10. Member Plan - Life
    Field Spouse life (Y/N) = N, or
    Child life (Y/N) = N
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

Proceed with Confirmation Process.

11. Member Change Menu
    Press F6 to proceed to the confirmation screen.

12. Confirmation Screen
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.7 Adding Dependent Coverage to Existing Member

Note: When adding a dependent spouse due to marriage, the marital status must be changed to "married" before the spouse may be added.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is *the later of*:
   (a) the date the request to add the dependent was signed, or
   (b) the date of the event.
   An exception to the above effective dates is in the case of **birth or adoption** (see Section 3.1).
   Field Option 12 (Family Status)
   <Enter>

5. Member Group
   Field Qualifying Change Reason
   10 = Benefits Choice
   30 = Birth
   31 = Adoption
   32 = Marriage
   33 = Spouse Loses Employment
   34 = Spouse's Employer Discontinues All Coverage
   35 = Dependent Becomes Ineligible for Other Coverage
   41 = Change Dep. Health Coverage in the 2+ Dep. Prem. Group
   45 = Spouse's Employer Makes Change in Prem. > 30%
   47 = Coordination of Spouse Annual Election Period
   63 = Change in Member, Spouse or Dependent Employment Status
   64 = Loss of Public Aid Status
   65 = Dependent Becomes Eligible
   66 = Court Order Results in Member Gaining Custody of Dependent

67 = Court Decree Establishes Member's Financial Responsibility for a Child's Health, Dental, or Other Health Care (Adjudicated Child).

Field Requested Date of Change (Date Initial Enrollment – Dependent Information form was signed)
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 23 (Add A Dependent)
   Note: If a dependent is in Terminated status, use the 'Reinstating Dependent Coverage' procedure, section 12.8.
   <Enter>
7. Dependent Add Menu
   Field Dependent Social Security Number. If newborn dependent does not have a social security number, enter 808 00 0000.
   Note: The system will generate a temporary SSN.
   Do not attempt to enter a temporary SSN for the dependent.
   Field Temporary SSN (Y/N)
   Field Dependent address same as member (Y/N). Default is Y.
   If no, enter either U(sa) or F(oreign)
   Field "Other address" is used when information regarding group insurance related issues is to be sent to another individual, in addition to, or other than the member.
   Other address (Y/N). Default is N.
   If Y, enter either U(sa) or F(oreign)
   <Enter>
8. Dependent Biographical
   Field Last name, first name, middle initial
   Field Date of birth (MMDDYYYY)
   Field Birth Seq #
   Field Sex (M/F)
   Field Retirement Date (leave blank unless dependent is retired)
   Field Medicare Status
   1 = Non-Medicare
   2 = Medicare eligible 65 and over
   3 = Medicare ineligible 65 and over *
   4 = Medicare disability
   5 = Medicare End Stage Renal Disease

* GIR/P's must submit documentation to GID from the member verifying Medicare ineligibility. GID will process the transaction to add the member to the system. See Section 3.3.F.1, 'Medicare' for documentation requirements.

If Medicare Status 1, press <enter> twice, go to next step.
If Medicare Status 2, 4, or 5, continue.

Field Part A begin date – input the date listed on the dependent's Medicare ID card as first eligible for Part A.
Field Part A end date will be 99 99 9999

Field Part A Free "Y" if dependent receives Part A free. If dependent must purchase Part A, "N".
Field Part B begin date – input the date listed on the dependent's Medicare ID card as first eligible for Part B.
Field Part B end date will be 99 99 9999
<Enter> and process.

Dependent Medicare Number History (Optional) – Screen will appear if 2, 4, or 5 was entered for the Medicare Status on the Dependent Biographical Screen.
Field SEL enter 'A' for Add
Field Medicare Number – enter the Medicare number from the dependent's Medicare ID card (the Medicare number is the dependent's SSN followed by either 1 or 2 alpha characters)
Field Begin Date – listed as Effective Date on Medicare card
Field End Date – enter 99 99 9999
Press <**enter**>: **No additional records** will appear on the bottom of screen.
Press <**enter**> again to proceed.

9. Dependent Address – (This optional screen will appear only if you answered 'No' to "dependent address same as member" on the Dependent Add Menu).
Field Dependent street address
Field Dependent city
Field Dependent state
Field Dependent zip code; the zip+4 field will automatically update
Field Dependent resident county
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

10. Dependent Other Addressee – (This optional screen appears if you answered 'Yes' to "other address" on the Dependent Add Menu).
Field Name, Last Name, First Name, Middle Name ***or*** Organization
Field Street Address (2 line maximum)
Field City
Field State/Zip code; the zip+4 field will automatically update
Field Type of Address

1. Custodial Parent	2. Trustee
3. Power Of Attorney	4. Legal Guardian
5. Mailing Address	6. In Care Of (C/O)

Field Country Code – only complete for foreign addresses
Field Country Name – only complete for foreign addresses
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

The system will advise if corrections are recommended for the zip code; therefore, double-check the city name after you press enter to make sure it is correct.

11. Dependent Group
    Field Dependent Type = Enter 10 (for Active) in the first field, leave second field blank (will look like '10 __' when input correctly).
    Field Relationship
    01 = Spouse
    02 = Natural Child
    03 = Adopted Child
    04 = Stepchild
    06 = Legal Guardian
    07 = Adjudicated Child
    08 = Student
    09 = Handicapped **(only GID may enter initial entry)**
    10 = Other
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

12. Dependent Plan – Health
    Field Active/Term – default is "A".
    Use "T" if dependent is not to be covered for health.
    Note: If dependent health is waived, dental and vision coverage must also be waived – Term/Waive Reason 63.
    Field Pre-existing months. Entry is required – if none, "0"
    Field Carrier Code. **Pre-filled with same carrier as member.**
    Field PCP/PCD#: If managed care, must enter PCP#, cannot be "000000".
    Field Go to COB (Y/N). Default is "N".
    If "Y", additional screen will appear after Dependent Plan Health screen.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

    Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the health plan screen.
    Field A(dd)
    Field Begin date – Effective date of the other group coverage.
    Field End Date – may be 99 99 9999
    Field Carrier Name – Insurance company name of other coverage.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

13. Dependent Plan – Dental
    Field Active/Term – Default is "A".
    Use "T" if dependent is not to be covered for dental.
    Note: If the dependent health was waived, dental coverage must also be waived – Term/Waive Reason 63.
    Field Carrier Code. **Pre-filled with same carrier as member.**

Field PCP/PCD#: Leave blank.
Field Accessible Y/N. Default is "Y" ("N" will revert back to "Y")
Field Go to COB (Y/N). Default is "N".
If "Y", additional screen will appear after Dependent Plan Dental screen.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the dental plan screen. **Instructions are the same as the COB portion of step 12.**

14. Dependent Plan – Life
Field Active/Term – Default is "A".
Use "T" if dependent is not to be covered for life insurance – Term/Waive Reason 63.
Field Carrier Code = C9
Field Certificate approval date **–*check the "Statement of Health" table to verify if a Health Certificate is required for the specific change being requested.**
Field Life amount. Pre-filled with $5,000.00 dependent coverage limit.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.
Note: If Spouse or Child Life is being added, the "Member Plan – Life" screen must be updated to reflect this change. If the member screen is not updated, the life premium will not calculate correctly. Instructions for the member life plan are given starting with step 16.

15. Dependent Plan – Vision
Field Active/Term – Default is "A".
Use "T" if dependent is not to be covered for vision.
Note: If dependent health was waived, vision coverage must be also be waived – Term/Waive Reason 63.
Field Carrier Code 'VS' – **Pre-filled**.
Field Go to COB (Y/N). Default is "N".
If "Y", additional screen will appear after Dependent Plan Vision screen.
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the vision plan screen. **Instructions are the same as the COB portion of step 12**.

To add another dependent, repeat instructions for **"Adding Dependent Coverage"** step 7.

Once all dependents have been added:

- proceed with member life update (step 16) if Child or Spouse Life was added, or
- proceed with confirmation process (step 20) if dependent life was not added.

If Child or Spouse Life was added for the dependent(s), the member life plan must be updated to reflect this addition of life coverage. If this step is not done, the member's life premium will not calculate correctly.

16. Dependent Add Menu
    Press F6 (Confirm)

17. Confirmation Screen
    Press F7 (Member Change Menu)

18. Member Change Menu
    Field Change date should be pre-filled from previous entry.
    Field Option 18 (Life Coverage)
    <Enter>

19. Member Plan – Life
    Field Spouse Life (Y/N) = Y, or
    Child Life (Y/N) = Y
    Press <enter>: "Data Added, Pending Confirmation" will appear.
    Press <enter> again to proceed.

Proceed with Confirmation Process.

20. Member Change Menu
    Press F6 to proceed to the confirmation screen.

21. Confirmation Screen
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.8 Reinstating Dependent Coverage

Note: When adding a previously covered dependent spouse due to re-marriage, the marital status must be changed to "married" before the spouse may be added.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is *the later of*:
   (a) the date the request to add the dependent was signed, or
   (b) the date of the event.
   Field Option 12 (Family Status)
   <Enter>

5. Member Group Screen
   Field Qualifying Chg Reason
   Field Reqdt – enter the date the member signed the request
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change Date (effective date) is *the later of*:
   Field Option 25 (Dependent Change Menu)
   Field Optional for Selection 23 to 25, Dependent SSN – enter the Social Security number of the dependent being reinstated (or if unknown, press enter and choose the dependent from the 'Dependent Selection Menu').
   <Enter>

7. Dependent Change Menu
   Field Option 10 (Multiple Group Fields)
   <Enter>

8. Dependent Group - Change
   Field Type Depend field must be changed to '10' and clear the remaining two fields
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

9. Dependent Change Menu
   MSG30 - THERE ARE CROSS-EDIT ERRORS ON THE DEPPLANRECORD will appear on the bottom of the screen.
   Field Option 12 (Multiple Plan Fields)
   Field For Opt 11 or 12, enter H, D, L OR V – enter an 'H' (health)
   <Enter>

10. Dependent Plan – Health
    Field Active/Term – change to "A"
    Field Term Reason. Use space bar to clear field
    Field Pre-existing months. Entry is required – if none, "0"
    Field Carrier Code. **Enter same carrier as member.**
    Field Carrier Change Reason.
    Field PCP/PCD#: If managed care, must enter PCP#, cannot be "000000".
    Field Go to COB (Y/N). Default is "N".
    If "Y", additional screen will appear after Dependent Plan Health screen.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

11. Dependent Change Menu
    MSG30 - THERE ARE CROSS-EDIT ERRORS ON THE DEPPLANRECORD will appear on the bottom of the screen.
    Field Option 12 (Multiple Plan Fields)
    Field For Opt 11 or 12, enter H, D, L OR V – enter a 'D' (dental)
    <Enter>

12. Dependent Plan – Dental
    Field Active/Term – change to "A"
    Field Term Reason. Use space bar to clear field
    Field Carrier Code. **Enter same carrier as member.**
    Field Carrier Change Reason.
    Field PCP/PCD#: Leave blank.
    Field Go to COB (Y/N). Default is "N".
    If "Y", additional screen will appear after Dependent Plan Dental screen.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

13. Dependent Change Menu
    MSG30 - THERE ARE CROSS-EDIT ERRORS ON THE DEPPLANRECORD will appear on the bottom of the screen.
    Field Option 12 (Multiple Plan Fields)
    Field For Opt 11 or 12, enter H, D, L OR V – enter a 'V' (vision)
    <Enter>

14. Dependent Plan – Vision
    Field Active/Term – Default is "A".
    Field Term Reason. Use space bar to clear field.
    Field Carrier Code. Enter 'VS'
    Field Carrier Change Reason.
    Field Go to COB (Y/N). Default is "N".
    If "Y", additional screen will appear after Dependent Plan Vision screen.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

    Dependent COB (Optional) – Screen will appear if "Y" was entered in COB field on the vision plan screen.

15. Dependent Change Menu
    MSG30 - THERE ARE CROSS-EDIT ERRORS ON THE DEPPLANRECORD will appear on the bottom of the screen.
    Field Option 12 (Multiple Plan Fields)
    Field For Opt 11 or 12, enter H, D, L OR V – enter an 'L' (life)
    <Enter>

16. Dependent Plan – Life
    Field Active/Term – Default is "A".
    Field Term Reason. Use space bar to clear field.
    Field Carrier Code. Enter 'C9'
    Field Carrier Change Reason.
    Field Certificate approval date **– "Statement of Health" approval is required when requesting Spouse or Child Life coverage reinstatement.**
    Field Life amount. Pre-filled with $10,000.00 dependent coverage limit.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.
    Note: If Spouse or Child Life is being added, the "Member Plan – Life" screen must be updated to reflect this change. If the member screen is not updated, the life premium will not calculate correctly. Instructions for the member life plan are given starting with step 17.

Once all dependents have been reinstated:

- proceed with member life update (step 17) if Child or Spouse Life was added, or
- proceed with confirmation process (step 20) if dependent life was not added.

If Child or Spouse Life was added for the dependent(s), the member life plan must be updated to reflect this addition of life coverage. If this step is not done, the member's life premium will not calculate correctly.

17. Dependent Change Menu
    Press F3 (Member Change Menu)

18. Member Change Menu
    Field Option 18 (Life Coverage)
    <enter>

19. Member Plan
    Field Spouse Life (Y/N) = Y, or
    Child Life (Y/N) = Y
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

20. Member Change Menu
    Press F6 to proceed to the confirmation screen.

21. Confirmation Screen
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.9 Member's Employment Changes
Full-time to Part-time & Vice Versa

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is *the later of*:
   (a) the date the member signed the request, or
   (b) the date the employment status changed.
   Field Option 11 (Member Type Enrollee)
   <Enter>

Full-Time to Part-time (member electing coverage)

5. Member Group
   Field Type Enrollee = 1016 Part-time eligible (electing coverage)
   Field FT/PT % **(Must be 50% or greater, less than 100%)**
   Field Qualifying Change Reason = 63 (Chg employment stat)
   Field Requested Date of Change (Date Part-time Employee Election/Waiver of Group Insurance Participation or Member Change Form was signed)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Option 21 (Multiple Plan Fields)
   Field 'Option 19 to 22 enter H, D, V OR L' field, enter an 'H' (health)
   <Enter>

7. Member Plan
   Field Est Annual Salary, enter the new part-time salary
   Field Chng Reason, enter '2' for 'Voluntary Reduction'
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

8. Member Change Menu
   Field Option 17 (Life Units)
   <Enter>

9. Member Plan
   Field Member Basic Life (Units)
   Press <enter>: "Data Added, Pending Confirmation" will appear.
   Press <enter> again to proceed.

10. Member Change Menu
    Proceed with Confirmation Process.
    Press F6 to proceed to the confirmation screen.
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

<u>Full-Time to Part-time (member waiving health/dental/vision coverage)</u>
(steps 1 – 4 are the same as above)

5. Member Group
   Field Type Enrollee = 1016 Permanent Part-time Employee
   Field Qualifying Chg Reason = 63 (Employment Status Change)
   Field Requested Date of Change (Date Part-time Employee Election/Waiver of Group Insurance Participation or Member Change Form was signed).
   Press <enter>: "Data Added, Pending Confirmation" will appear.
   Press <enter> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

<u>Part-time (member currently enrolled) to Full-time status</u>
(steps 1 – 4 are the same as above)

Note: If member was previously employed less than 50% or waived coverage, refer to 'Adding a New Member'; however, if member is currently enrolled as a part-time member, continue with step 5 below.

5. Member Group
   Field Type Enrollee = 1001 Full-time Employee
   Field FT/PT % = 100%
   Field Qualifying Change Reason = 63 (Chg Employment Stat)
   Field Requested Date of Change (Date Member Change Form was signed)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Option 17 (Life Units)
   <Enter>

7. Member Plan
   Field Member Basic Life (Units)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

8. Member Change Menu
   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

<u>Part-time to Full-time Electing to Opt Out</u>
(steps 1 – 4 are the same as above)

Note: If member was previously employed less than 50% or waived all coverage, refer to 'Adding a New Member'; however, if member is currently enrolled as a part-time member, continue with step 5 below.

5. Member Group
   Field Type Enrollee 1051 = FT Employee opting out
   1053 = Public Official opting out
   1056 = U of I Foundation employee opting out
   Field FT/PT % = 100%
   Field Qualifying Change Reason = 63 (Chg Employment Stat)
   Field Requested Date of Change (Date Member Change Form was signed)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Option 17 (Life Units)
   <Enter>

7. Member Plan
   Field Member Basic Life (Units)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

8. Member Change Menu
   Field Option 21, enter an 'H' (health)
   <Enter>

9. Member Plan (Health)
   Field Active/Term (A/T) "T" (will already be "T" if waived coverage)
   Field Term Reason 34 (Term Reason 33 if did not have life coverage)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.
   Repeat Step 9 for Dental and Vision

10. Member Change Menu
    "THERE ARE CROSS-EDIT ERRORS ON THE MEMBER PLAN RECORD" will appear.
    Field Option 21 for H, D and V (When you go to each screen "CROSS EDIT ERRORS ON THIS TABLE NO LONGER EXIST" will appear)

11. Member Change Menu

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.10 Member's Employment Changes
Leave of Absence to Active & Vice Versa

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is the later of:
   (c) the date the request was signed, or
   (d) the date the member's employment status changed.
   Field Option 11 (Member type enrollee)
   <Enter>

Active to Leave of Absence

***NOTE*: GID must process certain waivers of coverage**

5. Member Group
   Field Type Enrollee
   6001/6026 (6051 Opt Out) = Medical Leave (Disability Benefits)
   6002/6027 (6052 Opt Out) = Medical Leave (No Disability Benefits)
   6003 (6053 Opt Out) = Occupational Disability Leave
   6006/6028 (6056 Opt Out) = Educational/Sabbatical Leave
   6009/6030 (6059 Opt Out) = Personal/General Leave
   6029 = Seasonal Leave
   6008 (6058 Opt Out) = Permanent Layoff (6 to 24 months state paid) - May only be processed by Membership Unit staff
   6010/6031 (6060 Opt Out) = Family Medical Leave
   6011/6032 (6061 Opt Out) = Suspension/Docked (30 days or less)
   6012/6033 (6062 Opt Out) = Suspension/Docked (more than 30 days)
   6013 = Permanent Layoff (life only)
   6018 (6068 Opt Out) = Furlough (ISD and ISVI only)
   6019 (6069 Opt Out) = Military Call-up (Payroll)
   6039 (6089 Opt Out) = Military Leave Opt Out

Field Qualifying Change Reason = 63 (Chg Employment Stat)
Field Requested Date of Change (Date Leave of Absence and Election of Participation Certificate or Member Change Form was signed).
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed

Proceed with Confirmation Process.
Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

<u>Leave of Absence to Active</u> (steps 1 – 4 are the same as above)

5. Member Group

Field Type Enrollee
1001 = Full-time employee
1051 = Full-time employee opting out
1053 = Public Official opting out
1056 = U of I Foundation employee opting out
1016 = Part-time employee
6014/6034 (6064 Opt Out) = FMLA on Payroll (Member who has returned to work on an intermittent and/or part-time basis)
Field PT % - (**If entering a '1016' type enrollee code, a percentage of 50% or greater, but less than 100% must be input)**
Field Qualifying Change Reason = 63 (Chg Employment Stat)
Field Requested Date of Change (Date Member Change Form signed.)
Press <**enter**>: "Data Added, Pending Confirmation" will appear.
Press <**enter**> again to proceed.

Proceed with Confirmation Process.
Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

12.11 Changing Medicare Status

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member or Dependent's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

Member's Medicare Status

4. Member Change Menu
   Field Change date (effective date) enter the date Medicare became effective, **must be the 1st of the month**.
   Field Option 2 (Medicare Status)
   <Enter>

5. Member Biographical
   Field Medicare Status
   1 = Non-Medicare
   2 = Medicare eligible 65 and over
   3 = Medicare ineligible 65 and over *
   4 = Medicare disability
   5 = Medicare End Stage Renal Disease

* GIR/P's must submit documentation to GID from the member verifying Medicare ineligibility. GID will process the transaction to add the member to the system. See Section 3.3.F.1, 'Medicare' for documentation requirements.

If Medicare Status 1, press <enter> twice, go to next step.
If Medicare Status 2, 4, or 5, continue.

Field Part A begin date - input the date listed on the member's Medicare ID card as first eligible for Part A.
Field Part A end date will be 99 99 9999
Field Part A Free Y if eligible, N if not eligible.
Field Part B begin date - input the date listed on the member's Medicare ID card as first eligible for Part B.
Field Part B end date will be 99 99 9999
<Enter>
"Change in Medicare Detected – Cross Edit on Mem Grp – Recalc Prim Payer" message will appear.
Press F3 (Previous Menu)

6. Member Change Menu
   Field Change Date (Effective date)
   Field Option 15 (Multiple Group Fields)
   <Enter>

7. Member Group Screen
   "Cross Edit Errors on This Table No Longer Exist" message will appear.
   Press F3 (Prev Menu)

8. Member Change Menu
   Field Change Date (Pre-filled)
   Field Option 03 (Multiple Bio Fields)
   <Enter>

9. Member Biographical
   "Cross Edit Errors on This Table No Longer Exist" message will appear.
   Press F3 (Prev Menu)
   Press F6 (Confirm)

10. Confirmation Screen
    Type 'X' next to 'Confirm Updates'
    <Enter>

<u>Dependent's Medicare Status</u>
(Steps 1 – 3 are the same as above)

4. Member Change Menu
   Field Change date (effective date) enter the date Medicare became effective, **must be the 1st of the month**.
   Field Option 25 (Dependent Change Menu) *
   * If the dependent SSN is not known, press enter after choosing option 25. The 'Dependent Selection Menu' will list the dependents. Place an 'X' next to the dependent whose Medicare status is being changed. Press <Enter>.
   Field Dependent SSN
   <Enter>

5. Dependent Change Menu
   Field Option 01 (Medicare Status)
   <Enter>

6. Dependent Biographical
   Field Medicare Status
   1 = Non-Medicare
   2 = Medicare eligible 65 and over
   3 = Medicare ineligible 65 and over *
   4 = Medicare disability
   5 = Medicare End Stage Renal Disease

* GIR/P's must submit documentation to GID from the member verifying Medicare ineligibility. GID will process the transaction to add the member to the system. See Section 3.3.F.1, 'Medicare' for documentation requirements.

   If Medicare Status 1, press <enter> and process.
   If Medicare Status 2, 4, or 5, continue.
   Field Part A begin date - input the date listed on the dependent's Medicare ID card as first eligible for Part A.
   Field Part A end date will be 99 99 9999
   Field Part A Free Y if eligible, N if not eligible.
   Field Part B begin date - input the date listed on the dependent's Medicare ID card as first eligible for Part A.
   Field Part B end date will be 99 99 9999
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Dependent Change Menu
   "There are Cross-Edit Errors on the Depend Bio Record" message will appear.
   Field Option 10 (Multiple Group Fields)
   <Enter>

8. Dependent Group Change
   "Cross Edit Errors on this Table No Longer Exist" message will appear.
   Press F3 (Previous Menu)

9. Dependent Change Menu
   Field Option 03 (Multiple Bio Fields)
   <Enter>

10. Dependent Biographical
    "Cross Edit Errors on this Table No Longer Exist" message will appear.
    Press F3 (Previous Menu)

11. Dependent Change Menu
    Press F6 (Confirm)

12. Confirmation Screen
    Type 'X' next to 'Confirm Updates'
    <Enter>

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.12 Changing Health/Dental Carrier

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 6 (Mass Change – Mem/Dep)
   <Enter>

4. Mass Change Menu
   Field Effective Date: Enter the effective date of the change
   Field Plan H(ealth) or D(ental)
   Field Carrier Change Reason = 04 (Special Circumstances)
   Field New Carrier Code
   Field Qualifying Change Reason
   = 20 (Address Change)
   = 40 (Change In Managed Care)
   Field Request Date – Date the request was signed
   Field Event Date – Date the PCP left the network
   <Enter>

5. Mass Carrier Change Screen
   Field Member PCP/PCD – enter the member's PCP number
   Field PCP/PCD – enter the PCP for each dependent listed - "Press Enter to Apply PCP Codes" will appear on bottom of screen.
   <Enter>
   Field "Enter Y to Apply Changes" – 'Y'(or F9 to cancel)
   <Enter>

6. Confirmation Screen
   Field Place an 'X' next to 'Confirm Updates'
   <Enter>

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.13 Increase/Decrease Optional Life Above $50,000

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) - the date of a *decrease* the request was signed. The date of an *increase* is the first day of the pay period following approval from the life plan administrator.
   Field Option 12 (Family Status)
   <Enter>

5. Member Group Screen
   Field Qualifying Change Reason = 42 (Chg In Life Cov >50K)
   Field Requested Date of Change
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 18 (Life Coverage)
   <Enter>

7. Member Plan - Life
   Field Optional Term Life – 1-8 times member salary.
   Field Certificate approval date **is** required to increase.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

12.14 Add/Drop Spouse and/or Child Life

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed, if Statement of Health approval is not required. If Statement of Health approval is required, the effective date is the first day of the pay period following the approval. If Child Life coverage is requested for a newborn, the effective date is the date of birth.
   Field Option 12 (Family Status)
   <Enter>

5. Member Group Screen
   Field Qualifying Change Reason = 43 (Chg Spouse Chld AD&D)
   Field Requested Date of Change – date member signed request
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 25 (Dependent Change Menu)
   <Enter>

7. Dependent Selection Menu
   Field Place an 'X' next to affected dependent
   <Enter>

8. Dependent Change Menu
   Field Option 12 (Multiple Plan Fields)
   Field L = Life coverage
   <Enter>

<u>Adding Spouse or Child Life coverage</u> (steps 1 – 8 are the same as above)

9. Dependent Plan Menu
   Field A = Active
   Field Term Reason - press space bar twice to clear field
   Field Term Carrier Change Reason - press space bar twice to clear field
   Field Carrier Code = C9
   Field Certificate approval date **is** required to add (except for newborns, adopted children or newly acquired dependents).
   Field Life amount. Pre-filled with $10,000.00 dependent coverage limit.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

10. Dependent Change Menu
    Press F3 (Member Change Menu)
    <Enter>

11. Member Change Menu
    Field Change date should be pre-filled from previous entry.
    Field Option 18 (Life Coverage)
    <Enter>

12. Member Plan - Life
    Field Spouse Life (Y/N) = Y, or
    Child Life (Y/N) = Y
    Field Certificate approval date **is** required to add.
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

    Proceed with Confirmation Process.
    Press F6 to proceed to the confirmation screen.
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

<u>Terminating Spouse or Child Life coverage</u> (steps 1 – 8 are same as above)

9. Dependent Plan Menu
   Field T = Terminate
   Field Term Reason = 50 (dependent voluntary term)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

10. Dependent Change Menu
    Press F3 (Member Change Menu)
    <Enter>

11. Member Change Menu
    Field Change date should be pre-filled from previous entry.
    Field Option 18 (Life Coverage)
    <Enter>

12. Member Plan - Life
    Field Spouse life (Y/N) = N, or
    Child life (Y/N) = N
    Press <**enter**>: "Data Added, Pending Confirmation" will appear.
    Press <**enter**> again to proceed.

    Proceed with Confirmation Process.
    Press F6 to proceed to the confirmation screen.
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.15 Add/Drop AD&D Coverage

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed.
   Field Option 12 (Family Status)
   <Enter>

5. Member Group Screen
   Field Qualifying Change Reason = 43 (Chg Spouse Chld or AD&D)
   Field Requested Date of Change – date member signed request
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 18 (Life Coverage)
   Field L = Life
   <Enter>

7. Member Plan - Life
   Field N = None (No AD& D Coverage)
   B = Basic (Salary amount only)
   C = Combined (Salary + Optional life amount Max 4 times Opt)
   Field Certificate approval date **is not** required.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

12.16 Recertifying Dependents: 19th or 23rd Birthday

*** Currently this procedure may only be processed by the Bureau of Benefits Office.**

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) is the date of the 19th or 23rd birthday.
   Field Option 25 (Dependent Change Menu)
   Field Dependent's Social Security Number, if known. If unknown -
   <Enter>
   Dependent Selection Menu will appear
   Field Place 'X' next to appropriate dependent to select
   <Enter>

5. Dependent Change Menu
   Field Option 09 (Recertify Dependent)
   Field Recertification type – place 'X' next to either 19th or 23rd bdate
   <Enter>

6. Dependent Group Change
   All recertifications need verification documentation, see policy.
   Field Relationship
   08 = Student
   09 = Handicapped **(only GID may enter initial entry)**
   * Initial handicap determination must be input by GID - send verification information to Membership to be input. Annual recertification of Handicap status may be input by the GIR.
   10 = Other
   Field Recertification date - will be pre-filled from Member Change Menu effective date.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Dependent Change Menu

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.17 Recertifying Dependents: Annual/Semi-Annual

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) may vary from year to year. The Group Insurance Division will notify the GIR/P of the recertification effective date via an Administrative Bulletin.
   Field Option 25 (Dependent Change Menu)
   Field Dependent's Social Security number, if known. If unknown -
   <Enter>
   Dependent Selection Menu will appear
   Field Place 'X' next to appropriate dependent to select
   <Enter>

5. Dependent Change Menu
   Field Option 09 (Recertify Dependent)
   <Enter>

6. Dependent Group Change
   All recertifications need verification documentation, see Eligibility Requirements section 2.1, Dependent Recertification, for specific documentation requirements.
   Field Relationship – will be pre-filled
   08 = Student
   09 = Handicapped **(only GID may enter initial entry)**
   Initial handicap determination must be input by GID - send verification information to Membership to be input. Annual recertification of Handicap status may be input by the GIR.
   10 = Other
   Field Recertification date - will be pre-filled from Member Change Menu effective date.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Dependent Change Menu

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.18 Correcting Member/Dependent Address

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

Member Address Change

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed.
   Field Option 04 (Address Change)
   <Enter>

5. Member Address - This screen has additional correction capability. After entering the information, recommended corrections/completions will appear to the right of the data entered. Corrections/completions include street address, state, zip code (9 digits), and resident county. ***Note:*** If after researching the correct address you are unable to process the change, send a correction a GID for processing.
   Field Member address - 2 lines, if necessary
   Field Member city
   Field Member state
   Field Member zip code; the zip+4 field will automatically update
   Field Resident county
   Field Country Code – only complete for foreign addresses
   Field Country Name – only complete for foreign addresses
   Field Mail to this address (Y/N)
   If 'Yes', go to step 6.
   If 'No', the "other addressee" information screen will appear in which the other address must be entered.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

'Other' Address Change (Steps 1 – 3 are the same as above)

Note: Update this information when the custodial parent, legal guardian, trustee, power of attorney, mailing address, or in care of (c/o) needs updated or if the current addressee has a new address.

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed.
   Field Option 05 (Other Addressee)
   <Enter>

5. Member Other Addressee
   Field Name, Last Name, First Name, Middle Name ***or*** Organization
   Field Member address - 2 lines, if necessary
   Field Member city
   Field Member state/zip code; the zip+4 field will automatically update
   Field Country Code – only complete for foreign addresses
   Field Country Name – only complete for foreign addresses
   Field Type of Address

1. Custodial Parent	2. Trustee
3. Power Of Attorney	4. Legal Guardian
5. Mailing Address	6. In Care Of (C/O)

   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

<u>Dependent Address Change</u> (Steps 1 – 3 are the same as above)

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed.
   Field Option 25 (Dependent Change Menu)
   Field Dependent's Social Security Number, if known. If unknown -
   <Enter>
   Dependent Selection Menu will appear
   Field Place 'X' next to appropriate dependent to select
   <Enter>

5. Dependent Change Menu
   Field Option 04 (Dependent Address)
   <Enter>

6. Dependent Address
   Field Dependent street address
   Field Dependent city
   Field Dependent state
   Field Dependent zip code
   Field Dependent resident county
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

Proceed with Confirmation Process.
Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

5. Dependent Other Addressee – (This optional screen appears if you answered 'Yes' to "other address" on the Dependent Add Menu).
   Field Name, Last Name, First Name, Middle Name ***or*** Organization
   Field Street Address (2 line maximum)
   Field City
   Field State/Zip code; the zip+4 field will automatically update
   Field Type of Address
   1. Custodial Parent 2. Trustee
   3. Power Of Attorney 4. Legal Guardian
   5. Mailing Address 6. In Care Of (C/O)
   Field Country Code – only complete for foreign addresses
   Field Country Name – only complete for foreign addresses
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

The system will advise if corrections are recommended for the zip code; therefore, double-check the city name after you press enter to make sure it is correct.

<u>Member Work County Change</u> (Steps 1 – 3 are the same as above)

4. Member Change Menu
   Field Change Date (effective date) is the date the request was signed.
   Field Option 15 (Multiple Group Fields)
   <Enter>

5. Member Group Screen
   Field Work County (enter 3-digit number from county code list)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

Proceed with Confirmation Process.
Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.19 Change in Marital Status

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

Marriage

Note: When adding a dependent due to marriage, the member's marital status must be changed to "married" before dependent spouse coverage may be added.

4. Member Change Menu
   Field Change date (effective date) enter the actual date of the marriage or date of the request, whichever is later.
   Field Option 01 (Marital Status)
   <Enter>

5. Member Biographical
   Field Marital Status (S/M) enter 'M' for married
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 (Confirm)

7. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

<u>Divorce/Annulment</u>
(Steps 1 – 3 are the same as above)

Note: You must terminate the ex-spouse's coverage before the system will allow you to change the marital status to "single".

4. Member Change Menu
   Field Change date (effective date) enter the actual date of the divorce ("filed" date on the divorce decree)
   Field Option 01 (Marital Status)
   <Enter>

5. Member Biographical
   Field Marital Status (S/M) enter 'S' for single
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 (Confirm)

7. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

12.20 Correcting SSN

SSN corrections do not appear on the Membership system until the overnight system processing has completed.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

Correcting Member SSN

4. Member Change Menu
   Field Change Date (effective date) is the current date.
   Field Option 03 (Multiple Bio Fields)
   <Enter>

5. Member Biographical
   Field SSN Key Change - Enter correct Social Security number
   Field Temporary SSN - N
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

<u>Correcting Dependent SSN</u> (Steps 1 – 3 are the same as above)

4. Member Change Menu
   Field Change Date (effective date) Enter the effective date
   Field Option 25 (Dependent Change Menu)
   <Enter>
   Dependent Selection Menu will appear
   Field Place 'X' next to appropriate dependent to select
   <Enter>

5. Dependent Change Menu
   Field Option 03 (Multiple Bio Fields)
   <Enter>

6. Dependent Biographical
   Field SSN Key Change - Enter Social Security Number
   Field Temporary SSN - N
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.21 Updating Basic Life Units

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date)
   Field Option 17 (Life Units)
   <Enter>

5. Member Plan
   Field Basic life units (annual salary/100 – round up to nearest 100)
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

   Proceed with Confirmation Process.
   Press F6 to proceed to the confirmation screen.
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.22 Changing Organizational Processing Code

Do not make this change for members who are retiring.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>
2. Membership Menu
   Field Option 1 (Update)
   <Enter>
3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>
4. Member Change Menu
   Field Change Date (effective date) is the first day the member will be an employee of the agency to which they are transferring.
   Field Option 9 (Member Processing Org/Deduct Freq/County Work/CUSAS Work Agcy/Dist Code)
   <Enter>
5. Member Group Screen
   Field Ded Freq (S/M) – Enter the pay cycle of the new agency, if applicable (semi-monthly/monthly)
   Field GIR/GIP* - Enter the 9-digit org proc code of the agency to which the member is transferring.
   Note: GIR/P codes may be found by entering option 5 (Insurance Representative Listing) from the Group Insurance Systems Main Menu and following the instructions on the screen.
   Field Payroll Agency – Enter the first three digits of the CUSAS code of the agency from which the person will be paid.
   Field Work County – Change if necessary
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

Note: If you receive the edit message "GIR/GIP does not match Payroll Agency. Change or Confirm.", you must verify the data and either change or confirm the information. Once the org proc code has been changed to the 'receiving' agency, the member's data can no longer be viewed by the 'losing' agency.

Proceed with Confirmation Process.

Press F6 to proceed to the confirmation screen.
Enter an 'X' next to the 'Confirm Updates' field.
<Enter> to record the confirmation.

12.23 Requesting Forms to be Printed

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 3 (Print Forms)
   <Enter>

3. Print Forms Request Menu
   Field Group S(tate)
   Field Member's Social Security Number
   Field Option 1 (Turnaround / Change Document)
   Option 2 (Verification Form)
   Option 5 (Certificate of Group Health Plan Coverage)
   (Options 3 and 4 –ID cards, are no longer available)
   Field Dependent SSN (enter the dependent's SSN if a health certificate is being requested for the dependent).
   <Enter>

The following message will appear on the bottom of the screen: "MSG172 - THE UPDATE TO THE REQUEST FORMS DB2 DATA BASE WAS SUCCESSFUL".

All requested forms are printed at CMS and mailed directly to the member.

- Turnaround / Change forms are printed weekly.

- Verification forms are printed and mailed daily.

- Certificate's of Creditable Coverage may be generated by the GIR/P for any health carrier and are printed and mailed on a weekly basis.

12.24 Changing Coordination of Benefits (COB)

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group S(tate)
   Field Option 2 (Change Menu)
   <Enter>

Adding/Changing/Deleting Member COB

4. Member Change Menu
   Field Change Date (effective date)
   Field Option 06 (COB)
   Field Option 19 to 22 Enter H, D, V, or L – Enter the COB plan to be changed (H-health, D-dental, V-vision, L-life)
   <Enter>

5. Member COB List
   Field 'S' – enter either A (add), U (update), or D (delete)
   Field Seq (leave this field blank)
   Field Begin Date – enter the begin date of the plan
   Field End Date – enter the ending date of the plan. If adding a new plan, enter '99 99 9999'
   Field Carrier- enter the COB carrier (Insurance Company) name
   <Enter> twice

6. Member Change Menu
   Press F6 to proceed to the confirmation screen.

7. Confirmation Screen
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

Adding/Changing/Deleting Dependent COB

4. Member Change Menu
   Field Change Date (effective date)
   Field Option 25 (Dependent Change Menu)
   Field Dependent SSN
   If the dependent SSN is not known, press <enter>. The 'Dependent Selection Menu' will appear listing all dependents. Place an 'X' next to the dependent whose COB information is changing.
   <Enter>

5. Dependent Change Menu
   Field Option 06 (COB)
   Field For Option 11 or 12 Enter H, D, L, or V – Enter the COB plan to be changed (H-health, D-dental, L-life, V-vision)

6. Dependent COB List
   Field 'S' – enter either A (add), U (update), or D (delete)
   Field Seq (leave this field blank)
   Field Begin Date – enter the begin date of the plan
   Field End Date – enter the ending date of the plan. If adding a new plan, enter '99 99 9999'
   Field Carrier- enter the COB (Insurance Company) carrier name
   <Enter> twice

7. Dependent Change Menu
   Press F6 to proceed to the confirmation screen.

8. Confirmation Screen
   Enter an 'X' next to the 'Confirm Updates' field.
   <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.25 Member Death

Dependents are terminated automatically when member is terminated.

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) enter the **actual date of death**. (The system will calculate the date coverage terminates).
   Field Option 8 (Terminate – Member Death)
   Note: If option 8 is entered, the Member Group Screen will automatically be updated with a 8001 code and a COBRA letter will be generated for dependents.
   <Enter>

5. Member Biographical
   A message will appear at the bottom of the screen, "MSG280 - PLEASE PRESS ENTER TO PROCESS DATE OF DEATH."
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 'Confirm Menu'

7. Confirmation Screen
   Enter a 'X' in the field next to 'Confirm Updates'.
   <Enter>

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.26 Dependent Death

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S)tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change Date (effective date) **actual date of death**. (The system will calculate the date coverage terminates).
   Field Option 24 (Terminate Dependent Menu)
   Field Dependent SSN (Leave blank if not sure of SSN of deceased dependent)
   <Enter>

5. Terminate Dependent Menu
   If the dependent SSN is not known, press F2 (Dependent List).
   The 'Dependent Selection Menu' will list all dependents.
   Place an 'X' next to the dependent who died. Press <Enter>.
   Field Enter '52' in the reason code field
   <Enter>

6. Dependent Biographical Screen
   The name and social security number of the dependent who is being terminated will appear on the screen.
   The message, "MSG280 - PLEASE PRESS ENTER TO PROCESS DATE OF DEATH." will appear on the bottom of the screen.
   Press <**enter**>
   Press <**enter**> again to proceed.

If Child Life coverage for all children or Spouse Life coverage has been terminated, the "Member Plan – Life" screen must be updated to reflect this change. If the member life plan is not updated, life premium liability will not be calculated correctly.

Once the required dependent has been terminated:

- proceed with member life update (step 7) if Child or Spouse Life was dropped, or
- proceed with confirmation process (step 10) if dependent life was not changed.

7. Terminate Dependent Menu
   Press F3 (Member Change Menu)

8. Member Change Menu
   Field Change date should be pre-filled from previous entry.
   Field Option 18 (Life Coverage)
   <Enter>

9. Member Plan - Life
   Field Spouse life (Y/N) = N, or
   Child life (Y/N) = N
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

If the dependent was the Spouse, proceed to the Member Biographical screen to change the marital status to "S" single.

Proceed with Confirmation Process.

10. Member Change Menu
    Press F6 to proceed to the confirmation screen.

11. Confirmation Screen
    Enter an 'X' next to the 'Confirm Updates' field.
    <Enter> to record the confirmation.

**** Confirming updates will prevent further changes from being made to this member's file for the same effective dates after today.**
(i.e., dependent additions, optional life changes, carrier changes, etc.) **

12.27 Change in Medicare Number

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

Member

4. Member Change Menu
   Field Change date (effective date) enter the date the change was requested
   Field Option 26 (Medicare Nbrs)
   <Enter>

5. Member Medicare Number History
   Field SEL enter 'A' for Add, 'U' for Update, or 'D' for Delete
   Field Medicare Number – enter the Medicare number from the member's card (the Medicare number is the member's SSN followed by either 1 or 2 alpha characters)
   Field Begin Date – listed as Effective Date on Medicare card
   Field End Date – enter 99 99 9999 if Adding a Medicare number, or an end date if Updating a Medicare number.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 (Confirm)

7. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

Dependent

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change date (effective date) enter the date the change was requested
   Field Option 25 (Dependent Change Menu)
   <Enter>
   Dependent Selection Menu will appear
   Field Place 'X' next to appropriate dependent to select
   <Enter>

5. Dependent Change Menu
   Field Select Option – enter option 07 (Medicare Nbrs)
   <Enter>

6. Dependent Medicare Number History
   Field SEL enter 'A' for Add, 'U' for Update, or 'D' for Delete
   Field Medicare Number – if Adding, enter the Medicare number from the dependent's card (the Medicare number is the dependent's SSN followed by either 1 or 2 alpha characters)
   Field Begin Date – listed as Effective Date on Medicare card
   Field End Date – enter 99 99 9999 if Adding a Medicare number, or an end date if Updating a Medicare number.
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

7. Dependent Change Menu
   Press F6 (Confirm)

8. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

12.28 Change in Member's Phone Number

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change date (effective date) enter the date the change was requested
   Field Option 27 (PHONE NUMBERS)
   <Enter>

5. Member Biographical
   Field Phone Number: Home – enter the new or corrected home phone number
   Field Work – enter the new or corrected work phone number
   Field Effective Date – enter the date of the request to add/change
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 (Confirm)

7. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

12.29 Change in Member Handicap Status

1. Group Insurance Systems Main Menu
   Field Option 1 (Membership)
   <Enter>

2. Membership Menu
   Field Option 1 (Update)
   <Enter>

3. Membership Update Menu
   Field Member's Social Security Number
   Field Group (S) tate
   Field Option 2 (Change Menu)
   <Enter>

4. Member Change Menu
   Field Change date (effective date) enter the date the change was requested
   Field Option 03 (MULTIPLE BIO FLDS)
   <Enter>

5. Member Biographical
   Field Handicapped (Y/N): – enter the correct status
   Press <**enter**>: "Data Added, Pending Confirmation" will appear.
   Press <**enter**> again to proceed.

6. Member Change Menu
   Press F6 (Confirm)

7. Confirmation Screen
   Type 'X' next to 'Confirm Updates'
   <Enter>

12.30 Address Format

The Health Insurance Portability and Accountability Act (HIPAA) requires that addresses be maintained in a format consistent with the US postal regulations. The Group Insurance Membership System uses a software product called 'FINALIST' to edit address formats and ensure that they follow the federally mandated guidelines.

A complete and correct USA address consists of three pieces of information: 1) Recipient Name, 2) Street Address Line, and 3) City State Zip. Information that could be contained in the two line street address field include apartment or suite numbers, post office box addresses, and a complete rural/highway contract route address (with route and box numbers).

Up to two addresses may be recorded for a member. The 'Mail To This Address' indicator is used on each address to identify whether or not mail should be sent to the designated address. Each member must have at least one address where mail is to be sent.

A. Membership Address Screen Descriptions

There are four address screens in the Membership System.

- Member Address
- Member Other Addressee
- Dependent Address
- Dependent Other Addressee

1. **Member Address Screen**
   A member's actual residential address must be entered on this screen. If mail is to be sent to this address, the "Mail To This Address" indicator should be set to 'Y'.

2. **Member Other Addressee Screen**
   A member may record an alternate mailing address, or may need to record an address for a trustee, power of attorney, legal guardian, etc. This type of address should be entered on the 'Member Other Addressee' Screen. In order for mail to be sent to the "other" address, the 'Mail To This Address' indicator should be set to 'Y' on the "Member Other Addressee" Screen.

3. **Dependent Address Screen**
   A dependent's address should be entered on this screen in situations where the dependent does not live with the member, ***such as in the case of a college student who is living on a college campus***. The "Mail To This Address" indicator may be set to either 'Y' or 'N' depending upon whether Group Insurance notifications should be sent to this address.

4. **Dependent Other Addressee Screen**
   If a dependent has a custodial parent, legal guardian, or some other person or organization responsible for overseeing insurance matters for the dependent, the responsible party's address should be entered on this screen. Entering the responsible party's address on this screen and setting the "Mail To This Address" indicator to 'Y', allows the person to receive the dependent's insurance information.

B. Member/Dependent ADDRESS Fields

MEMBER/DEPENDENT NAME: The member/dependent's LAST, FIRST, and MIDDLE names, previously entered on the biographical screen, will be displayed.

LINE 1: Enter the street address of the member. Use the member's actual residential address when possible. Health and Dental provider accessibility will be based upon the address entered in this field.

LINE 2: Enter secondary address information, such as an apartment number, suite, building number, etc.

CITY: Enter the city in which the member/dependent resides.

STATE: Enter the state in which the member/dependent resides.

- ***U.S. Territories:*** These are countries that are U.S. territories, such as Puerto Rico, Virgin Islands, etc. A two-digit territory code must be entered in the 'State' field for these countries (see list of US territory codes in Appendix H, 'System Codes'). When the Membership system encounters an address for a 'Territory', domestic address format guidelines must be used, rather than foreign address guidelines.

- ***Canadian Provinces:*** Canada is divided into provinces, much like the United States is divided into states. A two-digit province code must be entered in the STATE field to identify the province. ***Note:*** The province code can only be entered when Canada is entered in the COUNTRY field.

ZIP: Enter the five-digit zip code of the member/dependent.

ZIP+4: The ZIP+4 is a protected field in which the user cannot enter data. The address program, FINALIST, will automatically update this field.

- ***Foreign Postal Codes*** are the U.S. equivalent to zip codes. Postal codes must be entered in the Zip and Zip+4 fields for foreign addresses. When addresses are entered for a foreign country, the zip plus four field becomes unprotected and will allow information to be entered into it.

RESIDENT COUNTY: Valid county codes for Illinois are 001-102. FINALIST will automatically insert a county based upon the city entered, or the user can enter a county code from the list provided in Appendix H, 'System Codes'.

- ***Out-of-State County Code:*** States other than Illinois have a county code of 103.
- ***Foreign County Code:*** Foreign countries have a county code of 104.

COUNTRY CODE: Each foreign country has been assigned a three-digit code (see listing of codes in Appendix H, 'System Codes'). No country code is required for USA addresses.

- ***Foreign Countries:*** The three-digit country code should be entered in this field. If the country code is not known, you may refer to the list of countries and their corresponding codes in Appendix H, 'System Codes', or a use the full country name in the COUNTRY field. If the country code is entered, the system will provide the country name and vice versa.

COUNTRY: Enter the name of the country in this field. ***Note:*** If the country code is entered in the country code field, the system will automatically display the name.

MAIL TO THIS ADDRESS (Y/N): Indicate whether or not mail should be sent to the address on this screen.

C. Member/Dependent OTHER ADDRESSEE Fields

MAIL TO PERSON: In situations in which a member/dependent is to receive their mail at another person's address (i.e., living at a different address temporarily, receiving their mail at a different address than their residential address, or when there is another person responsible for overseeing insurance matters for the member/dependent) enter the 'Other Addressee's' LAST, FIRST, and MIDDLE names in these three fields.

-OR-

MAIL TO ORGANIZATION: Members and/or dependents who need to receive their mail at an organization's address (i.e., may be living at a nursing home, or are having their insurance matters taken care of for them by a trustee at a financial institution) enter the ORGANIZATION name in this field.

LINE 1: Enter the street address, or post office box, of the 'Other Addressee' or mailing address.

LINE 2: Enter secondary address information, such as an apartment number, suite, building number, etc.

CITY: Enter the city in which the other addressee resides.

STATE: Enter the state in which the other addressee resides.

- ***U.S. Territories:*** These are countries that are U.S. territories, such as Puerto Rico, Virgin Islands, etc. A two-digit territory code must be entered in the 'State' field for these countries (see list of US territory codes in Appendix H, 'System Codes'). When the Membership system encounters an address for a 'Territory', domestic address format guidelines must be used, rather than foreign address guidelines.

- ***Canadian Provinces:*** Canada is divided into provinces, much like the United States is divided into states. A two-digit province code must be entered in the STATE field to identify the province. ***Note:*** The province code can only be entered when Canada is entered in the COUNTRY field.

ZIP: Enter the five-digit zip code of the member/dependent.

ZIP+4: The ZIP+4 is a protected field in which the user cannot enter data. The address program, FINALIST, will automatically update this field.

- ***Foreign Postal Codes*** are the U.S. equivalent to zip codes. Postal codes must be entered in the Zip and Zip+4 fields for foreign addresses. When addresses are entered for a foreign country, the zip plus four field becomes unprotected and may have information entered into it.

TYPE OF ADDRESS: This is a required field. When recording an address for a person or organization responsible for overseeing insurance matters for an individual, the type of relationship of the Member and 'Other Addressee', or the Dependent and 'Other Addressee' must be indicated in the 'Type of Address' field.

Mail may be sent to either a PERSON or an ORGANIZATION.

- **MAIL TO PERSON:** Use the following Type of Address code descriptions when mail is being sent to a person:

  1=Custodial Parent
  2=Trustee
  3=Power of Attorney
  4=Legal Guardian
  5=Mailing Address
  6=In Care of (C/O)

  - ***Custodial Parent, Trustee, Power of Attorney, or Legal Guardian (codes 1-4):*** Codes 1 through 4 are used to indicate the **relationship** between the member/dependent and the Other Addressee (i.e., CUSTODIAL PARENT, TRUSTEE, POWER OF ATTORNEY, or a LEGAL GUARDIAN).

  When one of these codes is used, only the Other Addressee's name will be listed on the mailing label. The member's name will not appear on the label, however, will appear on the actual correspondence.

  Example: John Q. Public is the member. He has an Other Addressee record for his Power of Attorney, who is Steven Jones. The mailing address label will contain Steven Jones' name and ***there will be no reference*** to John Q. Public on the label. The actual written correspondence, such as a letter, verification form, Explanation of Benefits (EOB), etc., will contain the member/dependent's name.

Example Mailing Label

Steven Jones
123 S Main Street
Anywhere IL 60000

Example Correspondence

Member Turning Age 65

Dear John Q. Public,

Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

- ***Mailing Address (code 5) and In Care Of (code 6):*** These two Types of Address are very similar and may be used interchangeably. Typically, options 5 and 6 will be used for post office box addresses. ***Note:*** When option 6 ('In Care Of (C/O)) is used, only the person's name should be entered in the 'Other Addressee' name field. *Do not type the word 'C/O' in this field.*

When using code 5 or 6, the name of an Other Addressee may or may not be indicated in the 'Mail To Person' field.

- If an Other Addressee's name **is** indicated in the Person field, the mailing label will contain both the Other Addressee and the member/dependent's names.
- If an Other Addressee's name is **not** indicated in the Person field, the mailing label will contain only the member/dependent's name.

Example 1: Mary Jones is the member and wants her mail sent to a post office box. If the GIR/P does not enter a name in the 'Mail to Person' field, all mailing labels and written correspondence will contain Mary Jones' name with the post office box address.

Example Mailing Label

Mary Jones
P.O. Box 123
Anytown IL 60001

Example Correspondence

Member Turning Age 65

Dear Mary Jones,

Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

Example 2: Sandy Williams is the member. She wants her mail sent to her father's house, Jim Williams, where she is living temporarily while her house is being remodeled.

The GIR/P enters Jim Williams' name in the Other Addressee field. The mailing label will contain both Jim Williams and Sandy Williams' names; however written correspondence will contain only Sandy's name. The mailing label will ***not*** contain a 'C/O' indicator in order to comply with postal preferred formatting.

Example Mailing Label

Sandy Williams
Jim Williams
120 S. State Street
Chicago, IL

Example Correspondence

Member Turning Age 65

Dear Sandy Williams,

Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

- **MAIL TO ORGANIZATION:** Use the following Type of Address descriptions when mail is being sent to an organization. A valid organization could be a bank in the case of a trustee, a law firm in the case of a power of attorney, a nursing home in the case of a legal guardian, etc.

  2=Trustee
  3=Power of Attorney
  4=Legal Guardian
  5=Mailing Address
  6=In Care of (C/O)

  - ***Trustee, Power of Attorney, or Legal Guardian (codes 2-4):*** Codes 2 through 4 are used to indicate the **relationship** between the member/dependent and the Organization (i.e., TRUSTEE, POWER OF ATTORNEY, or a LEGAL GUARDIAN).

  When one of these codes is used, only the organization's name will be listed on the mailing label. The member's name will not appear on the label, however, will appear on the actual correspondence.

  Example: Cheryl Martin is a member who wants her mail sent to her bank, First National Bank of Phoenix, as a Trustee (option 2). The mailing address label will contain the First National Bank of Phoenix and ***there will be no reference*** to Cheryl Martin on the label. The actual written correspondence, such as a letter, verification form, Explanation of Benefits (EOB), etc., will contain the Cheryl's name.

Example Mailing Label

First National Bank of Phoenix
123 S Main Street
Phoenix AZ 60000

Example Correspondence

Member Turning Age 65

Dear Cheryl Martin,

Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

- ***Mailing Address (code 5) and In Care Of (code 6):*** These two Types of Address are very similar and may be used interchangeably. Typically, options 5 and 6 will be used for post office box addresses. ***Note:*** When option 6 ('In Care Of (C/O)) is used, only the person's name should be entered in the 'Other Addressee' name field. *Do not type the word 'C/O' in this field.*

When using code 5 or 6, the name of an Other Addressee may or may not be indicated in the Organization field.

- If an organization's name **is** indicated in the Other Addressee field, the mailing label will contain both the Organization and the member/dependent's names.
- If a name is **not** indicated in the Organization field, the mailing label will contain only the member/ dependent's name.

Example: Jan Doe is the member. She has been admitted to a retirement home while she recovers from a broken hip.

Situation 1. The GIR/P enters XYZ Retirement Home name in the Organization field. The mailing label will contain both XYZ Retirement Home and Jan Does' names; however written correspondence will contain only Jan's name. The mailing label will ***not*** contain a 'C/O' indicator in order to comply with postal preferred formatting.

Example Mailing Label

Jan Doe
XYZ Retirement Home
120 S. State Street
Happy Hills, IL 60002

Example Correspondence

Member Turning Age 65

Dear Jan Doe,

Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

Situation 2. The GIR/P leaves the 'Mail to Organization' field on the Other Addressee screen blank and enters only the retirement home's address. Mailing labels and written correspondence will be sent the retirement home address, however, the label and correspondence will contain only Jan's name.

Example Mailing Label

Jan Doe
120 S. State Street
Happy Hills, IL 60002

Example Correspondence

Member Turning Age 65

Dear Jan Doe,
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah
Blahblahblahblahblah

MAIL TO THIS ADDRESS (Y/N): Indicate whether or not mail should be sent to the address on this screen. This field is pre-filled with 'Y'

COUNTRY CODE: Each foreign country has been assigned a three-digit code (see listing of codes in Appendix H, 'System Codes'). No country code is required for USA addresses.

- ***Foreign Countries:*** The three-digit country code should be entered in this field. If the country code is not known, you may refer to the list of countries and their corresponding codes in this section, or a use the full country name in the COUNTRY field. If the country code is entered, the system will provide the country name and vice versa.

COUNTRY: Enter the name of the country in this field. ***Note:*** If the country code is entered, the system will automatically display the name.

13.0 General Information

The Group Insurance Financial Control System (GIFCS) allows the GIR/P to view and analyze Membership and pay record information. GIFCS provides agencies an online real-time method of adjusting pay records and determining discrepancies for member accounts.

Following the GIFCS procedures allows the GIR/P the ability to recognize and correct payroll discrepancies; thereby, ensuring continuation of the member's coverage and proper carrier payments.

For information regarding GIFCS inquiry screens, refer to section 11, 'Group Insurance System Administration.'

Discrepancies

A member's account is considered discrepant when one or more of the following occur:

- Membership health/dental/life carrier code disagrees with the pay record carrier code.
- Membership health/dental/life deduct code disagrees with the pay record deduct code.
- Membership basic life units (BLU) disagrees with the pay record BLUs.
- Membership part-time percentage disagrees with the pay record part-time percentage.
- Membership premium liability disagrees with the pay record premium deduction.

13.1 Viewing a List of All Discrepant Members

A. Screen Description - Discrepant Account List (Screen 1)

A list of all members who have a discrepancy above the GIFCS tolerance level of $3.50 may be viewed using screen 1 – Discrepant Account List. Members will appear on this screen if the Membership codes and pay record codes do not match for a given pay period, or if the member paid premium is discrepant.

Members who have a discrepancy are displayed by Organizational Processing Code (org proc code) and Type/Subtype Code, in Social Security Number order. The GIR/P may display either a specific member, a specific group of members or all discrepant members. Once all discrepancies for a member have been resolved, the member's name may disappear immediately from this screen. However, underpaid members who are CFT (Candidate for Termination) may remain on the list until the next monthly run.

For those agencies with a large number of discrepancies, a filter may be requested through GID. The filter will allow only CFT and Priority members to appear on screen 1. The request should be submitted to the Supervisor of the Analysis and Resolution Unit for consideration.

B. Criteria

- **Org Proc Code**

  - *the first three digits of the org proc code only (i.e., cusas code)*: displays all discrepant members the GIR/P is authorized to access in Social Security Number order, by org proc code and type/subtype.

  - *the remaining six digits of the org proc code (i.e., facility and GIR/P code)*: displays all discrepant members in Social Security Number order, by type/subtype, for the displayed org proc code.

Type/ Subtype

- *the first two digits of the type/subtype code only (all nine digits of the org proc code must be entered for this option)* –displays a specific group of members whose type code matches the type enrollee code entered. This option is helpful when a GIR/P wishes to view a certain "type" of member. For example, a '60**' type enrollee code will display a list of all members on a leave of absence who are discrepant.

- *the entire four digit type/subtype code (all nine digits of the org proc code must be entered for this option)*: displays a specific group of members whose type/subtype code matches the enrollee code entered. This option is helpful when a GIR/P wishes to view a certain "type/subtype" group of members. For example, a 6007 "type" code will display all members on a seasonal leave of absence who are discrepant.

♦ **Social Security Number -** to inquire whether or not a member is discrepant, the GIR/P must enter the SSN at the top of the screen, as well as the complete org proc code and type enrollee code. If the member is not discrepant, the SSN will not appear on the screen.

Press the *F7/F8 (or PF7/PF8) key* to scroll through the discrepant account list when more than 13 members are discrepant. The 'More' indicator will be displayed at the bottom of the screen indicating more discrepant members exist.

C. Information Displayed

Information is displayed in SSN number order. Once the list has been displayed, a specific member's information may be selected by entering a screen number in the 'SEL' column next to the SSN/Name, and pressing ENTER. The fields displayed on this screen are the following:

Field	Description
SEL	The selected screen may be viewed by entering a screen number in this field.
SSNO	Member's Social Security Number.
Name	Member's name, as it appears on the Membership file.
Typ/Subtype	Member's employment status (e.g., 1001 is a full-time employee).
CFT/Priority	Members who are a Candidate for Termination (CFT) will have a number in the CFT field; Priority members will have a number listed in the Priority field. The number which appears in either the CFT or Priority column represents the number of months the member has been reported to the agency as being either a CFT or a priority. The number will increase each month until the member's discrepancy is resolved. At that time, the CFT or Priority number will disappear.

13.2 Determining Discrepant Pay Periods

A. Screen Description – Pay Period Summary Inquiry (Screen 2)

Discrepant pay periods may be viewed in GIFCS by using screen 2 – Pay Period Summary Inquiry. The Pay Period Summary Inquiry screen displays a comparison of member pay records against member liability (from the Membership System) for a specific pay period. The "Difference" column represents the Membership liability minus the member payment for the displayed pay period.

The 'Carrier Balances to Date' section of the screen displays the cumulative balance of each carrier. Regardless of the pay period displayed, the carrier balance encompasses all pay periods on GIFCS.

B. Criteria

The following fields must have criteria entered to display the desired information. Some of the fields are optional, others are required.

- **SSNO** (required field) – The Social Security Number of the member must be entered in order to view the pay periods.

- **Pay Period** (optional field) **-** A specific pay period may be viewed by entering the pay period end date (e.g., 2/15/01 for the 2/1/01 – 2/15/01 pay period). Or, the field may be left blank which will display the most recent pay record appearing on GIFCS.

Press the *F6 (or PF6) key* in order to scroll through previous pay period history.

Press the *F7/F8 (or PF7/PF8) key* to scroll through the 'Carrier Balances to Date' section when more than six carriers exist.

C. Information Displayed

Information is displayed on this screen according to the Social Security Number and pay period date entered.

Field	Description
Name	Member's name.
Discrepant Indicator	Agencies can identify discrepant pay records by the "Discrepant" indicator found on this screen. The discrepant indicator will reflect a 'Y' if there is a coding discrepancy for the displayed pay period, or a 'N' if the pay period shows no coding discrepancies. The "Discrepant" indicator identifies coding discrepancies only; monetary discrepancies are not indicated by the discrepant indicator.
Health, Life and Dental Deduct Code	The carrier and deduct codes indicated under the 'Pay Record' heading for health, life and dental are as they appear on the pay record(s). The carrier and deduct codes under the 'Membership' heading indicate the carriers and deductions as they appear on the Membership System. ***Note:*** **An '*' will appear in this field if there is more than one pay record for the same pay period and any of the codes do not match.**
Life Units	The basic life unit field indicated under the 'Pay Record' heading is the basic life units reported on the pay record for the member. The basic life units listed under the 'Membership' heading indicate the basic life units shown on the Membership System. ***Note:*** **An '*' will appear in this field if there is more than one pay record for the same pay period and the units do not match.**
Pycd/Procorg	The 'PYCD' field indicates the payroll code of the agency which submitted the pay record. The 'PROCORG' field shows the organizational processing code indicated on the Membership System for the member. Note: Differences between the 'PYCD' field and the 'PROCORG' field will not cause the discrepant indicator to read 'Y' for a pay period. The PYCD field must **never be changed**, even if incorrect.
Elcd/Mbrtype	The 'ELCD' is the eligibility code which the agency has coded the member on the pay record (e.g., 'A' indicates full-time active employee). The 'MBRTYPE' code shows the type/subtype code indicated on the Membership System (e.g., '1001' indicates a full-time active employee). Note: Differences between the 'ELCD' field and the 'MBRTYPE' fields, will not cause the discrepant indicator to read 'Y' for a pay period.
Part Time %	The part-time percentage field under the 'Pay Record' heading indicates the part-time percentage the member is coded on the pay record. The part-time percentage field under the 'Membership' heading indicates the part-time percentage the member is coded on Membership for the pay period displayed. ***Note:*** **An '*' will appear in this field if there is more than one pay record for the same pay period and the part-time percentage does not match.**

Information Displayed cont'

Field	Description
Payroll Type	The 'Deduct Frequency' indicated on the Membership file is reflected in this field. Members who are paid monthly are indicated in this field as 'M Monthly'; members who are paid semi-monthly or bi-weekly are indicated in this field as 'S Semi-monthly'.
# of Records	This field indicates the number of pay records on the system for the displayed pay period. In situations where the member has more than one pay record for a pay period (indicated with a number in the "# of records" field), the payments and coding will be combined to create a single record.
File Date	The file date in the 'Pay Record' column indicates either the date the pay record originally loaded to GIFCS, or the date of the most recent change made to screen 3, *whichever is later*. The file date in the 'Membership' column indicates the date of the most recent update on the Membership System.
Carrier Balances to Date	The 'Carrier Balances to Date' section indicates the balance for each carrier the member has been coded. The balances next to the carrier codes indicate the total amount a member is currently overpaid or underpaid. The balances include all pay periods on GIFCS. The 'More' indicator displayed at the bottom of the screen indicates more than six carriers for the member.
Member Payment	The dollar amount paid by the member for health/life/dental for the pay period displayed.
Member Liability	The amount the member owes for health/life/dental as determined by information on the Membership System for the pay period displayed.
Difference	'Member Payment' minus 'Member Liability' equals the 'Difference'. This column indicates whether a member is overpaid, underpaid or correctly paid for health/life/dental for the displayed pay period.

13.3 Manipulating a Pay Record

A. Screen Description – Pay Record Update/Inquiry (Screen 3)

Pay record coding errors must be corrected in GIFCS by using screen 3 – Pay Record Update/Inquiry screen. This screen compares individual pay records against Membership liability for a specific pay period. Please note, this screen does not have a "discrepant indicator" to indicate whether the pay record is discrepant.

The member paid premium for health, dental and life coverage is displayed for each pay record, along with the Membership liability for the corresponding pay period. Some pay periods may have more than one pay record.

B. Criteria

The following fields must have specific data entered to display the information desired. Some of the fields are optional, others are required.

- **A/C/D/I** (optional field) **-** The GIR/P should enter an 'A' to add a pay record, a 'C' to change a pay record, a 'D' to delete a pay record, or an 'I' to inquire (display) a pay record. This is an optional field which will default to 'I' (inquire) if a specific option is not entered.

- **SSNO** (required field) **-** The GIR/P must enter the Social Security Number of the member they wish to display, add, change or delete.

- **Pay Period** (optional field) **-** The GIR/P must delete the dates in the 'Pay Period' field and press ENTER to view all pay records. The GIR/P may enter a pay period end date if they wish to display a specific pay period. For example, if the GIR/P wishes to display the pay record of June 1 – 15th, 2001, the GIR/P should enter '06/15/01' in this field. If the pay period field is left blank, the most recent pay record will be displayed.

- **Record Number** (optional field) **-** The GIR/P should enter the record number they wish to view. In most cases the record number will be '01', since there is usually only one pay record per pay period. However, in cases of multiple pay records, the GIR/P must enter the record number. (Hint: The record number can be found by viewing the Pay Record History Inquiry screen (4)). If the record number field is left blank, the lowest record number (01, 02, etc.) will be displayed first.

Press the *F6 (or PF6) key* in order to scroll through individual pay records.

Press the *F7/F8 (or PF7/PF8) key* to scroll through the ‘Carrier Balances to Date’ section when more than six carriers exist.

C. Add/Change/Delete/Inquiry Process

The GIR/P may add, change, delete, or display (inquire) a specific pay period via screen 3.

1. **Adding a Pay Record:** The Add (A) function allows the GIR/P to add a pay record when there is no pay record for a pay period (i.e., new member's first deduction was not entered on payroll).

   To add a pay record:

   a. Enter an 'A' in the A/C/D/I field.

   b. Enter the Social Security Number and pay period end date of the pay period to be added, if needed, and press ENTER.

   c. All 'Payment Data' fields become populated with the corresponding Membership data for that pay period. The GIR/P must enter the appropriate information in the highlighted 'Pay Code' and Eligibility Code' fields, and press ENTER.

   d. A message will be displayed at the bottom of the screen indicating the pay record was successfully added.

   Note: Pay records should not be added for pay periods in which the member was on a leave of absence (60** type enrollee code on Membership).

2. **Changing a Pay Record:** The Change (C) function allows the GIR/P to change coding on pay records. When processing changes to pay records, the codes being changed **must** match the corresponding 'Membership Data' (with the exception of the Eligibility Code and Pay Code).

   Note: 'Eligibility' codes are one character codes indicating the type of employee (e.g., 'A' indicates an active full-time employee, 'M' indicates an active part-time employee) and will not match the four-digit Member Type Code on the 'Membership Data' field. See the Appendix for a complete list of Eligibility codes.

   An incorrect 'Pay Code' on a pay record should never be changed.

To change a pay record:

a. Enter a 'C' in the A/C/D/I field.

b. Enter the Social Security Number, pay period end date, and record number to be changed. Press ENTER. All 'Payment Data' fields that are allowed to be changed will become highlighted.

c. Change the necessary fields and press ENTER. A message will be displayed at the bottom of the screen indicating the change has been successfully processed. The 'Carrier Balances to Date' section will be updated immediately to reflect the coding change.

3. **Deleting a Pay Record:** The Delete (D) function allows the GIR/P to delete a pay record. Records without Membership liability may be deleted if they do not contain member-paid premium. The 'Payment Data' amount must be $0.00 before a record can be deleted.

Pay records cannot be deleted if:

- the record contains member-paid premium,

~ OR ~

- it is the only record for the pay period and there is Membership liability for that pay period (deleting this record would cause a discrepancy, which the system will not allow).

To delete a pay record:

a. Enter a 'D' in the A/C/D/I field.

b. Enter the Social Security Number, pay period end date, and record number to be deleted. Press ENTER.

c. The message "PRESS ENTER TO CONFIRM DELETE - PF9 TO CANCEL" will appear at the bottom of the screen. Press ENTER again to process the deletion, or press F9 to cancel. A message confirming the record has been deleted/cancelled will appear at the bottom of the screen.

4. **Inquiry:** The Inquiry (I) function allows the GIR/P to view 'Payment Data' and 'Membership Data' side-by-side for all pay records within a pay period. Each pay record is assigned a unique record number and may be viewed individually on this screen.

   To display a specific pay period and/or record number, the GIR/P enters the member's SSN, and optionally, the pay period and record number, and presses ENTER.

D. Information Displayed

Field	Description
Name	Member's name.
Record Type	Type of pay record represented. ♦ C – COMPPAY (Comptroller Pay) ♦ P – PCUDPAY (Premium Collection Unit / Agency Direct Pay) ♦ L – LOCAL (Local Payroll from universities) ♦ R – REVERSAL (Pay record reversal) ♦ F – REFUND (Refund processed through GIFCS) ♦ A – ADDPAYREC (Added pay record) ♦ T – TRANSFER (Member paid premium transfer) ♦ O – OFFSETADJ (Offsetting adjustment processed by GID) ♦ I – IPPADD (Insurance pay period add record from payroll voucher)
Health, Life and Dental Deduct Code	The carrier and deduct codes indicated under the 'Payment Data' heading for health, life and dental from the pay record. The carrier and deduct codes under the 'Membership Data' heading indicate the carriers and deductions as they appeared on the Membership System.
Life Units	The basic life unit field indicated under the 'Payment Data' heading is the basic life units reported on the pay record for the member. The basic life units listed under the 'Membership Data' heading indicate the basic life units shown on the Membership System.
Pycd/Procorg	The 'PAY CODE' field indicates the payroll code of the agency which submitted the pay record and the deduction frequency for that pay code. The 'PROC ORG' field shows the organizational processing code indicated on the Membership System for the member and the deduction frequency. Note: Differences between the 'PYCD' field and the 'PROCORG' field will not cause the discrepant indicator to read 'Y' for a pay period. The PYCD field must **never be changed**, even if incorrect.
Elcd/Mbrtype	The 'ELCD' is the eligibility code which the agency has coded the member on the pay record (e.g., 'A' indicates full-time active employee). The 'MBRTYPE' code shows the type/subtype code indicated on the Membership System (e.g., '1001' indicates a full-time active employee).
Part Time %	The part-time percentage field under the 'Payment Data' heading indicates the part-time percentage the member is coded on the pay record. The part-time percentage field under the 'Membership Data' heading indicates the part-time percentage the member is coded on Membership for the pay period displayed.

Information Displayed cont'

Field	Description
No. of Period(s)	Number of pay periods indicated in the insurance pay period field (IPP).
Age	The age of the member as of the pay period displayed is indicated in the 'Membership Data' column.
Begin Date	Begin date reported on a PCU/Direct Payment/Transfer record.
End Date	End date reported on a PCU/Direct Payment/Transfer record.
Carrier Balances to Date	The 'Carrier Balances to Date' section indicates the balance for each carrier the member has been coded. The balances next to the carrier codes indicate the total amount a member is currently overpaid or underpaid. The balances include all pay period on GIFCS. The 'More' indicator displayed at the bottom of the screen indicates more than six carriers for the member.
Last Change Date	The date the pay record was loaded into GIFCS, or the last date a change was processed to the displayed pay record.
Received Date	Date the original pay record was received by CMS.

13.4 Viewing a Member's Pay Record History

A. Screen Description – Pay Record History Inquiry (Screen 4)

A history of all pay records for a member may be viewed using screen 4 of GIFCS – Pay Record History Inquiry screen. This screen allows the GIR/P to view pay record coding and member paid premiums for each plan (health, life or dental). This screen also indicates whether or not an original pay record has been altered. Pay records that have been altered (via the Pay Record Update/Inquiry screen 3), are identified by an asterisk (*) appearing in the 'A' (Adjusted Record) column.

Pay records on this screen are listed in pay period date order, with the most recent pay record at the top of the screen. The GIR/P can transfer to a specific screen for a more detailed view of a pay record by choosing to audit (screen 7), update (screen 3), or transfer (screen 6).

B. Criteria

The following fields must have specific data entered to display the information desired. Some of the fields are optional, others are required.

- **SSNO** (required field) **-** The GIR/P must enter the Social Security Number of the member they wish to view.

- **Pay Period (thru)** (optional field) **–** The GIR/P must delete the dates in the 'Pay Period' field and press ENTER to view all pay records. GIR/Ps may change the pay period date fields to reflect a specific pay period or range of pay periods. For example, a GIR/P wishing to view the pay periods of August 15th – November 30th would enter the months and year in the format mm - yy (08-01 thru 11-01).

- **Active Records** (optional field) – The GIR/P may view all active records when the 'Active' indicator is 'Y' (which is the default). GIR/Ps may change the indicator to 'N' which will list all active and inactive records (i.e., deleted and moved records). Moved records will appear with the original pay period end date, as well as any subsequent pay period end dates. In other words, the 'N' indicator will show the same record more than once if it has been moved to a new pay period.

Press the *F7/F8 (or PF7/PF8) key* to scroll through previous and next pay records on the screen.

C. Screen Transfer Process

To select a pay record for review on a different screen:

1. Press the tab key until the cursor is in the 'S' column next to the pay record to be viewed.

2. Input one of the following codes in the 'S' column:

   - 'A' (Audit) – This option will display the selected pay record displayed on the Audit History Screen (7).

     The Audit History screen allows the GIR/P to view the requested pay record which has had changes processed via screen 3. The record will display the original format, as well as the history of changes made to the record. This screen helps the GIR/P to determine what changes were made, by whom and when.

   - 'U' (Update) - This option will display the selected pay record on the Pay Record Update/Inquiry screen (3).

     The Pay Record Update/Inquiry screen allows the GIR/P to view the requested pay record in it's current format (original or corrected). The GIR/P may process a change to the pay record, delete the pay record, or add a new pay record from this screen.

   - 'T' (Transfer) – This option will display the selected pay record on the Member Paid Premium Transfer screen (6).

     The Member Paid Premium Transfer screen allows the GIR/P to view premiums paid and Membership liability side-by-side. GIR/Ps may use this screen to transfer member paid premiums between fiscal years and/or carriers.

3. Press ENTER to transfer to the selected screen.

D. Information Displayed

Field	Description
Name	Member's name.
Active Records	Default is 'Y' indicating all active records will be shown. If the GIR/P changes this field to 'N', inactive (i.e., deleted, moved) records will be displayed.
'S'	The GIR/P may enter either an 'A', 'U', or 'T' in this column to transfer to the selected screen.
'A'	An asterisk '*' will appear in this column if an original pay record has been altered.
Pay Period	The pay period end dates are indicated in this field.
Record No	The number assigned to the record for the pay period indicated.
Record Type	Type of pay record represented. ♦ C – COMPPAY (Comptroller Pay) ♦ P – PCUDPAY (Premium Collection Unit / AgencyDirect Pay) ♦ L – LOCAL (Local Payroll from universities) ♦ R – REVERSAL (Pay record reversal) ♦ F – REFUND (Refund processed through GIFCS) ♦ A – ADDPAYREC (Added pay record) ♦ T – TRANSFER (Member paid premium transfer) ♦ O – OFFSETADJ (Offsetting adjustment processed by GID) ♦ I – IPPADD (Insurance pay period add record from payroll voucher)
Health, Life and Dental Deduct Code	The carrier and deduct codes indicated for health, life and dental are as they appeared on the pay record.
Health, Life and Dental Amount	The amount of premium for health, life and dental indicated on the pay record.
EL CD	The 'EL CD' is the eligibility code indicated on the pay record (e.g., 'A' indicates full-time active employee – see Appendix H, System Codes' for other eligibility codes).
Part Time %	The part-time percentage field indicates the part-time percentage indicated on the pay record.
Life Units	The life unit field indicates the basic life units indicated on the pay record.

13.5 Viewing Membership Liability

A. Screen Description – Membership Liability History Inquiry (Screen 5)

A history of Membership liability for a specific member may be viewed using screen 5 of GIFCS – Membership Liability History Inquiry screen. This screen allows the GIR/P to view the health, dental, and life coding, and the premium liability for a specific pay period as shown on the Membership file.

Pay periods on this screen are listed in pay period date order, with the most recent Membership liability at the top of the screen.

B. Criteria

In order to retrieve desired information, required fields must be entered, other fields are optional.

- **SSNO** (required field) **-** The GIR/P must enter the Social Security Number of the member they wish to view.

- **Pay Period (thru)** (optional field) - The GIR/P must delete the dates in the 'Pay Period' field and press ENTER to view all pay records. GIR/Ps may change the pay period dates to reflect a specific pay period or range of pay periods. For example, a GIR/P wishing to view the pay periods of August 15th – November 30th would enter the months and year in the format mm - yy (08-01 thru 11-01).

Press the *F7/F8 (or PF7/PF8) key* to scroll through previous and next pay records on the screen.

C. Information Displayed

Field	Description
Name	Member's name.
Membership File Date	The date in the 'Membership file date' indicates the date of the most recent update posted to the Membership file for the member.
Pay Period	The pay period end dates are indicated in this field.
Proc Org	The 'PROC ORG' field indicates the organizational processing code on the Membership file for the member.
Mbr Type	The 'MBRTYPE' code indicates the type/subtype code on the Membership file for the member (e.g., '1001' indicates a full-time active employee – see Appendix H, System Codes' for other type enrollee codes).
Life Units	The life unit field indicates the basic life units on the Membership file for the member.
Part Time %	The part-time percentage field indicates the part-time percentage on the Membership file for the member.
Health, Life and Dental Deduct Code	The carrier and deduct codes indicated for health, life and dental are the member's coverage elections indicated on the Membership file.
Health, Life and Dental Amount	The amount of premium liability for health, life and dental as indicated on the Membership file.

13.6 Transferring Member Paid Premium

A. Screen Description – Member Paid Premium Transfer (Screen 6)

Member paid premiums may be transferred from one fiscal year to another, or from one carrier to another, using screen 6 of GIFCS – Member Paid Premium Transfer screen.

The Member Paid Premium Transfer screen displays pay record data and the corresponding Membership liability, side-by-side. When processing a transfer on GIFCS, premiums may be moved from one carrier to another, or transferred from one fiscal year to another. **GIR/Ps do not need to transfer premium for the same carrier within the same fiscal year.**

Screen 6 will not allow a GIR/P to process a transfer for a pay period (or a pay period within a range of pay periods) which has a discrepancy.

B. Criteria

In order to retrieve desired information, required fields must be entered.

- **SSNO** (required field) **–** The GIR/P must enter the Social Security Number of the member.

- **Pay Period** (required field) **–** The GIR/P must enter a single pay period in order to transfer member paid premium from one pay period. The GIR/P also has the option of entering a range of pay periods when needing to transfer member paid premium from more than one pay period. The pay periods entered in the 'Pay Period(s)' field **must include** the time period for which the member is overpaid.

Press the *F9 (or PF9) key* to change the pay period dates at the top of the screen.

C. Information Displayed

The Transfer screen is divided into three horizontal sections from top-to-bottom: "Original Pay Period Data", "Take From Original Payment(s)", and "Give To New Pay Period(s)".

1. **"Original Pay Period Data"**: The information in this section is divided into two columns: "Payment" and "Liability".

   - ***"Payment"* –** lists health, dental and life plan coding, premiums deducted, basic life units and part-time percentage as indicated on the payroll file for the specified pay period(s).

   - ***"Liability"* –** lists health, dental and life plan coding, liability due, basic life units and part-time percentage as indicated on the Membership file for the specified pay period(s).

2. **"Take From Original Payment(s)"**: The carrier and deduct codes for the pay period(s) displayed are shown in this section. The amount of premium **to be transferred** must be entered in the health, dental, and/or life fields on the right side of this section.

   Note: If the carrier codes, deduct codes, basic life units and/or part-time percentage are different on any two pay records included in the range of pay periods to be transferred, the GIR/P must process separate transfers for each time period the codes do not match. ***Example:*** An overpayment in the health premium occurs over two pay periods; however, the health carrier is different in each pay period. In this case, separate transfers must be processed for each pay period. A separate transfer would also need to be processed if an overpayment crosses two fiscal years.

3. **"Give To New Pay Period(s)"**: The fields in this section are used to enter the pay period(s), carrier codes, deduct codes, and amounts to where the 'Take From' amounts are being transferred.

   The **"From – To"** fields are used to enter the range of pay periods for which the premium amounts will be transferred. For example, if the GIR/P is transferring an amount to cover an underpayment which occurred during the pay periods of April 1st through May 31st, the GIR/P should enter the dates 040101 – 053101.

   The carrier and deduct codes of the plans from which the premiums are being transferred to must be entered in the health, life, and dental fields. The premium to be transferred must be entered in the fields to the right of the code fields. If premiums are not being transferred to a certain plan carrier, entries in the corresponding fields are not required.

D. Transfer Process

To transfer premium:

1. Determine the pay period(s) in which the overpayment and underpayment occurred. **Make a note of the coding and amounts of the underpayment.**

2. Enter the Social Security Number and pay period begin through end dates of the pay period(s) where the premium is being transferred **from** in the section at the top of the screen. Press ENTER.

   Note: Press the F9 (or PF9) key in order to change the pay period begin and end dates.

3. Review the amounts in the 'Original Pay Period Data – Payment' section to ensure there is enough premium to complete the transfer. If there is not enough premium to complete the transfer, press the F9 (or PF9) key and edit the pay period fields to include a wider range of pay period dates.

4. Enter the premium amounts to be transferred in the Health, Dental and/or Life carrier fields in the 'Take From Original Payment(s)' section.

5. Enter the dates for which the premium is to be transferred **to** in the 'From – To' row of the 'Give To New Pay Period(s)' section.

6. Enter the Health, Dental, Life carrier codes, deduct codes and premium amounts to be applied in these fields. Press ENTER. *Example:* AH 3K 20.00

   Note: The **total** amount of all premium entered in the "Give To" section must equal the **total** amount of premium entered in the "Take From" section. Additionally, the codes in the "Give To" section must match the codes on the Membership file for the pay period range of the transfer.

7. Once the transfer has been processed, two "transfer" records will immediately appear on the Pay Record History Inquiry screen (4). The transfer records will be indicated with a 'T' in the 'Record Type' column. Please note that if premiums were transferred to a range of pay periods, the 'T' (transfer) record will appear on the pay record with the most current date of the pay period range. Additionally, the "Carrier Balances to Date" section will be immediately updated.

13.7 Viewing Pay Record Changes

A. Screen Description – Pay Record Audit History (Screen 7)

A GIR/P may view all changes which have been made to a specific pay record by using screen 7 of GIFCS – Pay Record Audit History screen. This screen allows the GIR/P to view the individual coding changes made, the date and time a pay record was changed, and the User ID of the person who changed the record. The most recent change to the pay record appears first on the screen; the original pay record appears last on the screen.

The Pay Record Audit History Inquiry screen displays up to the last four pay records at one time. The word "MORE" in the lower right corner of the screen indicates there are additional changes to the record to be viewed.

The GIR/P cannot view a pay record on this screen if a change has not been made.

B. Criteria

In order to retrieve desired information, required fields must be entered.

- **SSNO** (required field) **–** GIR/Ps must enter the Social Security Number of the member.
- **Pay Period** (required field) **–** GIR/Ps must enter a pay period date.
- **Record Number** (required field) **–** GIR/Ps must enter a pay record number. Only one pay record may be viewed at a time. The record number may be found by displaying either the Pay Record Update Inquiry (3) screen or Pay Record History Inquiry (4) screen.

Press the *F5 (or PF5) key* to transfer to the Pay Record Update/Inquiry screen (3).

Press the *F7/F8 (or PF7/PF8) key* to scroll through previous and next pay records on the screen.

C. Information Displayed

Field	Description
Name	Member's name.
Record Type	Type of pay record represented. ♦ C – COMPPAY (Comptroller Pay) ♦ P – PCUDPAY (Premium Collection Unit / AgencyDirect Pay) ♦ L – LOCAL (Local Payroll from universities) ♦ R – REVERSAL (Pay record reversal) ♦ F – REFUND (Refund processed through GIFCS) ♦ A – ADDPAYREC (Added pay record) ♦ T – TRANSFER (Member paid premium transfer) ♦ O – OFFSETADJ (Offsetting adjustment processed by GID) ♦ I – IPPADD (Insurance pay period add record from payroll voucher)
Change Date/Time	The date and time the record was changed will appear in this column.
Pay Code	The payroll code found on the pay record.
USER	The USER ID of the person who changed the pay record will appear to the right of the 'USER' field.
EL CD	The 'EL CD' is the eligibility code indicated on the pay record (e.g., 'A' indicates full-time active employee – see Appendix H, System Codes' for other eligibility codes).
Part Time %	The part-time percentage field indicates the part-time percentage shown on the pay record.
Life Units	The life unit field indicates the basic life units coded on the pay record.
Health, Life and Dental Deduct Code	The carrier and deduct codes for health, life and dental as indicated on the pay record.
Health, Life and Dental Amount	The amount of premium payroll deducted, or collected via direct pay, for health, life and dental as indicated on the pay record.

13.8 Refund Requests

A. Screen Description – Refund Request (Screen 8)

Premium refunds which cannot be processed on payroll may be entered on screen 8 of GIFCS – Refund Request screen. The Refund Request screen allows refunds to be added or changed. The GIR/P may also inquire on the status of the refund. Overpayments of premiums deducted on payroll or collected through the Premium Collection Unit or agency direct pay may be refunded using this screen. Please note, all coding discrepancies must be resolved before the refund may be processed.

Refund requests on GIFCS are allowed for:

- amounts $5.00 or greater,
- one carrier within a plan (health, dental, life) per refund request,
- one fiscal year, per refund request,
- overpayments which occurred during the previous 6 months.

If an overpayment occurs over two fiscal years, separate refund requests must be entered.

Example: If a member is overpaid June 1st through July 15th, the GIR/P must enter two refunds; one for June 1st – June 30th, the other for July 1st –July 15th.

B. Criteria

In order to retrieve desired information, required fields must be entered.

- **A/C/D/I** (optional field) **-** The GIR/P should enter an 'A' to add a refund request, a 'C' to change a refund request, or an 'I' to inquire (display) a refund request. GIR/P's should not use the 'D' (delete) option of this screen. This field will default to 'Inquire' if not changed.

- **SSNO** (required field) **-** The GIR/P must enter the Social Security Number of the member whose refund they wish to view, add, or change.

Press the *F7/F8 (or PF7/PF8) key* to scroll through previous and next carriers on the screen.

C. Information Displayed

The refund screen is divided into three sections: 'Payee Data', 'Refund Information', and 'Refund Status'.

Payee Data – Shows the Social Security Number, name, address, and marital status of the refund recipient.

Refund Information - Shows the specific carriers, overpaid amount, refund type, exemptions, dates of the overpayment, refund reason, and refund request date.

Refund Status - Displays the processing status of the refund request.

- The 'Voucher Number' field will display an assigned refund number once the refund has been vouchered.

- The 'Voucher Type' field will automatically display whether the refund is taxable or tax exempt as indicated below:

  - **C-02 (Taxable Refunds)**: C-02 refunds include all health and dental premiums collected on payroll, as well as Optional Life premiums up to $50,000 (basic plus optional).

  - **C-13 (Tax-exempt Refund)**: C-13 refunds include direct payments, Optional Life in amounts above $50,000, Child Life, Spouse Life and AD&D.

- The 'Status' and 'Status Date' fields will be automatically updated when a refund request is added or reviewed and finalized by ARU.

Voucher Status Description

Code	Status	Explanation
P	Pending	Once a refund request has been "added" to the system, the request will appear as 'Pending'. Requests in 'Pending' status may be changed by entering a 'C' in the A/C/D/I field and pressing the ENTER key.
R	Reviewed	The Analysis and Resolution Unit (ARU) will review the refund request and will manually update to 'Reviewed' status.
V	Vouchered	Once ARU has approved the refund the request will be sent to the Comptroller's office for payment. Once the refund has been paid, the status will be manually updated to 'Vouchered'. The 'Carrier Balances to Date' fields will be updated immediately upon the vouchering of the refund to reflect the refunded premium. A new pay record will be added for the pay period ending date appearing in the 'To Date' field.
D	Denied	If after reviewing the request, ARU determines the overpayment **not** to be valid and/or accurate, the refund request will be updated to 'Denied' status. When a refund request is changed to 'Denied' status, the agency will be notified of the reason for the denial.

D. Inquiry/Add/Change Process

1. **Inquiry -** The Inquiry (I) function is used to inquire about a refund request that has been entered into GIFCS. The oldest refund request is displayed first. If more than one refund request is posted for a member, the GIR/P may press the F6 key until the refund the GIR/P wishes to view is displayed.

2. **Adding a Refund Request -** A refund request may only be added while in 'Inquiry' (I) status and after all discrepancies have been resolved.

   a. Enter an 'A' in the A/C/D/I field.

   b. Enter the Social Security Number of the member, and press ENTER. The 'Name', 'Carrier Balances to Date', and 'Request Date' fields will populate.

   c. Complete all fields in the 'Refund Information' section from the 'From Date' field to the 'Reason' field.

      From Date* – enter the first day of the pay period for which the overpayment occurred (e.g., 08/01/01)

      To Date* – enter the pay period end date for which the overpayment occurred (e.g., 08/31/01).

      Refund Type – enter the refund type code that corresponds to the type of overpayment. Use the chart in the Appendix (Group Insurance Financial Control System Codes) to determine the correct refund type.

      Exemptions – enter the number of state tax exemptions the member claims.

      Health / Life / Dental – enter the health/life/dental carrier code and amount of the premium refund requested for each carrier.

      Reason – enter the reason code that corresponds to why the member is overpaid. Use the chart in the Appendix (Group Insurance Financial Control System Codes) to determine the correct reason code.

      Note: Code '01' – 'Collected in Error' should only be used when no other reason code applies.

      ***** Both 'From Date' and 'To Date' must be within the same fiscal year.

d. If the refund is to be issued to someone other than the member, or if no Membership file exists for the member, the 'Payee Data' fields must be completed by the GIR/P.

When the payee is an estate, the payee name field should be completed as follows: "Estate: c/o Payee's Name".

When the payee is an agency, the payee section should be completed as follows: the agency's FEIN number in the 'SSN/FEIN' field, the agency name in the 'Name' field, and the agency's address in the 'Address' field.

e. Once all the refund information has been entered, press the ENTER key. A message will be displayed at the bottom of the screen indicating the refund has been added, along with the reason code description, refund type description, refund amounts, dates, carriers, and all payee data.

If the system does not accept the refund request, the GIR/P should refer to the message at the bottom of the screen for explanation.

3. **Changing a Refund Request -** A refund may only be changed while in 'Pending' status. Once a refund has been updated to 'Reviewed' status, it can no longer be changed. If the refund request is in 'Reviewed' status and must be changed, the GIR/P must contact ARU.

a. Enter a 'C' in the A/C/D/I field to change the refund and press ENTER. Any fields from 'From Date' to 'Reason', in addition to any of the 'Payee Data' fields, may be changed.

b. Type over information in the fields requiring a change and press ENTER. A message will be displayed at the bottom of the screen indicating the refund has been changed.

13.9 Correcting Social Security Number

A. Screen Description – Change SSN/Pay Period on Pay Record (Screen 9)

A GIR/P may correct a Social Security Number (SSN) which was incorrect on a pay record by using screen 09 of GIFCS – Change SSN/Pay Period on Pay Record screen.

SSN changes must be processed separately when both the SSN and pay period end date need to be changed on the same pay record, or when the SSN needs to be changed on several records.

When changing an SSN the following apply:

- a pay record must exist for the original SSN and pay period end date
- membership liability must exist for the new SSN
- only one record may be processed at a time

B. Criteria

In order to retrieve desired information, required fields must be entered.

- **SSNO** (required field) **–** The Social Security Number which will be changed must be entered in this field.
- **Pay Period** (required field) **–** The pay period end date of the pay record which has the incorrect Social Security Number must be entered in this field.
- **Record Number** (required field) **–** The two-digit number assigned to the pay record must be entered in this field. The record number may be identified by viewing either the Pay Record Update/Inquiry screen (3) or the Pay Record History Inquiry screen (4).
- **New SSNO** (required field) **–** The new Social Security Number must be entered in this field.

C. Social Security Number Change Process

To change a Social Security Number associated with a pay record:

1. Enter the SSN, pay period end date, record number and new SSN in the appropriate fields. Press ENTER.

2. The 'Payment Data', 'Membership Data' and name of the member which corresponds to the new SSN will be displayed.

3. The message "PF9: TO CANCEL ENTER TO PROCESS" will appear at the bottom of the screen. The GIR/P has the option of pressing either the F9 (PF 9) key to cancel the request or pressing the ENTER key to process the request. Once the enter key has been pressed, the pay record will be moved to the new SSN immediately.

13.10 Moving Pay Record to New Pay Period

A. Screen Description – Change SSN/Pay Period on Pay Record (Screen 9)

A GIR/P may correct a pay period end date which was incorrect on a pay record by using screen 9 of GIFCS – Change SSN/Pay Period on Pay Record screen.

B. Criteria

In order to retrieve desired information, required fields must be entered.

- **SSNO** (required field) **–** The Social Security Number of the pay record which will be moved must be entered in this field.
- **Pay Period** (required field) **–** The pay period end date of the pay record which will be moved must be entered in this field.
- **Record Number** (required field) **–** The two-digit number assigned to the pay record must be entered in this field. The record number may be identified by viewing either the Pay Record Update/Inquiry screen (3) or the Pay Record History Inquiry screen (4).
- **New Pay Period** (required field) The end date of the pay period to which the pay record is to be moved.

C. Change Pay Period End Date Process

To change a pay period end date of a pay record:

1. Enter the SSN, pay period end date to be changed, record number and new pay period end date. Press ENTER.
2. The 'Payment Data' and 'Membership Data' which correspond to the new pay period end date will be displayed.
3. The message "PF9: TO CANCEL ENTER TO PROCESS" will appear at the bottom of the screen. The GIR/P has the option of pressing either the F9 (PF 9) key to cancel the request or pressing the ENTER key to process the request. Once the enter key has been pressed, the pay record will be moved to the new SSN immediately.

13.11 Troubleshooting Discrepancies

A. Discrepancy Problems and Causes

There are three basic steps used when determining and resolving discrepant accounts. The first step is to use the GIFCS screens to locate the problem (overpaid, underpaid, discrepant coding, or a combination thereof), followed by determining possible causes, and finally, taking the required steps to resolve the discrepancy.

Potential Problems – (may be a combination):

Premium Overpaid
Premium Underpaid
Coding Discrepancy

Potential Causes

Carrier Change
Benefit Choice Change
Add/Drop Dependent
Returning from Leave of Absence
Returning from Leave of Absence – coverage terminated while on leave
Going on Leave of Absence
Optional Life Change
Basic Life Units Change
Part-time Percentage Change
New member's first payroll deduction not taken
Transfer member is defaulted to basic health, dental and life by new agency
Terminated member's last deduction not taken on payroll
Estimated Annual Salary
Missing Pay Records
Member Not eligible
Dependent Not eligible

B. Troubleshooting Steps

1. Starting with the most current pay period, use the F6 key on GIFCS screen 2 to page back through **previous pay periods**, viewing each pay period. The "Discrepant Indicator" on this screen will display a 'Y' if there is a coding discrepancy. The GIR/P should make a note of the pay periods that are discrepant, including the pay periods which have carrier balance over/underpayments.

Note: Over/underpayments are not a cause for the discrepant indicator to be 'Y'.

The GIR/P should use the member election forms in the insurance file to verify that the following information on the Membership System is correct:

(a) Carrier Codes (health and dental)
(b) Dependent coverage
(c) Optional life choices
(d) Type enrollee code
(e) Part-time percentages
(f) Basic Life Units
(g) Deduct Codes (health and dental)
(h) Birth date

- *If the Membership System is not correct, proceed to step 2.*
- *If the Membership System is correct, proceed to step 4.*

2. The GIR/P must process the required change or send a Membership Correction form (CMS-340) to the Membership Unit for processing with the required documentation.

3. If no further coding discrepancies exist after the change/correction has been processed, the discrepant indicator will read 'N'. However, existing financial discrepancies must be resolved. Payroll overpayments within the most recent 6 month period must be refunded via the payroll system. Underpayments must be collected.

   If coding discrepancies still exist, continue with step 4.

4. Go directly to the most recent discrepant pay period ('Y' indicator) on screen 2 and review the payroll coding to determine which fields are discrepant. Use screen 3 to correct the coding on the payroll side of the record (see "Manipulating a Pay Record" procedure). Once corrected, go back to screen 2 to verify the pay period is no longer discrepant (discrepant indicator should now show 'N'). **Repeat this step for each discrepant pay period appearing on GIFCS.**

5. If the GIR/P identifies payroll coding discrepancies, they should verify the record layout on the agency's payroll and make the necessary change for future pay period deductions.

6. Overpayments which exist after the records have been corrected must be either purged or refunded.

   - **Payroll Overpayments for the Current Plus Previous 6 months**: GIR/P's should process a premium refund via the agency payroll system for payroll overpayments for the current plus previous 6 month period. The refund should include payrolls which have not yet posted to GIFCS which contain the same coding errors. If the refund is processed in a different fiscal year than the overpayment, the overpaid amount must be transferred to the fiscal year for which the refund was processed (see "Transfer" procedure). If the premium refund is for a member no longer on payroll, a refund request must be entered on screen 8. (See 'Refund' in this section for more details).

   - **Payroll Overpayments Occurring Prior to the Previous 6 Month Period**: Payroll overpayments incurred prior to the current plus the previous 6 month period must be purged. The GIR/P should submit a purge request to ARU via the Discrepancy Response form (CMS-321). (See section 7, 'Refunding Premiums' for more details).

   - **PCU/Direct Pay Overpayments**: Overpayments incurred while a member is on a leave of absence, or direct billed, cannot be processed on payroll. The GIR/P should contact ARU to refund the overpayment.

7. Payroll underpayments which exist after coding has been corrected **must** be collected through the agency's payroll. The underpaid amounts collected should include payrolls which have not yet posted to GIFCS. If the underpayment is collected in a different fiscal year than the underpayment occurred, the overpaid amount must be transferred to the fiscal year in which the underpayment was collected (see the "Transfer" procedure in this section). If the member is no longer on payroll, the agency must bill the member. (See section 7, 'Billing Member for Payroll Underpayments' for step-by-step instructions)

14.0 Reports

A. Membership Reports

Various Membership Unit reports are created and displayed on the online MOBIUS system, some requiring action, some that may require action, and others which do not require action. The GIR/P may need to **notify the payroll office** of changes affecting eligibility or premium deduction. Please refer to the following list for a brief description of each report.

Membership Reports

Report Title/Number	Frequency	Action Required	May Require Action	No Action Required	Report Description and Use
Member / Dependent Turning 65 (GIMBM071-01)	Monthly (3rd Friday of the month)		X		This report advises the GIR/P that a letter was sent to the member on the date of the report requesting the member's Medicare status; if no response is received the system will default the member/dependent turning 65 to Medicare Part A and B.
Updated Members / Dependents Turning 65 (GIMBM072-01)	Monthly (1st Friday of the month)			X	Report indicates updates on Medicare status.
Dependents Turning 19 or 23 (GIMBM073-01)	Monthly (2nd Friday of the month)		X		This report advises the GIR/P that a recertification letter was sent to the member on the date of the report; if no response is received from the member or agency, the dependent's coverage will be terminated.
Dependents Turning 19 or 23 Whose Birthdays are in (Month), Pre-Termination Listing (GIMBM617-01)	Monthly (1st Friday of the month)		X		This report advises the GIR/P that the dependents listed on the report have not yet been recertified for their 19th or 23rd birth date. This report will be generated the third Friday of each month prior to the terminations being processed. The GIR/P should verify with the member whether or not they have provided the recertification documentation for processing.
Termination Listing – Dependents Turning 19 or 23 (GIMBM070-01)	Monthly (1st Friday of the month)		X		Report indicates the member, the terminated dependent and the dependent's birth date. No action is required, unless the dependent was terminated in error. If no other dependent children are shown on the Membership System, check the 'Child Life' field on the Member Group Screen. If this field indicates 'Y', change to 'N'.
Notice for Recertification Fall -h/o(GIMBM272-01) Fall -stu(GIMBM467-01) Spg -stu(GIMBM475-01)	Semi-Annual (Student) / Annual (Handicap & Other)	X			This report advises the GIR/P that a recertification letter was sent to the member on the date of the report; if no response is received from the member or agency, the dependent's coverage will be terminated.

Membership Reports

Report Title/Number	Frequency	Action Required	May Require Action	No Action Required	Report Description and Use
Termination – Failure to Recertify Fall -h/o(GIMBM277-01) Fall -stu(GIMBM468-01) Spg -stu(GIMBM477-01)	Semi-Annual (Student) / Annual (Handicap & Other)		X		Report indicates members who have not responded to the recertification letter sent on behalf of a dependent for the annual or semi-annual recertification period. No action is required, unless the dependent was terminated in error. . If no other dependent children are shown on the Membership System, check the 'Child Life' field on the Member Group Screen. If this field indicates 'Y', change to 'N'.
Birthdate Corrections of Dependents Following 19th or 23rd Birthday Notification (GIMBM206-01)	Monthly (1st Friday of the month)			X	Report indicates dependents whose birth date has been corrected since the recertification letter was sent.
Medicare Unknown Status (GIMBM088-01)	Monthly (1st Friday of the month)	X			The GIR/P must contact the member to obtain a copy of Medicare card, and advise the Medicare COB Unit of the Medicare status of the members and/or dependents listed on this report.
Leave of Absence – Terminations (GIMBM082-01)	Weekly (Friday)		X		Report indicates the effective date of the leave of absence, number of months on the leave of absence and type of termination (group/plan). No action is required, unless the member was terminated in error.
Leave of Absence – Weekly Change (GIMBM083-01)	Weekly (Friday)		X		Report indicates a change in the leave of absence subtype code, date of the change and how many months the member was coded the previous subtype. No action is required, unless the member was terminated in error.
Leave of Absence – Monthly Status (GIMBM089-01)	Monthly (1st Friday of month)			X	Report indicates the leave of absence code, effective date and how many months on the leave of absence.
Member / Dependent SSN Change (GIMBM091-01)	Weekly (Friday)			X	Report indicates original and corrected Social Security numbers.
Life Units Not Updated on System (GIMBM249-01)	Weekly (Friday)	X			The GIR/P must research and advise the Membership Unit of the correct basic life units and effective dates.
Life Units Updated Per Pay Record (GIMBM248-01)	Per Pay Period (Friday)			X	Report indicates corrected basic life units and the pay record which was used to determine the effective date of the basic life unit change.
Dependents with Temporary SSN (GIMBM165-01)	Monthly (1st Friday of month)	X			The GIR/P must contact the member to verify the dependent's correct SSN and advise the Membership Unit of the correct number.
Members with Invalid Proc Org Codes (GIMBM250-01)	Weekly (Friday)	X			The GIR/P must enter the correct proc org code and effective date in the blank provided on the report and return to the Membership Unit.
FMLA Greater than 180 Days (GIMBM262-01)	Monthly (1st Friday of the month)		X		Report indicates the members of the GIR/P's agency who are on FMLA, the effective date of the FMLA and the number of days used to date. Agency should monitor the number of days on FMLA on payroll.

Membership Reports

Report Title/Number	Frequency	Action Required	May Require Action	No Action Required	Report Description and Use
Active Members with no April Pay Records (GIMBM-23401)	Annual (Mid-June)		X		Report identifies members within the agency whose Membership records could not be properly updated because no April pay record had been received for the member. The GIR/P must research the member's records and process a correction, as needed. If the member's coverage should be terminated, process a Membership transaction terminated coverage effective the first day the member was in termination status. If the member was coded 'C' on payroll in error, or if no pay record was submitted, process a Membership correction to the estimated annual salary, if necessary, and add the pay record in GIFCS. If the SSN is incorrect on the Membership file, process a change in SSN on the Membership file and change the estimated annual salary, if necessary. If the SSN is incorrect on the payroll record, correct the SSN using screen 9 of GIFCS.
Members with no Life Units on April Pay Records (GIMBM-23501)	Annual (Mid-June)		X		Report identifies members whose pay record did not contain the basic life units required to compute the estimated annual salary. Agencies need to determine the correct salary for each person based upon their annual salary as of April 1st. A Discrepancy Response Form (CMS-321) must be submitted to ARU with proper documentation indicating the correct April 1st basic life units.
Terminated Members with Pay Records after the Termination Date (GIMBM-23601)	Annual (Mid-June)		X		Report identifies members whose last transaction on the Membership file indicates that the member was terminated, but a pay record was received for April. If the Membership file needs to be updated to reactivate coverage, or to correct the termination date, submit a Membership Correction form (CMS-340) requesting the update. If a premium deduction was taken in error, request a refund of member paid premium through screen 8 of GIFCS. If the GIR/P does not have GIFCS access, a Discrepancy Response Form (CMS-321) must be submitted to ARU requesting the refund.
State Group Turnaround Documents – Agency Copy (GIMBM101-01)	On Request			X	Actual agency copy of a requested Turnaround document of a member.
State Group Verification Reports – Agency Copy (GIMBM108-01)	On Request			X	Actual agency copy of a requested Verification document of a member.
Agency Report of Members Who Are in Opt Out Type Codes (GIMBZ193)	Monthly			X	Report identifies members who have elected to Opt Out of health, dental and vision coverage. The member's SSN, type enrollee code and the effective date of the opt out appear on this report.

B. Group Insurance Financial Control System (GIFCS) Reports

The following is a list of all GIFCS reports generated and distributed via MOBIUS to GIR/P's. The table indicates report frequency, identification number, whether the report requires action, and a report description.

GIFCS Reports

Report Title/Number	Frequency	Action Required	No Action Required	Report Description and Use
Candidates for Termination (CFT) (GIFCZR35A) (GIFCZR35B) (GIFCZR35C)	Monthly	X		The CFT report lists all pay periods currently on GIFCS, and compares the Membership file codes and liability against the pay record codes and premium deducted. The report lists the amount a member is overpaid or underpaid. The GIR/P must complete a CMS-321 detailing action to be taken to correct the discrepancies and request a delay of termination.
Discrepancy Age Summary Report by GIRCODE (GIFCR78)	Quarterly		X	This report indicates the total number of CFT and Priority members an agency has, categorized by number of months in that status.
Members with Unresolved Discrepancies 6 Months or More (GIFCP80201)	Monthly	X		This report indicates the name and SSN of members with unresolved discrepancies for 6 month or more. The carrier code of the discrepancy is displayed on the report, as is the CFT or Priority status. Priority members listed on this report are subject to the 'Retroactive' policy. The GIR/P must complete a CMS-321 detailing action to be taken to correct the discrepancies and requesting GID to purge overpayments.
Members Receiving Warning Letters (GTERM1) Not On MOBIUS – CMS mails this report directly to the agency	Monthly	X		Members receiving a letter warning of impending termination are indicated on this report. The members are now a CFT at least two months and may be terminated by ARU at the end of that month if a response is not received by ARU. The GIR/P must research the discrepancies and send a CMS-321 detailing the action to be taken to correct the discrepancies and requesting a delay of termination. This report is mailed the day prior to the warning letters being mailed.
Pay Adjustment Discrepancy Notification – Detail (GIFCP951-A) (GIFCP951-B) (GIFCP951-C)	Per Pay Period	X		This report indicates coding discrepancies by member name and SSN. The report lists only the most recent pay record posted. An asterisk is placed next to the current carrier/deduction code(s) that does not match the Membership file. This report also includes part-time percentage and birth date. The GIR/P must review this report and determine which coding is correct.
Agency Payroll Notification of Insurance Deduction Code Changes (GIMBM09301) / Agency Payroll Notification of New Members (GIMBM27801)	Weekly	X		This report lists individual member names/SSN corresponding with Membership transactions processed which change an insurance deduction code or liability amount. The GIR/P must work this report to ensure the pay record information which prompted the Membership liability to update is correct. The GIR/P should forward this report to payroll to ensure proper deductions are taken on future payrolls. The GIR/P may also want to check previous pay periods for possible discrepancies.

GIFCS Reports

Report Title/Number	Frequency	Action Required	No Action Required	Report Description and Use
Agency Report of Discrepant Members (GIFCMR24)	Monthly	X		This report must be requested using the Sorting Sequence Request form. The form allows the GIR/P to request a report of all discrepant members in the sort order requested. The GIR/P should work this report to clear discrepancies.
All Records Coded 'C' – No Insurance (GIPTP009CO) (GIPTP007$) (GIPTP008CN)	Per Pay Period	X		This report lists all members who were coded for no insurance on the payroll indicated on the report and did not have premiums deducted from their paycheck. The GIR/P may also want to check previous pay periods for possible discrepancies. The GIR/P should determine if "no insurance" is correct on payroll.
Agency Report of Members Whose Discrepancies Have Been Purged (GIFC694)	Annual	X		This report lists the SSN of all members who had underpayments and/or overpayments on the records which were purged from GIFCS during the purge.
Agency Payroll Notification of Insurance Deduction Code Changes (GIMBP062) / Agency Payroll Notification of New Members (GIMBP062)	Annual (mid to late June)	X		This report must be requested by the GIR/P during the Benefit Choice Period annually. The report summarizes all Benefit Choice changes, listing individual member names/SSN corresponding with Membership transactions processed which change an insurance deduction code or liability amount effective July 1st. The GIR/P must work this report to ensure the pay record information which prompted the Membership liability to update is correct. The GIR/P should forward this report to payroll to ensure proper deductions are taken on future payrolls. The GIR/P may also want to check previous pay periods for possible discrepancies.

C. Premium Collection Unit (PCU) Reports

The following is a list of all PCU reports generated and distributed to GIR/P's. The table indicates report frequency, whether the report requires action, and a report description.

PCU Reports

Report Title/Number	Frequency	Action Required	No Action Required	Report Description and Use
Agency Direct Pay Billing Report (DBILLS 1-2)	Monthly	X		This report lists all members within an agency who are being billed by the Premium Collection Unit the first time for premiums due while on a leave of absence. The report indicates the amounts due for each plan, pay period(s) billed and total amount due. The GIR/P should make sure the leave period(s) listed on the report are accurate. GIR/P's whose members have returned to work must correct the type enrollee code on the Membership System and notify payroll to begin premium deductions.
Agency Direct Pay Final Notice Billing Report (DBILLS 2-2)	Monthly	X		This report lists all members within an agency who have been billed by the Premium Collection Unit a second time (final notice) for premiums due while on a leave of absence. The report indicates the amounts due for each plan, pay period(s) billed and total amount due. The GIR/P should make sure the leave period(s) listed on the report are accurate. GIR/P's whose members have returned to work must correct the type enrollee code on the Membership System and notify payroll to begin premium deductions.
Agency Direct Pay Supplemental Billing Report (DBILLS 3-2)	Monthly	X		This is a supplemental report which lists the members for which the Premium Collection Unit has extended the payment period or the member owes additional premium due to a change in liability. The GIR/P should make sure the leave period(s) listed on the report are accurate. GIR/P's whose members have returned to work must correct the type enrollee code on the Membership System and notify payroll to begin premium deductions.
Agency Direct Pay Termination Report (DTERM 2-3)	Monthly	X		This report lists all members who have been billed by the Premium Collection Unit who subsequently did not pay the premium and had coverage terminated for nonpayment of premium. If the member had optional life coverage, the GIR/P must notify payroll to stop deductions for the optional life coverage. If the member has returned to work prior to the termination being processed by PCU, the optional life premiums collected must be refunded. If the member has not yet returned to work, the GIR/P must notify payroll to change the life deduct code to not deduct for optional life.

D. Flexible Spending Accounts (FSA) Report

The following is a description of the FSA report generated and distributed to GIR/P's. The table indicates report frequency and whether the report requires action.

FSA Reports

Report Title/Number	Frequency	Action Required	No Action Required	Report Description and Use
Plan Participation Report (PEFSV040)	Annual	X		This report lists the agency org proc code, member's name and SSN, MCAP and DCAP deductions elected and payroll frequency. The GIR/P should forward this report to the agency payroll office to ensure deductions for the current fiscal year are removed from payroll after the last check issued in June. Agencies/universities who have seasonal employees (e.g., faculty, groundskeepers, etc.) should use this report to determine the participants who will be going off payroll before the end of the plan year. Notification should be sent to the FSA Unit.

14.1 System Mass Updates

The following "mass update" changes are made on the Membership System periodically. The GIR/P can determine if a change was made due to a mass update by the source code on the Membership inquiry screens. The source code (SRC) on the bottom of the screen will show a '70' for mass updates.

A. Change of Basic Life Units

Agency and university payroll files are received by CMS on a weekly basis. Basic Life Units (BLU's) are automatically updated on the Membership file as agency payrolls are received. The effective date of the updated units is the first day of the pay period.

Agencies will receive the 'Automatic Update of Basic Life Units on the Membership File Report of Members Whose File Was Not Updated' report indicating members whose BLU's were not updated. This report is generated from the information received from the payroll file sent to CMS. GIR/P's must correct BLU's on this report to prevent discrepancies.

B. Change of Organizational Processing Code (Org Proc Code)

GID can process a mass update changing all members within a specific code to another code. The agency must submit a written request, which includes the following:

- Code that needs to be changed
- Replacement Code
- Effective date of the change

The mass update will be processed on the test system for agency review prior to being applied to the production system.

C. Estimated Annual Salary (EAS)

CMS reviews each employee's April 1st pay record during the month of June to determine base salary. This base salary is used to update the EAS field on each employee's health plan record. Agencies will receive notification of those employee's whose EAS has been updated in order to ensure the correct deductions are taken for the July payroll. See section 10, 'Premium Calculation and Coding' for more information regarding EAS.

D. Address Updates

Agencies may elect to provide CMS with a file of address updates to be applied to the Membership System. The file must be in the format specified by CMS. The file may be provided as frequently as the agency desires (e.g., weekly, monthly, etc.). When CMS processes the address update file, the agency will receive a report of any address that could not be updated such as the effective date of the change is earlier than the most recent change on file, the address format did not pass system edits, etc. Agencies interested in providing an address file should contact the Benefits Systems Division.

E. Carrier Change

Occasionally, a health, dental, vision, or life carrier will be dropped from the state's Group Insurance Program. When this occurs, all member's with this carrier code will be changed to a different carrier via a mass update.

14.2 System Generated Letters

A. Letter Descriptions

The Membership System automatically generates letters for the following events:

19th Birth Date – This letter will be produced for members whose dependent is turning 19. The letter is produced two months prior to the dependent's birth date. The letter indicates the dependent must be recertified.

23rd Birth Date – This letter will be produced for members whose dependent is turning 23. The letter is produced two months prior to the dependent's 23rd birth date. The letter indicates the dependent must be recertified in either the Handicapped or "Other" category in order to maintain coverage.

Annual Recertification of Dependent – This letter, indicating the member must verify eligibility of the dependent in order to maintain coverage, will be produced for members whose dependent (Handicapped or "Other") is 19 or above. This recertification period is held during the Fall each year.

Semi-Annual Recertification of Dependent – This letter, indicating the member must verify eligibility of the dependent in order to maintain coverage, will be produced for members whose dependent (Student) is between the ages of 19 and 23. This recertification period is held during the Spring and Fall of each year.

COBRA Rights Notice – This letter is produced for new members once they have been added to the Membership System. The letter indicates that members who meet the COBRA eligibility requirements will be provided with the opportunity to purchase COBRA coverage upon termination of state service.

COBRA Eligibility Notice – This letter, detailing the enrollment process, will be produced for members and/or dependents whose coverage has been terminated on the Membership file and who are eligible for COBRA.

COBRA Expiration Notice – This letter will be produced for members and/or dependents enrolled in COBRA whose coverage under COBRA will be exhausted. The member will receive the letter two months prior to the termination of coverage.

Medicare Annual (Part B Reduction Letter) – This letter will be produced in the fall and mailed to retired members who are enrolled in Medicare Part A but have not enrolled in Medicare Part B. This letter notifies members that benefits are being reduced under the state plan. These members can enroll in Part B during the Medicare election period held January through March each year, if they choose to do so.

Medicare 65th Birth Date – This letter, indicating the member may be eligible for Medicare, will be produced for, and mailed to, members turning 65 years of age. These members should contact the Social Security Administration with any questions regarding Medicare B. The member will receive this letter approximately two months prior to turning age 65.

Opt Out Notice – This notice, detailing the conditions of opting out/in, will be produced for members whose opt out request is approved. The notice will be mailed with the Verification form which indicates the type enrollee code change from active to opt out.

B. Determining Date Letter Was Sent

The GIR/P can view the date that the following letters were generated and sent by the Membership System: COBRA Rights Notice, COBRA Expiration Notice, Medicare Annual Part B Reduction, Medicare 65th Birthday, Annual and Semi-Annual Recertifications of dependents.

To view this information, the GIR/P must press the F5 (PF5) key while on the "Member Group" screen of the Membership System.

The GIR/P may also view whether or not a letter has been generated and sent to a dependent, as well as the date sent, for any of the system generated letters. The GIR/P can view this information by pressing the F5 (PF5) key while on the "Dependent Group" screen on the Membership System.

15.0 General Information

The AFSCME agreement of July 2004 provided health benefits for employees who have an eligible same-sex domestic partner. Effective July 1, 2006, **unrelated**, **same-sex** individuals who reside in the same household and have a financial and emotional interdependence, consistent with that of a married couple for a period of not less than one year and continue to maintain such arrangement are eligible for medical, dental and vision benefits through the State Employees Group Insurance Program.

In May 2006, the director of the Department of Central Management Services (DCMS) extended the domestic partner benefit to all employees of those agencies under the jurisdiction of the Governor. All other agencies, boards, commissions, state officers, universities and retirement systems were given the opportunity to allow their members to participate in the domestic partner program. Any GIR/P who is not certain whether or not a given office chose to participate should contact the Membership Unit to verify agency participation.

Domestic partners enrolled in the State Employees Group Insurance Program are subject to the same pre-existing conditions, deductibles, family caps, etc. as any other dependent.

15.1 Eligibility

Group health coverage, including medical, pharmacy, dental and vision, is available for unrelated, same-sex domestic partners of eligible members. Domestic partners are **not** eligible for life coverage and may not participate in the Flexible Spending Accounts (FSA) Program, the Adoption Benefit Program or the Smoking Cessation Program. If both parties are State members, one may not waive coverage as a member to become a dependent of the other member. Domestic partners are not eligible for survivor benefits through the retirement system.

A. Eligibility Requirements

1. **Age**
   The minimum age of a domestic partner is 19 years old. An exception may be granted for emancipated minors who are at least 18 years of age and meet all the remaining criteria.

2. **Marital Status**
   Neither the member, nor the domestic partner, may be married at the time of enrollment. If either partner gets married at any time after the enrollment, the domestic partner's coverage must be terminated.

3. **Agency Participation**
   The agency/university in which the member is employed must have elected to participate in the domestic partner portion of the State Employees Group Insurance Program. If a member enrolls a domestic partner and then transfers to an agency/university that does not offer the benefit, the domestic partner must be terminated from the coverage.

B. Qualifications for Eligibility

In order to enroll a domestic partner in the State Employees Group Insurance Program, a member must provide proof of the domestic partner's eligibility. The following eligibility requirements must be met:

- The member must be participating in the State Employees Group Insurance Program; and
- The member and the domestic partner must be each other's sole domestic partner and intend to remain so indefinitely, responsible for each other's common welfare; and
- The domestic partner must be at least 19 years of age, the same sex as the member, must reside at the same residence of the member for at least twelve (12) months prior to filing the Domestic Partnership Affidavit and intend to do so indefinitely and must be mentally competent to consent to the affidavit; and
- The member and domestic partner must be **unrelated** and share a committed and mutually dependent relationship with each other that is similar to that of a married couple; and
- Neither the member nor the domestic partner can be married or legally separated (if the member or the domestic partner was previously married, proof of dissolution of marriage is required); and
- The member and the domestic partner must be jointly responsible for each other's common welfare and share financial obligations, which must be demonstrated by the existence of at least two of the supporting documents listed in section 15.3.B.3, "Supporting Documentation."

C. Annual Recertification Process

Each year beginning with calendar year 2007, the member will receive a recertification document from DCMS. The member must complete the document certifying whether or not the domestic partner continues to meet eligibility requirements. If during the recertification process it is determined that a domestic partner has changed tax status, that is, was previously not eligible to be a tax dependent but has since become eligible, or vice versa, the relationship code will be changed accordingly. The change will not be retroactive.

15.2 Tax Status

A. Tax Dependent Definition

A same-sex domestic partner can qualify as a tax dependent of the member under the Internal Revenue Code Section 152(a), only if:

- For the entire calendar year, he or she lives with the member as a resident of the household the member maintains and occupies; and
- During the calendar year, the member provides more than half of his or her total support; and
- The domestic partner earned less than the allowable exemption amount (the amount for the FY05 tax year was $3200.00); and
- Cannot be claimed as a dependent of another taxpayer.

B. Imputed Income

There are strict regulations that must be met for a domestic partner to qualify as a tax dependent. Under federal tax law, if a same-sex domestic partner **does not qualify** as the member's tax dependent as defined by the IRS (see definition in 15.2.A, "Tax Dependent Definition"), the portion of the premium paid by the State of Illinois for the domestic partner's coverage will be added to the member's annual gross income that is subject to federal income tax withholding and employment taxes and will be reported on a W-2 form at the end of each calendar year. The IRS refers to this as imputed income.

Members who indicate on the Domestic Partner Enrollment Form (CMS-511) that the domestic partner is a tax dependent must provide a copy of the most recent year's income tax return. No portion of the premiums paid for these dependents by the State of Illinois will be reported as imputed income.

Members who have a domestic partner who qualifies as a tax dependent, but then loses that tax status (i.e., the domestic partner earns more than the $3200 per year), will need to have the relationship code of the domestic partner changed from a '1B' to a '1A' on the Membership System (see section 15.3.D, "Membership System Coding" for more information on relationship codes). The State will calculate the imputed income for the portion of the tax year in which the domestic partner was not a tax dependent.

1. **University Employees Imputed Income**
   University employees who have a domestic partner enrolled on their coverage who is not their tax dependent will have imputed income added to their W-2 at the end of the calendar year. DCMS will provide the imputed income amount for each member to the university. The university will be responsible for reporting the imputed income.

2. **Estimating Imputed Income**
   Some employees may request an estimation of their imputed income amount prior to the end of the calendar year for planning purposes. If requested, the GIR/P can calculate the amount by following the directions below, making sure to use the Health and Dental Rate tables for the appropriate year (not the reimbursement rates).

   GIR/Ps should take the amount the State pays for the 'Member Plus One' dependent coverage and then subtract what the State pays for 'Member Only' coverage then multiply by the number of months in the tax year they receive the benefit to estimate the total year's imputed income.

Example of Imputed Income*: A Health Alliance HMO member enrolls a domestic partner during the FY07 Benefit Choice Period. The member's earnings are in the range of $28,600 - $43,300.

Formula (must do two calculations, one for health and one for dental) – Use the Health and Dental rate tables
Member Plus One – Member Only = Monthly Imputed Income
Monthly Imputed Income x Number of Months Covered = Yearly Imputed Income

Health: AH/2L ($688.96) - AH/2K ($400.22) = $288.74 (monthly imputed income)

Dental: D6/X1 ($33.20) - D6/W1 ($16.36) = $16.84 (monthly imputed income)

Yearly Imputed Income: $288.74 + $16.84 = $305.58 x 6 months = $1833.48

* Example is based on FY07 rates.

15.3 Enrollment

Only the Membership Unit can add a domestic partner to the Membership System. Once enrolled, the domestic partner's information may be updated by the GIR/P.

A. Enrollment Periods and Effective Dates

An eligible domestic partner may be added to a member's coverage during the annual Benefit Choice Period, mid-year enrollment upon the member or domestic partner experiencing a Qualifying Change in Status or upon the initial enrollment of a newly hired employee.

1. **Benefit Choice Period**
   The effective date of coverage for domestic partner coverage requested during the annual Benefit Choice Period will be July 1st.

2. **Qualifying Change in Status**
   Coverage for a domestic partner enrolled due to an eligible Qualifying Change in Status will be effective the first day of the pay period following the date the Domestic Partner Enrollment Form (CMS-511) is received by the GIR/P or, if requested, the first day of a specified pay period in the future. In the event the domestic partner loses other coverage, coverage may be effective the date of the loss of other coverage if requested prior to losing that coverage.

   Examples of Qualifying Changes in Status in which a domestic partner may be added to a member's coverage include, but are not limited to, loss of other coverage, significant change in premium amount, coordination of domestic partner's open enrollment period, Medicare eligibility, residence or work location change, 1 year anniversary of the relationship or a divorce.

3. **New Hire (Initial Enrollment)**
   Coverage for a domestic partner requested within 10 days of the initial hire will be effective the hire date.

B. Required Forms and Documentation to Establish Proof of Relationship

Members seeking to enroll an unrelated, same-sex domestic partner in the State Employees Group Insurance Program must complete the required forms and submit them to the agency GIR/P. The required documentation must also be provided within the same timeframe allowed as for any other dependent being added (see Appendix B, Documentation Time Limit Requirements).

The three items that must be submitted to the agency GIR/P are the Domestic Partnership Affidavit (CMS-510), the Domestic Partner Enrollment Form (CMS-511) and any supporting documentation.

1. **Domestic Partnership Affidavit**
   The Domestic Partnership Affidavit (CMS-510) must be completed in full and submitted with a copy of the domestic partner's birth certificate or driver's license/State identification card. Also required are two forms of proof of the relationship (or only one if the member can provide a Cook County Domestic Partner Certificate). The GIR/P must sign and date the last page of the affidavit (in the 'Benefits Staff Use Only' section) and submit to the Group Insurance Membership Unit with the supporting documentation. Upon receipt, the Membership Unit will complete the remaining portion of the 'Benefits Staff Use Only' section of the form.

2. **Domestic Partner Enrollment Form**
   The Domestic Partner Enrollment Form (CMS-511) must be completed in full and submitted with a copy of the domestic partner's Medicare card (if applicable) and the prior year's tax return (see below) to the GIR/P. The GIR/P must complete the top portion of the 'Benefits Staff Use Only' section on the bottom of the form and then submit to the Group Insurance Membership Unit. Upon receipt, the Membership Unit will complete the effective date and relationship code fields.

   If the member indicates on the form that the domestic partner qualifies as a dependent for Federal income tax purposes, the member must provide a copy of the most recent year's tax return showing the domestic partner was claimed as a dependent.

3. **Supporting Documentation**
   The member must provide at least two forms of documentation from the list below in order to prove that they and the domestic partner are jointly responsible for each other's common welfare and share financial obligations. An exception to the requirement to provide two forms of documentation can be made if the member provides a Cook County Domestic Partnership Certificate, which may be the sole form of documentation submitted.

- **Cook County Domestic Partnership Certificate -** Members eligible to register with the Cook County Registry for same-sex couples may submit the Cook County Domestic Partnership Certificate in lieu of providing two items.
- Ownership of a joint bank account – cannot be a blank check or deposit slip
- Joint ownership or holding of investments
- Ownership of a joint credit card
- A joint mortgage or lease
- Evidence of a joint obligation on a loan
- Mutually granted durable power of attorney
- Joint ownership of a residence
- Affidavit by a creditor able to testify to the partner's financial interdependence
- Evidence of a common household (e.g. utility bills, joint public assistance, telephone bills)
- Joint ownership or lease of a motor vehicle
- Evidence of other joint responsibility, such as child care (e.g., school documents, guardianship)
- Designation of one partner as the representative payee for the other's government benefits
- Mutually granted authority to make healthcare decisions (e.g., healthcare power of attorney)
- Authorized signatory authority on the partner's bank account, credit card or charge card
- Other proof establishing economic interdependence
- Beneficiary designation under the other's life insurance policy, retirement benefits account, will or executor of each other's will

C. Responsibilities

1. **Member Responsibility**
   Members interested in the domestic partner benefit can access the required domestic partner forms on the Benefits Website (www.benefitschoice.il.gov). The completed forms and documentation must be given to the agency GIR/P within the allowable timeframe, specifically, the month of May for a Benefit Choice enrollment, 60 days from the event date for a mid-year enrollment due to a Qualifying Change in Status or 10 days from the date of initial hire.

2. **GIR/P Responsibility**
   The GIR/P must confirm the appropriate documentation has been submitted to them by the member. Both the Domestic Partnership Affidavit and Domestic Partner Enrollment Form must be signed and dated by the GIR/P prior to a copy being made for the member's file. The GIR/P should also make a copy of the supporting documentation for the file. The original forms and documentation must be forwarded to the Group Insurance Division Membership Unit for processing.

For those members who indicate the domestic partner as a tax dependent on the Domestic Partner Enrollment form, the GIR/P should verify the member provided the most recent year's tax return. Once the enrollment of the domestic partner is processed, the GIR/P should check the verification form to ensure the dependent was approved as an eligible tax dependent, which will be indicated on the form (as a relationship code '1B'). If so, the GIR/P should notify payroll to begin deductions, if necessary (see #4 below).

3. **GID Responsibility**
Upon receipt of the Domestic Partnership Affidavit, the Domestic Partner Enrollment Form and the supporting documentation, GID will review the materials and either accept or reject the request to add the domestic partner. If accepted, the Membership Unit will enroll the domestic partner as a dependent. The member and the GIR will be notified via a verification form once the enrollment is processed on the Membership System.

If the request is rejected, a denial letter will be sent to the member and the GIR/P will receive a copy.

4. **Payroll and/or Special Payment Programs Unit Responsibility**
The party responsible for collecting the premium amount due from the member (agency payroll or the Special Payment Programs Unit) depends upon whether the domestic partner qualifies as a tax dependent or not (see section 15.2.A, 'Tax Dependent Definition' for more information).

Agency Payroll: If the domestic partner **qualifies as a tax dependent under IRS rules**, the agency should review the member's current payroll deductions/codes to determine whether or not a change is necessary. For example, if a member is already coded in the 2+ category, no change to payroll is required.

Special Payment Programs Unit (SPPU): If the domestic partner does **not** qualify as a tax dependent under IRS rules, the Special Payment Programs Unit (SPPU) at DCMS will bill the member each month for the premium amount due.

D. Membership System Coding

1. **Relationship Code:** The relationship code indicated for the dependent on the Membership System is used to identify the relationship between the dependent and the member. Dependents who are domestic partners will have a relationship code of either 1A or 1B, depending on whether or not they are the member's tax dependent.

   - Does not qualify as a tax dependent – relationship code 1A
   - Qualifies as a tax dependent – relationship code 1B

2. **Health and Dental Deduct Codes:** Every member enrolled in the State Employees Group Insurance Program is assigned a health and dental deduct code. These codes are used by GID to determine the contribution amount due from the member for coverage. These codes are derived using various criteria including the number of enrolled dependents, member status (i.e., active or retired), salary, Medicare status, etc. Refer to Section 10, 'Premium Calculation and Coding' for more information regarding health and dental deduct coding.

   The health and dental deduct codes for a member who enrolls a domestic partner as their tax dependent will follow the same deduct coding structure as that of any other member. For more information regarding health and dental coding structure, see Section 10.1, "Health Coding" and Section 10.2, "Dental Coding."

   The health and dental codes of a member who enrolls a domestic partner who is not their tax dependent will not change once the domestic partner is enrolled.

15.4 Premiums

A. Contribution Amount

The contribution amount a member will pay for domestic partner coverage depends upon whether or not the domestic partner is a tax dependent of the member under the Internal Revenue Code, Working Families Tax Relief Act, Section 152(a). When a domestic partner has Medicare and Medicare is their primary health coverage, the appropriate contribution amount should be used when determining the premium amount due. Medicare primacy rules apply the same as for any other dependent. Contact the Medicare Coordination of Benefits (COB) Unit for more information if Medicare questions arise.

1. **Domestic Partner Qualifies as the Member's Tax Dependent**
   The contribution amount a member will pay for domestic partner coverage is the same as the amount charged for any other dependent and must be payroll deducted. The premium is **not** subject to imputed income (see section 15.2.B, 'Imputed Income').

2. **Domestic Partner Does Not Qualify as the Member's Tax Dependent**
   The contribution amount a member will pay is based on the 'One Dependent' contribution amount, regardless of the number of dependents enrolled on the member's coverage If the member is a part-time employee, the premium will include a percentage of the State's cost for health and/or dental coverage based on the percentage of time worked. Additionally, if the member is on a leave of absence in which they are responsible for percentage of their premium, the member will also be charged 100% of the 'One Dependent' premium. The member will be direct billed monthly for the contribution amount due (one dependent rate). The State contribution for the domestic partner (one dependent) is subject to imputed income and will be reported to the member at the end of the year (see section 15.2.B, 'Imputed Income'). Note: The premium for the member and any other dependents enrolled will continue to be payroll deducted.

B. Billing Procedure

The Special Payment Programs Unit (SPPU) will direct bill the member each month for the domestic partner's coverage if the domestic partner does not qualify as the member's tax dependent. Billing notices will be generated the first week of each month with payments due by the 25th of each month. **Note:** If the member is on an approved leave of absence, two billing notices will be generated, one for the domestic partner and one for the member and any other covered dependents.

15.5 Children of a Domestic Partner

Dependent children of a domestic partner are not eligible for group insurance coverage under the State Employees Group Insurance Program unless the member has legally adopted the children or is the legal guardian of the children. Court documentation proving the relationship is required. Any child who is the member's legal dependent should be added to the member's coverage on the Membership System the same as any other dependent child.

15.6 Termination of Coverage

Following the termination of a domestic partner relationship, a minimum of twelve (12) months must elapse before another domestic partner may be added to the member's coverage. This includes domestic partners previously covered by the member under the State Employees Group Insurance Program. Upon the GIR/P receiving a termination request, the coverage should be terminated by the GIR/P, as these requests do **not** need to be processed by the Membership Unit.

A. Termination Due to a Qualifying Change in Status

Domestic partner coverage may be terminated upon the member experiencing an eligible Qualifying Change in Status. The domestic partner may be re-added upon the member or domestic partner experiencing an eligible Qualifying Change in Status or during the annual Benefit Choice Period. The effective date of the termination is the date the written request is received by the GIR/P.

B. Termination Due to Ineligibility

If at any time the member's domestic partner becomes ineligible for benefits, it is the member's responsibility to immediately notify the agency GIR/P. Reasons for ineligibility include the termination of the domestic partner relationship, death and marriage. The member must complete, sign and submit a Termination of Group Insurance Coverage for Domestic Partner form (CMS-512) to the agency GIR/P. The termination date is the date that either the GIR/P or CMS is made aware of the domestic partner's ineligibility.

In the event the member or the domestic partner gets married to an opposite-sex partner, the domestic partner's coverage will terminate the date of the marriage. If, for any reason, a member fails to notify their agency GIR/P within 60 days of the date of a domestic partner's ineligibility for coverage, a premium refund will not be granted.

In the event of death, the termination date that should be used is the actual date of death.

C. Termination for Non-Payment of Premium

If the member does not pay the premium due for the domestic partner's coverage by the due date indicated on the billing statement, the domestic partner's coverage will be terminated for non-payment of premium, effective the last day of the pay period for which appropriate premiums were paid. If coverage is terminated for this reason, the member **will not be allowed to re-enroll** the domestic partner until the next annual Benefit Choice Period.

D. Processing the Termination

The GIR/P is responsible for processing the termination on the Membership System of the domestic partner from the member's coverage. The appropriate dependent termination code should be used when processing the termination. In situations in which a **domestic partner relationship ends**, the 'Dependent Ineligible' dependent termination code '66' must be used in order for a domestic partner who qualifies as a tax dependent to receive a COBRA eligibility letter.

15.7 COBRA

A. COBRA Eligibility

COBRA coverage will be offered only to domestic partners who qualify as a tax dependent under IRS rules. COBRA will not be offered to the domestic partner if the member voluntarily terminates the coverage (i.e., due to a Qualifying Change in Status) or if coverage is terminated due to non-payment of premium.

B. COBRA Coverage

COBRA coverage options for a domestic partner who is the member's tax dependent are the same as provided for any other dependent. Please refer to Section 6, 'Termination and COBRA' for more information.

16.0 HIPAA General Information

A. HIPAA Definition

The federal government enacted Title I of the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Title II was enacted later and designed to protect the confidentiality and security of health information. These national standards strive to:

- protect the rights of consumers,
- ensure the privacy and security of health information,
- reduce administrative costs through standardization and,
- improve the efficiency and effectiveness of the health care system.

A critical key of HIPAA is the concept of **Protected Health Information (PHI).** Protected Health Information (PHI) refers to any individually identifiable information in conjunction with medical information relating to a condition, treatment or payment that is transmitted or stored electronically, written, or in any other form. PHI may relate to past, present, or future healthcare or conditions.

HIPAA mandates that a "firewall concept" be established between PHI from the health plan and medical information considered to be employment records. The following are considered part of personnel records and are **not** considered PHI from the health plan.

- Disability benefit applications
- Workers' Compensation benefits
- Medical leave requests
- EEO compliance documents
- FMLA records
- ADA records
- Records relating to an occupational injury
- Records relating to sick leave requests and justifications
- Drug screening results
- Workplace medical surveillance
- Fitness for duty test results
- Life insurance evidence of insurability information
- Other medical information voluntarily disclosed by the individual to an employer

Additional information regarding transactions, privacy and security, can be found on the federal Department of Health and Human Services website at http://aspe.os.dhhs.gov/admnsimp.

B. HIPAA Privacy Rules

Privacy rules apply to all records, electronic and paper, that contain PHI, and require "reasonable and appropriate" administrative, physical, and technical safeguards to protect PHI.

The purpose of the HIPAA Privacy Rule is to:

- define and limit the circumstances in which organizations may use or disclose protected health information (PHI),
- inform consumers about how their health information is being used, and
- give consumers access to their own health records and the right to make corrections.

C. Suggested Communication Procedures for GIR/Ps

When a GIR/P is asked to assist a member with a health plan issue such as claim resolution, special care must be taken in order to ensure the member's privacy and security rights are not infringed upon and that the GIR/P is not subject to an illegal breach of confidentiality. GIR/Ps should become familiar with the suggested procedures below to be prepared when a member (or a member's dependent/ guardian/power of attorney, etc.) requests assistance.

1. **Authorization Forms:** The Bureau of Benefits and its vendors require the Authorization Form for Release of Health Information (CMS-550) be completed by the member when a GIR/P is acting on behalf of the member to resolve a claim issue. Plan Administrators **cannot/will not** release any information without an Authorization form on file.

   Group Insurance Representatives/Preparers should make reasonable efforts to limit Protected Health Information to the minimum necessary when disclosing or requesting information. The authorization form <u>is</u> required when a member is requesting information or help from the Bureau of Benefits or a vendor; however, the authorization form is <u>not</u> required when a member goes to the carrier directly.

   To ensure the integrity of the Authorization Form for Release of Health Information (CMS-550), **it is imperative that the form not be altered or reproduced in any capacity.**

2. **Personal Representatives:** To release information to a personal representative, all legally appointed persons and court orders must be on file (i.e., court-appointed guardians, Power of Attorney, Qualified Medical Child Support Order). Verification is required.

3. **Confidential Address:** Individuals have the right to request a confidential/alternate address. Confidential addresses will not be maintained in the Membership System. Individuals must be directed to the appropriate vendor if they request a confidential address for mailings.

D. Safeguards

The following suggested safeguards may ensure a member's privacy.

a. **Visitors/Walk-ins:** Identify physical space to conduct business with visitors/ walk-ins. Accompany a visitor/walk-in to a secured area to conduct business.

b. **Storage:** Close and lock all file cabinets when not in use. Secure correspondence files containing PHI when you are away from your desk. HIPAA requires that "fire-walls" be in place for Personnel records and health plan records. This firewall concept simply means that personnel and health plan records contained in the member's file should be separated.

c. **Shredders:** When possible, shred any document containing confidential information that is not part of the permanent record. ***Note:*** Screen prints from the mainframe are designated as confidential information and must be shredded.

   GIR/Ps who assist members with claim issues should shred the supporting documentation once the issue is resolved.

d. **Inbound Faxes:** Faxes should be received in private, secured areas and not left in public bins. Designated staff should deliver faxes to the intended recipients.

e. **Outbound Faxes:** Coordinate with leadership in your organization to determine whether confidentiality statements could be included on fax cover sheets.

f. **Outbound Email:** Include minimum necessary information for the purpose of email. If possible, include a confidentiality statement as advised by your agency. Include only an individual's first name and last four digits of SSN or "Confidential" in email subject line. The member's SSN may be used in the text of the email.

Appendix A contains a summary of the Change in Status and Consistency IRS rules, as well as the Consistency Matrix.

The Consistency matrix is used to determine which changes are allowed for each Qualifying Change in Status a member may experience. If the GIR/P is not sure if a particular situation qualifies as a change in status, he/she should contact the Group Insurance Membership Unit for a determination.

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CHANGES IN STATUS

(taken from Section 125 of the Federal Regulations)

Changes in Status Rule: A cafeteria plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefits plan to which this paragraph (i.e., changes in status) applies and make a new election for the remaining portion of the period if, under the facts and circumstances of –

- A change in status described below occurs, **and**
- The election change satisfies the consistency rule

Consistency Rule: An election change satisfies the requirements of this paragraph (i.e., consistency rule) with respect to accident or health coverage or group-term life insurance only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan.

Change in Status Events:

1. Events that change an employee's legal marital status, including:
    a. marriage
    b. death of spouse
    c. divorce
    d. legal separation
    e. annulment
2. Events that change an employee's number of dependents, including:
    a. birth
    b. death
    c. adoption
    d. placement for adoption
3. Events that change the employment status of the employee, the employee's spouse, or the employee's dependent, including:
    a. a termination or commencement of employment
    b. a strike or lockout
    c. a commencement of or return from an unpaid leave of absence
    d. a change in worksite
    e. a change in the individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan
4. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
5. A change in the place of residence of the employee, spouse, or dependent.

CONSISTENCY MATRIX FOR QUALIFYING CHANGES IN STATUS

Reason Code	QUALIFYING CHANGE IN STATUS X – Election allowed for the corresponding Qualifying Change P – Applies to Part-time members only **MEMBER-RELATED Qualifying Changes in Status**	Opt Out	Member May Enter the Program ***	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dep. Cvg. (except spouse)	Terminate Spouse Coverage	Change Health Carrier	Waive Health & Dental Coverage
67	Adjudicated Child: Member financially responsible			X						
31	Adoption (or placement for adoption)			X						
30	Birth			X						
66	Custody awarded and requires dependent coverage (court ordered)			X	X					
66	Custody loss (court ordered) / Court order expires						X			
40	Dental PCD leaves network									
60	Divorce/Legal separation/Annulment		X				X	X		
65	Eligibility: Member becomes eligible for non-State group insurance coverage	X								
68	Eligibility: Member loses eligibility (for other than non-payment of premium) of non-State group insurance coverage		X							
63	Employment Status: Full time to part time (part time = 50% or greater)						X	X		P
63	Employment Status: Part-time participating to full time	X								
63	Employment Status: Part-time waiving coverage or <50% to full time	X			X	X				
40	Health PCP leaves network								X	
N/A	Initial enrollment – within 10 days	X			X	X				P
63	Leave of Absence: Member entering non-pay status	X					X	X		X/P
63	Leave of Absence: Member entering non-pay status responsible for 100%						X	X		X/P
63	Leave of Absence: Member returns to work from non-pay status	X	X		X	X				P
32	Marriage	X	X	X		X				P
64	Medicaid or Medicare eligibility gained	X					X	X		
64	Medicaid or Medicare eligibility loss		X		X	X				
63	Military Call-up: Member called-up by executive order *						X	X	X	X/P
63	Military Call-up: Member returns to work **				X	X			X	
45	Premium increase 30% or greater: Employee's non-State health insurance		X		X	X				
45	Premium increase 30% or greater: Member's STATE health insurance						X	X		P
20	Residence/Work location: Member's county changes								X	
63	Retirement	X	X		X	X	X	X	X	

* Members who are in the military and are called up by an Executive Order may elect to **waive** health, dental, vision coverage upon going on the leave of absence.

** Members returning from military call-up may elect to have their health/dental/vision coverage reinstated.

*** Members who had previously opted out of health, dental and vision and wish to opt back into the State Group Insurance Program may choose not to participate in the dental plan at that time. **This is the only situation where a member can alter their dental coverage selection other than during the Benefits Choice Period.**

Note: Premiums for certain coverages are not tax exempt, therefore, those coverages can be changed anytime during the plan year without experiencing a Qualifying Change in Status. These changes include Adding or Terminating an eligible dependent in the 2+ category, Adding or Terminating Child or Spouse Life, Adding or Terminating AD&D coverage, and Increasing or Decreasing Optional Life above $50,000 (Statement of Health may be required for life coverage changes, see Section 4.2 of the Group Insurance Manual for more details).

Reason Code	QUALIFYING CHANGE IN STATUS	HEALTH & DENTAL								
	SPOUSE-RELATED Qualifying Changes in Status	Member May Opt Out	Member May Enter the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dep. Cvg. (except spouse)	Terminate Spouse Coverage	Change Health Carrier	Waive Health/ Dental Coverage
47	Coordination of spouse's annual election period	X	X		X	X	X	X		P
61	Death of spouse		X					X		
34	Eligibility: Spouse loses eligibility for group insurance coverage		X		X	X				
46	Eligibility: Spouse now provided with group insurance coverage	X					X	X		
62	Employment Status: Spouse gains employment	X					X	X		P
33	Employment Status: Spouse loses employment		X		X	X				
64	Medicare eligibility: Spouse gains							X		
64	Medicare eligibility: Spouse loses					X				
45	Premium of spouse's employer increases 30% or greater, or spouse's employer significantly decreases coverage		X		X	X				
20	Residence/Work location: Spouse's county changes								X	

Reason Code	QUALIFYING CHANGE IN STATUS	HEALTH & DENTAL								
	DEPENDENT-RELATED (other than spouse) Qualifying Changes in Status	Member May Opt Out	Member May Enter the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dep. Cvg. (except spouse)	Terminate Spouse Coverage	Change Health Carrier	Waive Health/ Dental Coverage
61	Death of dependent						X			
65	Eligibility: Dependent becomes eligible for State group coverage				X					
35	Eligibility: Dependent loses eligibility for non-State group coverage				X					
65	Eligibility: Dependent now eligible for non-State group coverage						X			
64	Medicare eligibility: Dependent gains						X			
64	Medicare eligibility: Dependent loses				X					
20	Residence/Work location: Dependent's county changes								X	

Change in Status Events:

- Events that change an employee's legal marital status, including marriage, death of spouse, divorce, legal separation, annulment.
- Events that change an employee's number of dependents, including birth, death, adoption, placement for adoption.
- Events that change the employment status of the employee, the employee's spouse, or the employee's dependent, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, a change in the individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan.
- Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- A change in the place of residence of the employee, spouse, or dependent.

Appendix B contains the Documentation Requirements which are required when a member and/or dependent is being added to the Membership System. The documentation must be provided to the GIR/P within the timeframes indicated on the Documentation Timeline in order to add the member/dependent.

Appendix B also contains The Insurance File Recordkeeping Requirements which explain the recordkeeping and transfer requirements for Group Insurance files.

Index	Appendix B - 1
Documentation Time Limit Requirements	Appendix B - 2
Documentation Requirements	Appendix B - 3
Insurance File Recordkeeping Requirements	Appendix B - 11

DOCUMENTATION FOR DEPENDENT COVERAGE
TIME LIMIT REQUIREMENTS

(Health Plan Only)

Mitigating Circumstances* - If documentation is not going to be secured/provided within the allowable time period, the GIR/P must send a dated, written request to the Membership Unit for an extension of time (email is acceptable). The request must be sent prior to the expiration of the allowable period.

Event or Qualifying Change in Status	*Coverage Requested*	*Documentation Provided*	*Effective Date*
Initial Enrollment Period *	Day 1 – 10 after hire date	Day 1 – 15 days after hire date	Date of hire
	Day 1 – 10 after hire date	16 days or more after hire date	The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
	Greater than 10 days after hire date	N/A	The member is defaulted to Quality Care coverage without dependent coverage. The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
Benefit Choice Period	During BC Election Period	Within 10 days of the Benefit Choice Election Period ending	July 1st
	During BC Election Period	Greater than 10 days after the Benefit Choice Election Period ends	The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
Qualifying Change in Status requested prior to, or the day of, the event *	Before event, or the day of event	1 – 60 days after the event	Date of event
		61 days or more after the event	The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
Qualifying Change in Status requested after the event * ***(exceptions are adjudicated child and birth – see below)***	Day 1 – 60 after event	1 – 60 days after the event	Date of request
	Day 1 – 60 after event	61 days or more after event date	The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
Birth of Child (Natural or Adopted) *	From birth up to 60 days after the birth	From birth to 60 days after the birth	Date of birth
	Greater than 60 days after the birth	N/A	The member must wait until the next Benefit Choice Period or Qualifying Change in Status.
Adjudicated Child	N/A	N/A	Date of receipt of order

* ***Mitigating Circumstances*** – A member may be granted an exception when mitigating circumstances occur, such as the member having difficulty obtaining an out-of-state or foreign birth certificate, or marriage certificate. Mitigating circumstances require GID approval to allow the additional time to collect the documentation.

DOCUMENTATION REQUIREMENTS

Once a qualifying change in status requirement has been met, the member may add/drop the associated dependent once the indicated documentation has been provided.

- ***Dropping dependents***, *due to ineligibility*, requires an email or signed memorandum from the member indicating (1) the dependent's name, (2) the reason for the termination, and (3) the effective date of the termination. No other documentation is required. The memo/email must be retained in the member's insurance file.

- Please submit only photocopies of required documentation (original documents must be kept in the member's insurance file).

Request or Qualifying Change in Status	***Change Allowed***	***Supporting Documentation Required***
Adjudicated child * (court establishes member's financial responsibility for child)	*Add Child*	**Birth Certificate not required;** however one of the following is required: - Judicial Support Order from a judge, ~ 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*	*Add Child*	**Birth Certificate not required;** however one of the following is required: - Adoption Decree/Order with judge's signature and circuit clerk's file stamp, ~ OR ~ - Petition for Adoption filed with the court/circuit clerk with the circuit clerk's file stamp.
Birth / Natural child *	*Add Child*	**Birth Certificate from the state or hospital indicating the member is the parent** (or, if birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed).
Coordination of spouse's annual election period	*Add Spouse or Child* ~ OR ~ *Terminate Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) - (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and one of the following: - Documentation from spouse's insurance provider or employer indicating this is the only enrollment/change period for dependent coverage, ~ OR ~ - Documentation similar to the Benefit Choice Booklet.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Qualifying Change in Status	*Change Allowed*	*Supporting Documentation Required*
Custody awarded and requires dependent coverage *	*Add Child*	**Birth Certificate not required;** however the following is required: - Court Order with judge's signature with circuit clerk's file stamp indicating the member has been awarded custody of the dependent.
Custody loss (court ordered) or court order expires *	*Terminate Child*	- Court Order indicating the member no longer has custody of the dependent. The Order must have judge's signature with circuit clerk's file stamp.
Death of spouse or dependent	*Terminate Spouse or Child*	- Documentation of death, e.g., copy of obituary, death certificate.
Dental PCD leaves the network	*Change Dental Carrier*	- Letter from dentist and/or carrier, or written notification from the managed care network, indicating the dentist is no longer participating in the network.
Divorce	*Terminate Spouse*	- Divorce Decree filed in a U.S. Court – 1st and last pages with judge's signature with circuit clerk's file stamp.
Eligibility: Dependent becomes eligible for State group coverage *	*Add Child*	**Birth Certificate** (or, if birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - Documentation indicating the reason/date the child became eligible for the State's group insurance coverage. *See individual type of dependent child for additional required documentation (i.e., student, handicapped, adjudicated, stepchild)*
Eligibility: Dependent loses eligibility for non-State group coverage *	*Add Child*	**Birth Certificate** (or, if birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - Documentation indicating the child is no longer eligible for the non-State group insurance coverage. *See individual type of dependent child for additional required documentation (i.e., student, handicapped, adjudicated, stepchild)*
Eligibility: Dependent now eligible for non-State group coverage *	*Terminate Child*	- Documentation/email indicating that the dependent is now provided with other group insurance coverage, **AND** - Documentation indicating enrollment in the other plan with the effective date of coverage.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Qualifying Change in Status	*Change Allowed*	*Supporting Documentation Required*
Eligibility: Spouse loses eligibility for group insurance coverage *	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) **–** (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed); and one of the following: - Documentation from the employer of the spouse indicating the loss of coverage and the effective date of the insurance discontinuation, ~ OR ~ - Certificate of Creditable Coverage.
Eligibility: Spouse now provided with group insurance coverage	*Terminate Spouse or Child*	- Documentation from spouse's insurance or employer indicating that they are now providing group insurance coverage to the spouse. The enrollment period must be included in the documentation, ~ OR ~ - Documentation similar to the Benefit Choice Booklet.
Employment status: Member changes from full time to part time (part time = 50% - 99%)	*Terminate Spouse or Child*	- Personnel action form indicating member's employment status has changed to part time.
Employment status: Member changes from part time waiving coverage or < 50%, to full time	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed). - Personnel action form indicating member's employment status has changed to full time.
Employment Status: Spouse gains employment	*Terminate Spouse or Child*	- Documentation from the spouse's employer verifying the gain of employment and effective date.
Employment Status: Spouse loses employment	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and one of the following: - Documentation from the affected spouse/dependent employer verifying the employment change and effective date of event, ~ OR ~ - Certificate of Creditable Coverage.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Qualifying Change in Status	*Change Allowed*	*Supporting Documentation Required*
Handicapped child *	*Add Child*	**Birth Certificate** (or, if birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - 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** - CMS-138 (Dependent Recertification form).
Health PCP leaves the network	*Change Health Carrier*	- Letter from physician and/or carrier, or written notification from the managed care network, indicating the physician is no longer participating in the network.
Initial enrollment period	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed). *See individual type of dependent child for additional required documentation (i.e., student, handicapped, adjudicated, stepchild).*
Leave of Absence: Member entering non-pay status	*Terminate Spouse or Child*	- Personnel action form verifying the leave of absence reason (code), **AND** - Email or signed memo from the member indicating they are choosing to drop dependent coverage for a specific dependent.
Leave of Absence: Member returns to work from non-pay status	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) **–** (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), **AND** - Personnel action form verifying the date the member returned to work.
Legal separation or annulment	*Terminate Spouse*	- Court Order with judge's signature with circuit clerk's file stamp.
Marriage *	*Add Spouse or Newly Acquired Child*	**Marriage certificate** (or, if marriage certificate is not available, the previous year's tax return is acceptable indicating the spouse was claimed). *See individual type of dependent child for additional required documentation (i.e., student, handicapped, adjudicated, stepchild).*

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Qualifying Change in Status	*Change Allowed*	*Supporting Documentation Required*
Medicaid or Medicare: Member gains eligibility	*Terminate Spouse or Child*	- ***Medicaid:*** Documentation from Public Aid, such as eligibility letter, ~ OR ~ - ***Medicare:*** Copy of Medicare card and/or Social Security Administration letter.
Medicaid or Medicare: Spouse gains eligibility	*Terminate Spouse*	
Medicaid or Medicare: Dependent gains eligibility	*Terminate Child*	
Medicaid or Medicare: Member loses eligibility	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), **AND** - Documentation such as a letter from Medicare/Medicaid indicating the termination of coverage.
Medicaid or Medicare: Spouse loses eligibility	*Add Spouse*	
Medicaid or Medicare: Dependent loses eligibility	*Add Child*	
Military Call-up: Member called-up by executive order	*Terminate Spouse or Child; Change Health or Dental Carrier*	- Copy of the Executive Order.
Military Call-up: Member returns to work	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed. - Personnel action form verifying the date the member returned to work.
Premium of spouse's employer increases 30% or greater; **Or,** **Spouse's employer significantly decreases coverage**	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - Documentation from spouse's employer on business letterhead indicating the date of change, as well as, the old and new premium amounts. Documentation should include the last date of insurance coverage.
Premium increase 30% or greater: Employee's non-State health insurance (only applies if the member has Opted Out of State coverage)	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) – (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - Documentation from member's non-State insurance provider indicating the date of change, as well as, the old and new premium amounts.
Premium increase 30% or greater: Member's State health insurance	*Terminate Spouse or Child*	- Documentation indicating the date of change, as well as, the old and new premium amounts.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Qualifying Change in Status	*Change Allowed*	*Supporting Documentation Required*
Residence/Work location: County changes for member, spouse or dependent	*Change Health or Dental Carrier*	- Official memo from workplace indicating the date the work location changed, or email/signed memo from the member indicating the date the home address changed.
Retirement	*Add Spouse or Child*	**Marriage Certificate** (spouse) **or Birth Certificate** (child) - (or, if marriage or birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), **AND** - Personnel action form indicating the date of the retirement.
	Terminate Spouse or Child; Change Health or Dental Carrier	- Personnel action form indicating the date of the retirement.
Stepchild *	*Add Child*	**Birth Certificate, 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 member's address.
Student *	*Add Child*	**Birth Certificate** (or, if birth certificate is not available, the previous year's tax return is acceptable indicating the dependent was claimed), and the following: - Documentation indicating the student is enrolled full time at an accredited school, **AND** - CMS-138 (Dependent Recertification form).

NOTE: If mitigating circumstances prohibit the acquisition of the required documentation, the GIR/P must contact the Group Insurance Division for acceptable alternatives.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

Request or Change	*Change Allowed*	*Supporting Documentation Required*
Incorrect or Temporary Social Security Number	*Correcting Social Security Number*	Copy of SSN card or tax return.
Member wishes to add/increase life coverage	*Increase of Optional Life Above $50,000* *Addition of Child Life / Spouse Life / Optional Life*	Approved Statement of Health.
Opting Out of health, dental, and vision – may be done during the Benefit Choice Enrollment Period, the Initial Enrollment Period, or when an eligible Qualifying Change in Status occurs.	*Allows the member to drop all State Group Insurance Health, Dental, and Vision Coverage*	Proof of comprehensive major medical indemnity or managed care health plan coverage.
Opting Into health, dental, and vision - may be done during the Benefit Choice Enrollment Period or when an eligible Qualifying Change in Status occurs.	*Allows the member to join the State Group Insurance Program and have Health, Dental, and Vision Coverage*	Documentation supporting the Qualifying Change Reason, if applicable. Documentation is not required if the member is opting in during the Benefit Choice Period.
Permanent layoff	*Any Change Allowed; however, documentation must be provided to GID to change the member's status to permanent layoff*	Documentation (e.g., CMS 2 or documentation that the employee was put on a recall list or Reemployment Register) stating the position has been permanently eliminated with no intent of rehiring in the future.

* A Qualifying Change in Status is not required to add a dependent when the member has at least 2 dependents active on the Membership System. Additionally, a member may drop a dependent without a Qualifying Change in Status if the member will have at least 2 dependents active on the Membership System after dropping the dependent (see Irrevocability Rule in the Group Insurance Manual, page 4-41).

INSURANCE FILE RECORDKEEPING REQUIREMENTS
Central Management Services
Group Insurance Division

Maintenance

Personnel Rule 304.40 defines employee personnel records, including insurance files, as confidential records, therefore, access is restricted.

Insurance files should contain all original signed enrollment/change forms, annual dependent recertifications, copies of birth certificates on newborn additions, marriage certificates, divorce decrees, court-ordered insurance coverage, and any other documentation or verification which support eligibility.

Part of the insurance file, medical records, and related health information should be separately maintained to prevent access which has not been authorized by the member. These documents include, but are not limited to, Statement of Health forms, disability statements, medical reports, medical records, or any correspondence containing a diagnosis code.

Retention

Existing State law requires the permanent retention of insurance record originals. – State Records Commission, 2/17/80.

Agencies are responsible for maintaining the employee insurance file indefinitely. An agency may elect to ***microfilm/image*** original records. The original records may then be destroyed. A ***security copy*** of the microfilm/image must be sent to the State archives at Secretary of State for **permanent retention**.

Agencies without online access should forward copies of any change or correction forms with supporting documentation to the Group Insurance Division for online entry. The agency should retain all original documents in their agency file.

Transfer

When an employee transfers or resigns to accept a position in another agency, a copy of the agency personnel file, if any, shall be forwarded to such agency. – Personnel Rule 302.460

The Group Insurance Division requires that a copy of the entire insurance file be transferred to the new agency. The State Records Commission requires the losing agency to maintain all original documents signed by the member as well as any verifications obtained for eligibility. The receiving agency should verify the accuracy of information in the file, update any changes, as well as, ask the member to complete a new life insurance beneficiary designation form.

Retirement System Exception to Forwarding Copy of Insurance File

Agencies with members entering the retirement system, either with a retirement annuity or a disability leave of absence **should not** forward the member's insurance file to the Retirement System. The agency from which the member has retired is responsible for retention of all other records in the insurance file.

Appendix C contains the forms which agencies must use for corresponding with the Group Insurance Division. The index below lists the forms contained in this section and the corresponding page number.

Index	Appendix C - 1
Special GIFCS Reports – Sorting Sequence Request (CMS-325)	Appendix C - 2
Agency Org. Processing Code File Set-Up Form (CMS-139)	Appendix C - 3
Direct Payment Summary (CMS-309)	Appendix C - 5
Discrepancy Response Form (CMS-321)	Appendix C - 6
Non-payroll Member and Direct Payment Report (CMS-328)	Appendix C - 7

Obtaining and Printing Agency Forms: GIR/Ps may print forms by going to the GIR/P website address located at: http://www.state.il.us/cms/2_servicese_ben/gir.htm. Once access to the website is gained, simply click on the 'Forms' tab and select the necessary form.

Health and Dental Claim Forms: CMS does not supply agencies, universities or providers with claim forms. Claim forms must be obtained from the member's specific Plan Administrator. See the list of plan administrators in the most current Benefit Choice Options book.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Special GIFCS Reports – Sorting Sequence Request

Agencies may request three specialized discrepancy reports that may assist with identifying the highest dollar discrepancy or CFT by the sorting sequence. If the agency is requesting a report for each facility, one (1) form needs to be filled out for each facility. If ordered by facility, ach facility will be separated for easy distribution. Only one (1) form should be completed if the agency does not want facilities separated.

Please answer all the questions below. This information will assist Central Management Services, Group Insurance Division in completing the request accurately.

1. What is the agency Organizational Processing Code? ☐ ☐ ☐

2. Does the agency want this report for all their facilities? Yes ☐ No ☐

   If Yes, then skip to item 3.
   If No, what facility Organizational Processing Code is requested? ☐ ☐ ☐

3. Is the default tolerance of $3.50 (plus or minus) acceptable? Yes ☐ No ☐
   If Yes, then skip to item 4.

   If No, what tolerance level, in dollars, is being requested? $ ☐ . ☐

4. What sequence type report is requested?
   - Highest dollars (highest negative to smallest positive) (GIFCMR24-1) ☐
   - Last name and then dollars (GIFCMR24-2) ☐
   - Highest CFT values, then highest Priorities, then dollars (GIFCMR24-3) ☐

5. How many copies of the report are requested? ☐

Mail request to: Central Management Services
Group Insurance Division
Attn: Analysis and Resolution Unit, Dan Ewald
201 E. Madison, Suite 2B, PO Box 19208
Springfield, IL 62794-9208

Agency Completed
Requested by: _____ Date _____ Phone No._____

GID Use Only: _____

CENTRAL MANAGEMENT SERVICES – BENEFITS SYSTEMS DIVISION
AGENCY ORGANIZATIONAL PROCESSING CODE FILE SET-UP FORM

AGENCY NAME: _____ **CUSAS CODE:** ____ ____ ____

CONTACT NAME AND PHONE NUMBER: _____ (_____)_____-_____

GIR _____ **GIP**_____ **OPTION:** ☐ **ADD** ☐ **CHANGE** ☐ **REMOVE**

ORG PROC CODE: _____ _____ _____ **EFFECTIVE DATE:** _____

FIRST NAME: _____ **MI** ___ **LAST NAME:** _____

ADDRESS (1): _____ **(2)**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ - _____

PHONE: (_____) _____ - _____ **EXT:** _____ **FAX NUMBER:** (_____) _____ - _____ **EXT:** _____

E-MAIL ADDRESS: _____

SHOULD THIS GIR/P APPEAR ON THE GROUP INSURANCE REPRESENTATIVE CONTACT LIST ON THE BENEFITS WEBSITE? ☐ **YES** ☐ **NO**

RACF ID: _____ **SOCIAL SECURITY NUMBER:** _____ - _____ - _____

ORG PROC CODE(S) PERSON NEEDS ACCESS TO: _____ _____

PLEASE CHECK WHICH SYSTEMS THE PERSON NEEDS ACCESS TO BELOW:

☐ **MEMBERSHIP FULL UPDATE & FSA INQUIRY** ☐ **MEMBERSHIP LIMITED UPDATE & FSA INQUIRY**
☐ **MEMBERSHIP & FSA INQUIRY** ☐ **GIFCS PAY ADJUSTMENT**

Please indicate the date by which the person needs to be trained: _____

MOBIUS REPORTS WILL BE PROVIDED ONLINE ONLY. IF YOU WANT PRINTED REPORTS, YOU MAY SUBMIT A WRITTEN REQUEST, ALONG WITH JUSTIFICATION, TO THE BENEFITS SYSTEMS DIVISION FOR REVIEW AND APPROVAL.

Note: *The Benefits Systems Division must receive a written request from the agency to: 1) establish a new GIR/P, 2) remove or replace an existing GIR/P or 3) change a GIR/P's information. If access is requested to one of GID's systems, the GIR/P must be trained by GID before access will be granted. Once the Benefits Systems Division receives the written request for access, agencies will be contacted by GID regarding the necessary training.*

INSTRUCTIONS

AGENCY NAME – indicate the name of your agency in this space.

CUSAS CODE – indicate the three-digit Comptroller CUSAS code for your agency in this field.

CONTACT NAME AND PHONE NUMBER – indicate the name and phone number of the Group Insurance Representative (GIR) for your agency. ***All requests to add, change or remove GIR/P information must be approved by the GIR.***

GIR/GIP - place an "x" or checkmark next to the one(s) that applies.

OPTION: ADD/CHANGE/REMOVE – check the box to indicate why this form is being submitted. The 'Add ' box should only be checked if you are adding a new person and need to establish a new organizational processing code (OPC). If you are replacing a person who is in an existing OPC, check the 'Change' box. The 'Change' option should also be checked to update address, phone, email address, etc. The 'Remove' box should only be checked if you want to eliminate an OPC. Note, there may be active employees on the Membership System under the OPC you are eliminating. If so, you need to provide instructions as to what OPC code should replace the one that is being eliminated so GID can update the employee's records.

ORG PROC CODE – this code uniquely identifies each GIR/P at your agency. If you are adding a new person, indicate the Organizational Processing Code (OPC) that you would like to assign to the person. Please note that this code must be different from any other person's code within your agency. If you are changing the information for a person in an existing OPC or requesting removal of an OPC, enter the code that the change applies to or that is being removed.

EFFECTIVE DATE – indicate when the Add, Change or Removal is effective.

FIRST NAME/MIDDLE INITIAL (MI)/LAST NAME – indicate the person's full name as you want it to appear on all Group Insurance documentation.

ADDRESS – indicate the person's work address. All mail for that person will be sent to this address.

PHONE #, FAX # & EMAIL ADDRESS – indicate the phone number, fax number and email address for the person in the space provided.

BENEFITS WEBSITE GROUP INSURANCE REPRESENTATIVE CONTACT LIST – Check 'Yes' or 'No' to indicate if the person should or should not appear on the Group Insurance Representative Contact List on the Benefits Website (www.benefitschoice.il.gov).

RACF ID & SOCIAL SECURITY NUMBER – if the person has been assigned a RACF security code, enter the code in the space provided. If the person does not have a security code, write 'None'. Provide the person's SSN.

ORG PROC CODE ACCESS – enter each 9-digit organizational processing code to which the person needs access.

SYSTEM ACCESS – if the person needs on-line access to the Membership System or the Group Insurance Financial Control System (GIFCS), check the box(es) that identify the systems to which they need access. Note, there are three levels of access for the Membership System: full update (can process new enrollments, addition/deletion of dependent coverage, changes in plans, etc.), limited update (can process only limited changes such as changes of address, type/subtype changes, terminations, etc.), and inquiry only (can view but not update information). ***If Membership access is requested, check only one of the three types of access.***

QUESTIONS: If you have any questions regarding the completion of this form, please contact Brian Hayes at (217) 558-3486.

Please return this form to:

Benefits Systems Division
Attn: Brian Hayes
201 East Madison, Suite 1B
Springfield, IL 62794-9208
Fax #: 217-557-2080

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DIRECT PAYMENT SUMMARY

Date _____

Coverage Period (Mo/Yr) _____ Agency/Facility _____

Type Payroll: (circle one) S/M Mo Prepared By _____

Payroll Code _____ Phone ( ) _____

A. DIRECT PAYMENTS BY CARRIER BEING SUBMITTED WITH THIS REPORT:

Carr Code	HEALTH CARRIER	Health dollar Amount	Carr Code	DENTAL CARRIER	Dental Dollar Amount
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____
____	_____	$_____	**Carr Code**	**LIFE CARRIER**	**Life Dollar Amount**
____	_____	$_____			
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____

B. TOTAL DIRECT PAYMENTS SUBMITTED WITH THIS REPORT – ALL CARRIERS $_____

NOTE: A check or treasurer's draft, made payable to CMS Group Insurance Fund, must accompany this report for the Amount indicated on Line B.

FOR OFFICE USE ONLY

CMS 309 IL 401-0232 (REV 5/00)

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Discrepancy Response

Date: _____

Member Name: _____ Agency Name: _____

SSN: _____ GIR Name: _____

Org. Proc. Code: _____ Phone #: _____

DCMS USE ONLY

Int	Mth
_____	_____
_____	_____

Received

_____

_____

REQUESTING: (*Mark Only One*)

_____ Delay Termination for CFT Member

_____ Reinstate Coverage

_____ Adjustment Indicated Below

ATTACHMENTS:

_____ Copy of Payroll / Direct Payment Report

_____ All Necessary Membership Documentation

ADJUSTMENTS:

_____ **PAYROLL** Adjustment Processed on Pay Period(s): _____

Health $ _____ Life $ _____ Dental $ _____

_____ **CREATE** (Add) Pay Record(s):

PAY PERIOD(S)		PAY CODE	ELIG CODE	Int	Date
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____

_____ **CORRECT** Pay Record Code(s):

PAY PERIOD(S)		ORIG INFO	CORR INFO		
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____

_____ **TRANSFER** Member Paid Premium: _____ _____

Pay Period(s) Member Is / Will Be Overpaid: _____

Health $ _____ Life $ _____ Dental $ _____

Pay Period(s) Member Is / Will Be Underpaid: _____

Health	Life	Dental
Carrier/Code _____ $_____	Carrier/Code _____ $_____	Carrier/Code _____ $_____

REMARKS: _____

_____

_____

CMS-321 IL 401-1564 (5/00)

Printed on Recycled Paper

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NONPAYROLL MEMBER AND DIRECT PAYMENT REPORT

Date _____ Agency/Facility _____ Preparer's Name & Phone # _____

Member's Name (Last, First, MI) (1)					Social Security Number (2)				Pay Code (3)		Ded Freq (4)	Birthdate (5)	PT % (6)	Elig. Code (7)	Basic Life Units (8)
Health Carrier Code (9)	Health Opt. Code (10)	Health Carrier Dollar Amount (11)	Dental Code (12)	Dental Opt. Code (13)	Dental Carrier Dollar Amount (14)		Life Carrier Code (15)	Life Opt. Code (16)	Life Carrier Dollar Amount (17)		Total Amount Paid 11+14+17 (18)	Pay Period Coverage Dates Ending (19)		Beginning (20)	
					— —							/ /			
		$			$				$			$			
					— —							/ /			
		$			$				$			$			
					— —							/ /			
		$			$				$			$			
					— —							/ /			
		$			$				$			$			
					— —							/ /			
		$			$				$			$			

*** Note: All fields MUST be filled.**

DEDUCTION FREQUENCY:
M = Monthly
S= Semi-Monthly

CMS 328 (REV 3/00) IL 401-0965

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Appendix D contains forms requiring the member's signature. Below is a list of the forms contained in this section and the corresponding page number.

Index	Appendix D - 1
Beneficiary Designation form (CMS-617)	Appendix D - 2
Coordination of Benefits Worksheet	Appendix D - 3
Blank page for a new form	Appendix D - 4
Dependent Change form (CMS-313)	Appendix D - 5
Dependent Coverage Certification Statement (CMS-138)	Appendix D - 7
Initial Enrollment form – Member Information (CMS-310)	Appendix D - 9
Initial Enrollment form – Dependent Enrollment (CMS-311)	Appendix D - 11
Member and/or Dependent Address Change form (CMS-314)	Appendix D - 13
Member Change form (CMS-312)	Appendix D - 15
Membership Correction form (CMS-340)	Appendix D - 17
Other Dependent Address Information Worksheet	Appendix D - 19
Part-time Employee Election/Waiver of Group Insurance Participation (CMS-563)	Appendix D - 20
Authorization Form for Release of Health Information (CMS-550)	Appendix D - 21
Waiving Annuitant Health Insurance Coverage Notification and Election (CMS-565)	Appendix D - 22
Opt Out & Opt In Election Certificate (CMS-500)	Appendix D - 23
Domestic Partnership Affidavit (CMS-510)	Appendix D - 25
Domestic Partner Enrollment Form (CMS-511)	Appendix D - 28
Termination of Group Insurance Coverage for Domestic Partner (CMS-512)	Appendix D - 29

Obtaining and Printing Agency Forms: GIR/Ps may print forms by going to the GIR/P website address located at: www.GIResources.illinois.gov. Once the GIR/P has gained access to the website, they should simply click on the 'Forms' tab and select the necessary form.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS GROUP LIFE INSURANCE PROGRAM BENEFICIARY DESIGNATION

MEMBERS MAY DESIGNATE PRIMARY CONTINGENT BENEFICIARIES. **Beneficiaries will receive equal shares, unless specific percentages are indicated.** Contingent beneficiaries become effective only when all primary beneficiaries have died prior to the member's death. A beneficiary may be a person, trust, estate, or other legal entity. You may designate as many primary or contingent beneficiaries as you feel necessary. If you need more space, please copy this sheet or attach another form CMS-617.

Beneficiary designations may be changed by the member at any time by submitting a new form.

If a beneficiary has not been designated, or all designated beneficiaries have died prior to the member's death, any proceeds payable shall be paid according to the Facility of Payment section of the State of Illinois Group Life Insurance Program book. Call Minnesota Life at 888-202-5525 if you would like assistance completing this form.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE EMPLOYED	MEMBER STATUS (Check all that apply) ☐ FULL TIME EMPLOYEE ☐ PART TIME EMPLOYEE ☐ IMMEDIATE ANNUITANT ☐ DEFERRED ANNUITANT ☐ SURVIVOR				

Transaction Type

☐ Initial Designation ☐ Change of Beneficiary ☐ Change of Address of Beneficiary

Primary *or* Contingent Percent

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

I hereby designate the above-named beneficiary(ies). I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions. The above designation supersedes all prior designations of beneficiaries I have made.

Form must be signed and filed with Minnesota Life Insurance Company to validate designation.
Minnesota Life Insurance Company ▪ 1 North Old Capitol Plaza #305 ▪ Springfield, IL 62701

MEMBER SIGNATURE	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	DATE
X	( )	( )	

CMS-617 (Rev 1/03) IL 401-1116 F. 57549 1-2003

COORDINATION OF BENEFITS WORKSHEET

If you, or any of your dependents who are covered under any State of Illinois health plan, are covered under any other health plan(s), you must provide this information to your Group Insurance Representative to ensure health claims are correctly processed (examples include non-state group health plans, Medicare and Medicaid).

You must complete Section A and Section C below. If you have other insurance, you must also complete Section B **and** provide a copy of the insurance identification card from the other coverage. You must return the completed COB Worksheet to your Group Insurance Representative/Preparer.

SECTION A

Member Name: _____ Social Security #: _____

☐ I and/or my dependents do NOT have other group health insurance coverage.

☐ I and/or my dependents DO have other group health insurance coverage (you must complete Section B indicating the other coverage). **YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSURANCE COMPANY.**

SECTION B

Insurance Company Name: _____

Policy Holder Name: _____

Identification Number: _____ Group Number: _____

Effective Date: _____ Policy Type: Medical _____ Dental _____

Covered Persons	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

SECTION C

It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental insurance. If other coverage is added or terminated for any individuals covered under my State Employees' Group Insurance Program, I must notify the Group Insurance Representative immediately.

I certify the above information is accurate.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY TO EXPEDITE CLAIM PROCESSING.

This page intentionally left blank

Agency Name:_____	Org. Proc. Code: _____
Member Name: _____	Member SSN: _____
Dependent Name: _____	Dependent SSN: _____
Mbr signature _____	Date: _____
GIR Signature: _____	Date: _____

DEPENDENT CHANGE FORM

Check One: Change ☐ Termination ☐ Correction ☐

DEPENDENT BIOGRAPHICAL: **Effective Date of Change: ___/___/____**

Dependent. SSN	Temp SSN (Y/N)	Last Name	First Name	Middle Name
_____-____-_____	_____	_____	_____	_____

Birthdate	Sex (M/F)	Retirement Date	Medicare Number
___/ ___/ ____	_____	____/ ___/ _____	_____

Medicare Status Code	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
_____	____/ ____/ _____	_____	____/ ___/ _____

DEPENDENT GROUP: **Effective Date of Change: ___/___/____**

Type Dependent - Check One**:** ____ Active (type 10) ____ Terminated (80) ____ Term Reason Code

Relationship Code: _____

Recertification Date: Annual: ___/___/____ 19th Birthdate: ___/___/____ 23rd Birthdate: ___/___/____

Note: Annual date must be 09/01 of current year; 19th and 23rd Birthdate must be dependent's birth month and day and current year.

DEPENDENT PLANS: **Effective Date of Change: ___/___/____**

Plan	Actv/Term A/T	Waiver Reason	Pre-exist. Months	Carrier Code	Carrier Chg. Reason	PCP# If Appl.
Health	___	____	_____	___	_____	_____
Dental	___	____	_____	___	_____	_____
Life	___	____	N/A	___	Life Certificate Approval Date: ___/___/____	

COORDINATION OF BENEFITS: When adding a dependent to the insurance coverage, the member must complete a Coordination of Benefits form certifying whether or not the dependent has other health/dental coverage.

10/2004

INSTRUCTIONS FOR COMPLETING THE DEPENDENT FORM

This form is used for changes, terminations and corrections **only**. Check the appropriate box under the title of the form to indicate the type of transaction being submitted, i.e., change, termination or correction.

Complete the areas labeled Agency Name, Organizational Processing Code, Member name, Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign the form, attach a memo/letter from the member with his/her signature and date requesting the changes. ***GIR signature and date is required.***

Dependent Biographical Section:

Enter the Dependent's SSN. Enter 'Yes' (Y) if the SSN # is temporary; enter 'No' (N) if the SSN# is not temporary.

Complete any other information that may be changing: Please note the following:

> If the dependent is retired, enter the date of retirement.
>
> Medicare status codes are listed in Appendix H of the Group Insurance Manual.
>
> If the member is enrolled in Medicare, enter the information requested for Part A and Part B, as well as the Medicare number.

Dependent Group Section:

Type Dependent: If the type of dependent is changing, indicate the dependent type, either active or terminated. Dependent types are '10' for dependents of active members and '80' for terminated dependents. If the dependent's coverage is being terminated, enter the termination reason code, found in Appendix H, page 7 of the Group Insurance Manual.

Relationship Code: Enter the dependent relationship code. For example, if the relationship is changing from son to student, enter the relationship code for student. Relationship codes are found in Appendix H of the Group Insurance Manual.

Dependent Plans Section:

Enter the information that is changing. Please note the following:

> The dependent must have the same health and dental plans as the member. For example, if the member elects health plan A, the dependent must be enrolled in health plan A.
>
> Health Carrier Codes are listed in the Benefit Choice Booklet. Dental and Life Carrier Codes are listed in Appendix H of the Group Insurance Manual.
>
> PCP# for managed care providers are located in the individual provider listings.

CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS GROUP INSURANCE PROGRAM

DEPENDENT COVERAGE CERTIFICATION STATEMENT

EMPLOYEE NAME:_____ **MBR. SSN:** _____

DEPENDENT NAME:_____ **DEP. SSN:** _____

CERTIFICATION EFF. DATE: _____

I certify that the above dependent meets ALL of the qualifications for continued coverage in the dependent category checked below. I have attached the required documentation as stated on the back of this Statement.

Dependent Category ***(Check One)***	**Qualification**
___ Student	Dependent at least age 19 but not yet 23, **and** (1) enrolled as a full-time student in an accredited school, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ Handicapped	Age 19 or older, **and** (1) continuously disabled from a cause originating prior to age 19, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ OTHER: Mother, Father, Son, Daughter, Brother Sister, Niece, Nephew Grandparent	Dependent is (1) financially dependent upon me, **and** (2) eligible to be claimed as my dependent for income tax purposes, **and** (3) has either: (3a) received an organ transplant after June 30, 2000, **or** (3b) has been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Please contact your insurance representative for questions regarding continuous coverage or transplant eligibility.
Note: Dependents enrolled in the 'Other' category are not eligible for life insurance coverage.

___ **Terminate Dependent**: My dependent no longer meets the eligibility criteria. By checking the 'Terminate Dependent' line and signing below, I am authorizing the termination of my dependent's coverage.

I understand that it is my responsibility to notify my agency Insurance Representative when and if the above person ceases to meet the qualifications as stated above. I acknowledge and understand that failure to notify the State of changes in my dependent's status will result in termination of coverage retroactive to the last eligible date, recovery of all claim payments and possible forfeiture of premiums paid.

_____ _____
(Member's Signature) (Date) (Insurance Rep's Signature) (Date)

RETURN THIS FORM TO YOUR INSURANCE REPRESENTATIVE

04/23/2004

201 E. Madison, Suite 2B, P.O. Box 19208, Springfield, IL, 62794-9208
Printed on Recycled Paper

Qualifying Criteria and Required Documentation
For Student, Handicapped or 'Other' Dependent Categories

STUDENT: **Qualifying Criteria**

a. Unmarried child age 19 through age 22, **and**

b. Enrolled as a full-time student in an accredited school, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. Verification of enrollment as a full-time student *, **and**

2. Dependent Coverage Certification Statement

* *Examples of documentation include: letter from the Office of the School Registrar, tuition bill marked "paid", copy of enrollment from the university's web-site, abbreviated transcript, copy of grant award or tuition waiver, itemized statement of account.* **Full-time student status must be indicated on the document submitted.**

Note: If your dependent no longer qualifies as a 'Student', he/she may qualify as 'Handicapped' or 'Other' as follows:

HANDICAPPED: **Qualifying Criteria**

a. Unmarried child age 19 or older who is mentally or physically handicapped, **and**

b. Continuously disabled from a cause originating prior to age 19, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. A diagnosis from a MD with an ICD-9 diagnosis code, **and**

2. Letter from the doctor detailing the dependent's limitations, capabilities and onset of condition, **and**

3. Statement from the Social Security Administration with the Social Security disability determination, **and**

4. Dependent Coverage Certification Statement

OTHER: **Qualifying Criteria**

a. Financially dependent upon the member, **and**

b. Eligible to be claimed as a dependent for income tax purposes by the member, **and** has either:

(1) received an organ transplant after June 30, 2000, or has
(2) been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Required Documentation

1. Dependent Coverage Certification Statement

If you have any questions regarding dependent eligibility or the information provided above, please contact your agency Insurance Representative or CMS Group Insurance Division at (217) 558-4978 or (800) 442-1300.

Agency Name: _____
Member SSN: _____-_____-_____

Department of Central Management Services
State of Illinois
Group Insurance Initial Enrollment Form

MEMBER BIOGRAPHICAL INFORMATION: (Please print or type)

Member SSN:_____-____-_____ GI Proc Org:_____ _____ _____ Eff. Date of Add: _____-_____-_____

Name:_____ _____ _____
Last First Middle

Marital Status (S/M): _____ Handicapped (Y/N): _____ Birthdate (mm/dd/ccyy): ____-____-_____

Sex: (M/F): ____ Phone Number: Home (_____) _____-_____ Work (_____) _____-_____

Medicare Status: (check one)

1	Non-Medicare	☐	If Medicare is 2, 4, or 5, complete the following:
2	Medicare Eligible	☐	Part A (Begin Date) _____ - _____ - _____
3 *	Medicare Ineligible 65+	☐	Part B (Begin Date) _____ - _____ - _____
4	Medicare disability	☐	Part A Free (Y) ☐ (N) ☐
5	End Stage Renal	☐	Part A Free (Y) ☐ (N) ☐

* If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If the member has a power of attorney, legal guardian, or trustee, please complete the Other Addressee information, if different than member's.

Member Residential Address

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Other Addressee Information

Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

MEMBER GROUP:

Type Enrollee:_____ _____ Full Time/Part Time % _____
Deduction Frequency: Semi Monthly/Monthly (S/M) _____

Survivors Only:

SSN of deceased member:_____-_____-_____ Relationship to Deceased Member (S/C/P) ____

07/15/2004

Agency Name: _____
Member SSN: _____-_____-_____

Agency Information:
Payroll Agency:_____ Work County:_____
Distribution Code:_____

MEMBER PLANS (Health/Dental/Life):
Health:

Actv/Term A/T	Waiver Reason	Pre-existing Months Appl.	Carrier Code	PCP# (If Applicable)	Estimated Annual Salary

Dental:
☐ I elect not to participate in the Dental Plan. (GIR/P: Enter dental carrier code 'DD' on Membership)
☐ Active (GIR/P: Enter Quality Care Carrier Code 'D6' on Membership)
☐ Terminated: Enter waiver reason _____

Life:
Active/Term (A/T):_____ Waiver reason, if applicable:_____

Member Basic Life Units	Optional 1 – 8 times	AD&D (N/B/C) (none/basic/combined)	Survivors Only Opt. Life (Y/N)	Spouse Life (Y/N)	Child Life (Y/N)

COORDINATION OF BENEFITS: Upon electing to participate in the Group Insurance Program, the member must complete a Coordination of Benefits form for themselves and each dependent certifying whether or not they have other health/dental coverage.

I authorize prevailing premiums (if any) to be deducted from my pay or annuity for those coverages I have selected. This authorization is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all appropriate rules. I agree to furnish any additional information if requested.

My signature confirms that I understand all above options selected. At all times this form must be signed by the member.

Required Member Signature:_____ Date:_____

I have reviewed and explained all options available to the above member. This form must be completed by the agency personnel and reviewed with the member. This form is not to be completed by the member.

Group Insurance Representative Signature:_____ Date:_____

CMS 310 (REV 10/04) IL 401-1601

Agency Name: _____
Member SSN: _____-_____-_____
Dependent _____ of _____

Department of Central Management Services
State of Illinois

Group Insurance Initial Enrollment Form
DEPENDENT INFORMATION

DEPENDENT BIOGRAPHICAL: (Please print or type) Eff. Date of Add:_____-____-_____

SSN	Temp (Y/N)	Last Name	First Name	Middle Name
_____ - _____ - _____	_____	_____	_____	_____

Birthdate	Birth Sequence # *	Sex (M/F)	Retirement Date
_____ - _____ - _____	_____	_____	_____ - _____ - _____

* Only enter a Birth Sequence number when the dependent is one of a multiple birth on the same date (i.e., first born – 1, second born – 2, etc., born on the same day, month and year).

Medicare Status **	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
_____	_____ - _____ - _____	_____	_____ - _____ - _____

** If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (Other than Member's)
(e.g., college campus address)

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Dep. Other Addressee (custodial parent, guardian, etc.)
Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

Type Dependent:
Relationship Code *: _____ See GI Manual, Appendix H, page 6 for listing of relationship codes.
* Dependents coded as Student, Handicapped, or "Other" must have backup documentation (refer to the Group Insurance Manual for documentation requirements). Dependents must be enrolled with the same health and dental carrier as the member.

Health
Status (circle one) Active or Terminated
Carrier Code _____
6-digit PCP# (if managed care) _____
Pre-Existing Months _____

Dental
Active / Term

Dependent Life
Yes / No

I understand that I must provide documentation as proof of my relationship to my dependents (i.e., children/spouse).

Required Member Signature:_____ **Date:**_____

07/15/2004

Agency Name: _____
Member SSN: _____-_____-_____
Dependent _____ of _____

Department of Central Management Services
State of Illinois

Group Insurance Initial Enrollment Form

DEPENDENT INFORMATION

DEPENDENT BIOGRAPHICAL: (Please print or type) Eff. Date of Add:_____-____-_____

SSN	Temp (Y/N)	Last Name	First Name	Middle Name
____ - ____ - _____	____	_____	_____	_____

Birthdate	Birth Sequence # *	Sex (M/F)	Retirement Date
____ - ____ - _____	_____	_____	_____ - _____ - _____

* Only enter a Birth Sequence number when the dependent is one of a multiple birth on the same date (i.e., first born – 1, second born – 2, etc., born on the same day, month and year).

Medicare Status **	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
____	____ - ____ - _____	____	_____ - _____ - _____

** If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (Other than Member's)
(e.g., college campus address)

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Dep. Other Addressee (custodial parent, guardian, etc.)
Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

Type Dependent:
Relationship Code *: _____ See GI Manual, Appendix H, page 6 for listing of relationship codes.

* Dependents coded as Student, Handicapped, or "Other" must have backup documentation (refer to the Group Insurance Manual for documentation requirements). Dependents must be enrolled with the same health and dental carrier as the member.

Health
Status (circle one) Active or Terminated
Carrier Code _____
6-digit PCP# (if managed care) _____
Pre-Existing Months _____

Dental
Active / Term

Dependent Life
Yes / No

I understand that I must provide documentation as proof of my relationship to my dependents (i.e., children/spouse).

Required Member Signature:_____ **Date:**_____

CMS 311 (REV 07/04) IL 401-1603

07/15/2004

Agency Name: _____ Org. Proc. Code: _____
Member Name: _____ Member SSN: _____-_____-_____
Dependent Name: _____ Dependent SSN: _____-_____-_____
Mbr Signature: _____ Date: _____
GIR Signature: _____ Date: _____

MEMBER AND/OR DEPENDENT ADDRESS CHANGE FORM

Member Address Change:

Effective Date of Change: _____/_____/_____

Residential Address

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Change/Addition of Other Addressee:

Name: _____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Relationship: _____ 1=Custodial Parent
Enter one of the 6 listed codes.
2=Trustee
3=Power of Attorney
4=Legal Guardian
5=Mailing Address
6=In Care Of (C/O)
Send Mail to this Address (Y/N): _____

Dependent Address Change:

Effective Date of Change: _____/_____/_____

Residential Address (Other than Member's)

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Change/Addition of Other Addressee (custodial parent, guardian, etc.)

Name: _____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Relationship: _____ 1=Custodial Parent
Enter one of the 6 listed codes.
2=Trustee
3=Power of Attorney
4=Legal Guardian
5=Mailing Address
6=In Care Of (C/O)
Send Mail to this Address (Y/N): _____

INSTRUCTIONS FOR COMPLETING THE MEMBER AND/OR DEPENDENT ADDRESS CHANGE FORM

- This form is used to change the member's address on both the Membership and FSA Systems. The form also is used to change the dependent's address on the Membership System.

- Enter a dependent's residential address only if the address is different than the members.

Complete the areas labeled Agency Name, Organizational Processing Code, Member Name, and Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign the form, attach a memo/letter from the member with his/her signature and date they are requesting the change. ***GIR signature and date is required.***

Other Addressee: In some cases, a member or dependent may need to record the name and address of another person who may be responsible for their insurance, such as in the case of a trustee, custodial parent or legal guardian. The 'Other Addressee' portion of this form is to be used for this purpose.

Send Mail to this Address (Y/N): If a 'Y' is entered in this field, mail will be sent to this address. It is possible to have mail sent to multiple addresses, such as in the case of members who have both a residential address and an 'Other Addressee'; however, in most cases, the 'Mail To' indicator would be set to 'Y' for only one of the addresses on file.

Foreign Addresses: When entering a foreign address on the Member or Dependent Address screen, enter 104 in the county code field. Enter either a Country Code (the 3-digit country codes can be found in Appendix H – System Codes section of the Group Insurance Manual) or the Country Name. When a foreign country is entered, the zip+4 field becomes unprotected and allows the foreign postal code to be entered.

Refer to Section 12.29, Address Format, in the Group Insurance Manual for further explanation of entering address information into the Membership System.

Agency Name:_____ Org. Proc. Code: _____

Member Name: _____ Member SSN: _____

Member Signature _____ Date: _____

GIR Signature: _____ Date: _____

MEMBER CHANGE FORM

Check One: Change ☐ Termination ☐ Correction ☐

MEMBER BIOGRAPHICAL INFORMATION: **Effective Date of Change:** ___/___/____

Member SSN: ____-___-_____ Previous SSN: ____-___-_____

SSN Change: ____ - ___ - _____

Name_____ _____ _____

Last First Middle

Marital Status: (S/M) ___ Birth date (mm/dd/ccyy): ___/___/____ Sex: (M/F): ___

Date of Death: ___/___/____

Medicare Status: ____ Part A (Begin Date): ___/___/____ Part A Free (Y/N): ___

Medicare Number: _____ Part B (Begin Date): ___/___/____

MEMBER GROUP INFORMATION: **Effective Date of Change:** ___/___/____

Type Enrollee: __ __ __ __ Full Time/Part Time %: _____

Deduction Frequency - Semi-Monthly / Monthly (S/M): ___

Qualifying Change Reason: ___ Request Date: ____/____/_____

Org. Proc. Code Change: _____

Cusas Work Agency:_____ Work County:_____ Distribution Code:_____

MEMBER PLAN INFORMATION: **Effective Date of Change:** ___/___/____

Health/Dental:

Plan	Actv/Term (A/T)	Waiver Reason	Pre-exist. Months	Carrier Code	Chg. Reason	PCP# If Appl.	Estimated Annual Salary
Health	___	____	_____	____	_____	_____	$_____
Dental	___	____	_____	____	_____	__n/a__	

COORDINATION OF BENEFITS: When adding a dependent to the insurance coverage, the member must complete a Coordination of Benefits form certifying whether or not the dependent has other health/dental coverage.

Life Plan: **Effective Date of Change**: ___/___/____

Active/Term (A/T):___ Waiver Reason (if applicable):____ Certificate Approval Date: ___/___/____

Member Basic Life Units	Optional Life 1 – 8 X	AD & D (N/B/C) (None/Basic/Combined)	Survivor's Only Opt. Life (Y/N)	Spouse Life (Y/N)	Child Life (Y/N)
_____	_____	_____	_____	_____	_____

10/15/2004

INSTRUCTIONS FOR COMPLETING THE MEMBER CHANGE FORM

This form is used for changes, terminations and corrections **only**. Check the appropriate box under the title of the form to indicate the type of transaction being submitted, i.e., change, termination or correction.

Complete the areas labeled Agency Name, Organizational processing code, Member name and Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign this form, attach a memo/letter from the member with his/her signature and date requesting the changes. ***GIR signature and date is required.***

Member Biographical Section:

Enter the Member SSN. Enter 'Yes' (Y) if the SSN # is temporary; enter 'No' (N) if the SSN# is not temporary. If the member is on the Membership System under a previous SSN, enter this number in the 'Previous SSN' field. If you are requesting a change in SSN, indicate the change in the 'SSN Change' field and attach a copy of the member's Social Security card.

Complete any other information that may be changing: Please note the following:

Medicare status codes are listed in Appendix H of the Group Insurance Manual.

If the member is enrolled in Medicare, enter the information requested for Part A and Part B, as well as the Medicare number. Attach a copy of the Member's Medicare card.

Member Group Section: Enter the information that is changing. Please note the following:

Type enrollee codes can be found in Appendix H of the Group Insurance Manual.

If you are transferring a member from a monthly-paid Agency to a semi monthly-paid agency, the transfer must be effective the first day of the month to avoid discrepancies (the Membership System will not allow a change for any date other than the 1st for this kind of transaction).

Qualifying Change Reason codes can be found in Appendix H of the Group Insurance Manual.

Member Plan Section: Enter the information that is changing. Please note the following:

Waiver reasons are located in Appendix H of the Group Insurance Manual.

Pre-existing months indicate how long the pre-existing condition applies to this member.

Health Carrier Codes are listed in the Benefit Choice Booklet. Dental and Life Carrier Codes are listed in Appendix H of the Group Insurance Manual.

Carrier change reason codes are listed in Appendix H of the Group Insurance Manual.

PCP# for managed care providers are located in the individual provider listings.

Member Basic Life Units are derived by dividing the member's annual base salary by 100 and rounding up. This information will change if the member experiences an increase or a decrease in base salary. The effective date should be the actual date of change; **not the pay period end date.**

Health certificates for increasing life insurance coverage must be attached to this form.

Turnaround Document? (Y/N) ____

MEMBERSHIP CORRECTION FORM

Member Name: _____ SSN: _____

Corrected Name: _____ Corrected SSN: _____

Org. Proc. Code: _____

	CHANGE TO	START DATE	END DATE
MEMBER BIO.			
____ Marital Status			
____ Medicare Status			
____ Part A Effective	Free (Y / N)		
____ Part B Effective			
MEMBER GROUP			
____ Type Enrollee			
____ Part-time %			
____ Deduct Freq.			
____ Qual Chg Reason (w/request date)			
____ Org. Proc. Code			
____ Cusas Code			
____ Work County			
MEMBER HEALTH			
____ Active/Term (T/W code)			
____ Carrier (Chg. code)			
____ Est. Ann. Salary			
MEMBER DENTAL			
____ Active/Term (T/W code)			
____ Carrier (Chg. code)			
MEMBER LIFE			
____ Active/Term (T/W code)			
____ Basic Life Units			
____ Optional Life			
____ A.D.&D.			
____ Spouse Life			
____ Child Life			

Certificate Approval Date: _____

THINGS TO REMEMBER

* Marriage or divorce is a *Change in Status*.

All Medicare changes require a copy of the Medicare Card.

All Medicare effective dates are the 1st of the month.

* Going off or returning to payroll (Type 10xx to 60xx or vice versa), or changing back and forth from part-time to full-time is a *Change in Status*.

Changes in Part-time % will alter Basic Life Units.

All Deduct Freq. effective dates are the 1st of the month.

ENTER *Change in Status* Codes under Qualifying Change Reason.

*Request date *must be* within 60 days of the *Change in Status*.

H/D/V plans must all be active or terminated. Please provide term/waive code, if applicable.

* Carrier change requires *Change in Status*.

Estimated annual salary only changes for reduction, retirement or return to state employment from termination or retirement at a different salary.

H/D/V plans must all be active or terminated. Please provide term/waive code, if applicable.

* Carrier change requires *Change in Status*. Carrier Change Reason code corresponds to this.

Please provide term/waive code, if applicable.

Basic Life Units are affected by any change in base pay, including changes in part-time % (Admin. Bulletin 99-4).

Evidence of Insurability (health certificate) is required when spouse, child or optional life is added; *Change in Status* is not required to add spouse or child life.

Change in Status *is not required* for a change in life coverage greater than $50,000 (total of basic+optional).

Effective date of change in life coverage must be within 90 days of the health certificate approval date.

GIR/GIP Signature: _____ *Date:* _____

GIR Phone #: _____

Attachments: _____

***Note:** Change in Status Requires Member's signature*

Member Name: _____ Member SSN: _____

Dep. Name: _____ Corrected Name: _____

Dep. SSN: _____ Corrected SSN: _____

Date of Birth (D.O.B.) _____ Corrected D.O.B. _____

(Please attach extra sheet, if necessary)

DEPENDENT BIO.	CHANGE TO	START DATE	END DATE
___ Medicare Status			
___ Part A Effective	Free (Y / N)		
___ Part B Effective			
DEPENDENT GROUP			
___ Type Dependent			
(T/W Code)			
___ Relationship Code			
___ Recert Date (Ann. 19/23)			
DEPENDENT HEALTH			
___ Active / Term			
(T/W Code)			
___ Carrier			
(Chg. Code)			
___ PCP			
DEPENDENT DENTAL			
___ Active / Term			
(T/W Code)			
___ Carrier			
(Chg. Code)			
___ PCP			
DEPENDENT LIFE			
___ Active / Term			
(T/W Code)			
Certificate Approval Date			

THINGS TO REMEMBER

All Medicare changes require a copy of the Medicare Card.

All Medicare effective dates are the 1st of the month.

Include termination reason code, if necessary. NOTE: 8050 does NOT generate COBRA letter. Rel. code 10 ("other") must be continuously enrolled prior to 2/11/83 and eligible to be claimed on member's taxes. Recertify annually.

Annual Recert date must be 9/1. Recert Date for age 19 and 23 is dependent's birthdate. Note: Dependents age 19 and 23 may have to recertify twice in the same year.

H/D/V plans must *all* be active or terminated. Please provide term/waive code, if applicable.

Dependent carrier must match member's carrier.

PCP code required for new dependents.

H/D/V plans must *all* be active or terminated. Please provide term/waive code, if applicable.

Dependent carrier must match member's carrier.

PCP code required for new dependents.

Note: All liability is generated from Member Life Data. Please provide term/waive code, if applicable.

Effective Date of change in life coverage must be within 90 days of the Health Certificate approval date.

Other: _____

Additional Comments: _____

SAMPLE
"ON AGENCY LETTERHEAD"

OTHER DEPENDENT ADDRESS INFORMATION WORKSHEET

Member Name: _____ **Member SSN:** _____

Dependent Name: _____ **Dependent SSN:** _____

Dependent Residential Address: If a covered dependent resides at an address that is different from the member address, e.g., student away at college, indicate the address in the section below.

USA Address:

Street: _____

_____

C/S/Z: _____ _____

Foreign Address:

Street: _____

_____

Country: _____

DO YOU WANT INFORMATION REGARDING THE GROUP INSURANCE PROGRAM SENT TO YOUR DEPENDENT AS WELL AS YOU? **YES** _____ **NO** _____

Other Addressee: Federal law requires insurance plan administrators to provide claim-related information for covered dependents to the custodial parents. In order to do this, the address of the custodial parent must be provided to CMS. Address information also needs to be provided for individuals serving as power of attorney, legal guardian, or trustee of a covered dependent. Please provide the following information for any covered dependents who do not reside with you.

Name: _____

Street Address: _____

_____

City/State: _____**Zip Code:** _____

Relationship: (Check one)

Custodial Parent: _____

Trustee: _____

Power of Attorney: _____

Legal Guardian: _____

It is the member's responsibility to maintain correct mailing address information for dependents and/or custodial parents. The Group Insurance Representative is to be notified of any change in information.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY.

Part-time Employee Election/Waiver of Group Insurance Participation

New part-time employees must use this form to either elect to participate in the Group Insurance Program or waive group insurance coverage. ***Failure to complete this form will result in automatic enrollment in the Quality Care Health and Dental Plans with no dependent coverage.*** Current employees who change from full-time to part-time status, or current part-time employees whose insurance premiums increase 30% or greater when changing to a lower part-time work percentage, may use this form to waive coverage.

Employee Name: _____ **Employee SSN:** _____

Premium for Part-time Health and Dental Coverage:

	PT Premium Amount♦		PT Premium Amount♦
HEALTH Coverage	$ /mo.	**DENTAL Coverage**	$ /mo.

Part-time employees who work at least 50% are eligible to participate in the State Employees' Group Insurance Program. Participation in health and dental coverage is voluntary. Basic life coverage is provided at no cost to employees. Vision coverage is provided at no cost to employees participating in the health program.

Before making your decision, you should carefully read the following:

1. If you choose to participate in the health, dental and vision coverage, you will be responsible for the state's portion of the health and dental premiums based on the percentage of time employed, in addition to the regular employee contribution. For example, if you work 75% time, the State will pay 75% of the state portion for your basic health and dental coverage. You would be required to pay the remaining 25% of the cost.
2. If you elect **not** to participate in health and dental, you will not be able to enroll in the program until the next Benefit Choice Period (coverage effective July 1 of each year), unless you experience an eligible Qualifying Change in Status.
3. Part-time employees who work 50% or greater cannot become a dependent of their state-employed spouse.
4. Provisions and conditions of the Group Insurance Program are applicable to you if you elect to participate in the Program.
5. The decision to elect coverage or waive coverage must be made within ten (10) days of employment for new hires and within 60 days of a Qualifying Change in Status for current employees.

Please indicate your choice below and sign.

____ **YES**, I do want to participate in the coverage initialed below and understand I will be responsible for the premium payments. If I choose this option, I also understand I am eligible to elect Optional Life coverage.

____ Health, Dental, Vision and Basic Life.

____ Health, Vision and Basic Life, electing not to participate in Dental. *

*** Only new State employees or employees completing this form during the annual Benefit Choice Period may elect this option. Employees choosing not to participate may only re-enroll in the dental plan during the annual Benefit Choice Period.**

____ **NO,** I do not wish to participate in Health, Dental and Vision coverage. I understand that I cannot change this election until the next Benefit Choice Period or until I experience a Qualifying Change in Status which would allow me to enroll in the Program. *Note: This election will not affect your Basic Life coverage or any Optional Life coverage in which you are currently enrolled.*

_____ _____

Signature of Part-time Employee Date

_____ _____

Signature of Group Insurance Representative Date

GIR/P USE ONLY	**Effective Date of Part-time Status:**_____ **Part-time:** _____%
	♦ GIR/Ps should use the Deduction Calculation Screen (5C) to determine the amount of premium due from the member based on the part-time employee's percentage.

CMS-563 (IL 401-1635) 03/05

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Department of Central Management Services, Bureau of Benefits

I, _____ _____
(Print First and Last Name) (Membership Number)

hereby authorize _____ to disclose protected health information related to
(Entity, Name, Plan Administrator, etc.)

services provided in connection with my medical treatment.

This medical information may be disclosed to:

Personnel within the Bureau of Benefits, Benefit Plan Administrators with which the department contracts and other individuals (specify, if applicable) _____ assisting me with this request.

Describe the information to be used or disclosed.

_____

Indicate the reason for the release or request of information:

At the Request of the Individual or Personal Representative

Other: _____

I understand that if I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that:

- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by written notification to the entity listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on _____.
(Date)

Signature: _____ Date Signed:_____

If a personal representative executes this form, that representative warrants that he or she has authority to sign this form on the basis of _____.
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

_____ _____
(Signature) (Date)

CMS-550 IL 401-1614

05/01/2003

CMS

ILLINOIS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

WAIVING ANNUITANT GROUP INSURANCE COVERAGE NOTIFICATION AND ELECTION FORM

In accordance with Public Act 93-553, this Notification and Election Form is provided to State of Illinois Retirement Systems Annuitants to inform them of the consequences of electing to participate in the State Employees Group Insurance Program as a *Dependent*, and the conditions and procedures for re-enrolling at a later time as an eligible *Member*. By completing this waiver and signing below, a person eligible to participate in the Group Insurance Program as an Annuitant, can elect to waive health, dental and vision Group Insurance coverage, and instead participate as a dependent of their spouse.

Dependent Name: _____	**Spouse Name:** _____
Dependent SSN: _____	**Spouse SSN:** _____
Daytime Phone #: _____	**Daytime Phone #:** _____

I fully understand and certify to the following:

1. In electing to participate in the health plan as a dependent of my eligible Spouse, I acknowledge that I am waiving health, dental and vision coverage as an Annuitant.
2. I will be enrolled as an Annuitant with Basic Life insurance coverage. If I currently have optional life coverage, I have the option of continuing that coverage. Statement of Health approval will be required to obtain additional optional life insurance coverage.
3. I cannot be enrolled in Spouse Life coverage as a dependent of my eligible spouse.
4. Re-enrollment in the health, dental and vision Program as an eligible Member can be done only during the annual Benefit Choice period (May 1-31 of each year) or within 60 days of a qualifying Change in Status. If I wish to re-enroll, I must contact my Group Insurance Representative to complete and sign the Initial Enrollment form (CMS-310), and submit the required back-up documentation.
5. I must provide a copy of my marriage certificate to my Group Insurance Representative.

Dependent Signature: _____ **Date:** _____

GIR/P USE ONLY

Effective date Dependent is/was added to Spouse's H/D/V plan: _____

Effective Date of Dependent Annuity: _____

Type Enrollee Code _____ _____ **Part-time Percentage** _____ % **Basic Life Units** _____

Comments:_____

_____ _____

Group Insurance Representative Signature/Date Phone #

_____ _____

Agency Name Organizational Processing Code

CMS-565 IL401-1619 (02/05)

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

OPT OUT & OPT IN Election Certificate

Section A: OPT OUT (See Section B to Opt In)

In accordance with Public Act 92-0600, State of Illinois full-time employees, retirees/annuitants and survivors may elect not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program). Enrolled dependents of individuals electing to opt out will be terminated on the same date as the Member.

Member Name:_____ **Member SSN:**_____

I fully understand and certify the following:

1. The election to opt out of the Program is entirely voluntary. If I elect to opt out, any dependent coverage will also be terminated. The State of Illinois is not responsible for any expenses incurred, for myself or my dependents, on or after my termination date. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
2. I must complete Section A of the Opt Out & Opt In Election Certificate and furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source other than the Illinois Department of Central Management Services (Department) including the Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program before my coverage will be terminated. My Program coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of opt out is at the discretion of the Department and must comply with Program requirements regarding opt out.
3. I may opt out of the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
4. If my spouse is a Member of any plan administered by the Department including the State of Illinois Group Insurance Program, Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program, I may not enroll as a dependent of my spouse in that plan.
5. If I elect to opt out of the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I am eligible to participate in the optional life insurance plan.
6. At a later date, if I wish to re-enroll in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage from my previous insurance carrier that reflects that there has been no break in coverage greater than 63-days.
7. To the best of my knowledge, the opt out documentation furnished to substantiate coverage in another health benefit plan is accurate and the policy is currently (or will be, prior to my termination) in force.

Member Signature:_____ **Date:** _____/_____/_____

Please send this completed form with proof of other coverage to your agency Group Insurance Representative (GIR). Employees electing to opt out of the Program during the annual Benefit Choice Period must also complete and submit the Benefit Choice Election form, which is available through your agency GIR.

GIR/P Use Only

Proof of comprehensive coverage attached? ☐

Check the appropriate Opt Out eligibility period:

☐ Initial Enrollment (attach completed Initial Enrollment form, CMS-310) ☐ Benefit Choice

☐ Qualifying Change in Status*; Reason Code:_____

* ***Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Marriage (32)
Change from PT to FT (63)
Spouse Gains Employment (62)
Retirement (63)
Return from/Entering into Non-pay Status (63)
Spouse now provided with Group Insurance coverage (46)
Medicare or Medicaid Eligibility Gained (64)
Coordination of Spouse's Election Period (47)
Member Becomes Eligible for Non-State Group Insurance Coverage (65)

_____ _____
Group Insurance Representative Signature/Date Telephone Number

_____ _____
Agency Name Organizational Processing Code

Coverage Documentation Submitted: ☐ Approved **Opt Out Effective Date:** _____

☐ Denied

Section B: OPT IN (See Section A to Opt Out)

State of Illinois full-time employees, retirees/annuitants and survivors who have previously elected not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program), may elect to opt back into Program only upon experiencing a qualifying change in status or during the annual Benefit Choice Period.

Member Name:_____ **Member SSN:**_____

I fully understand and certify the following:

1. I may opt into the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
2. I must complete Section B of the Opt Out & Opt In Election Certificate and furnish proof of a qualifying change in status (unless election is made during the Benefit Choice Period) before my coverage will be activated. My Program coverage will not be activated until appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of coverage is at the discretion of the Department and must comply with Program requirements regarding opt in.
3. If I elect to opt into the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I may be eligible to apply for optional life coverage if my qualifying change in status is consistent with the optional life coverage being requested.
4. Upon re-enrolling in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage with no break in coverage of more than 63-days from my previous insurance carrier.
5. Upon re-enrolling in one of the health plans administered by the Department, I understand that I can elect not to participate in the dental plan and remain enrolled in health and vision. If I elect not to participate in dental, I will not be able to re-enroll in the dental plan until the next Annual Benefit Choice period.

Member Signature:_____ **Date:** _____/_____/_____

Employees electing to opt back into the Program during the Benefit Choice Period must complete and submit a Benefit Choice Election form (CMS-350). Employees electing to opt back into the Program due to a Qualifying Change in Status must complete and submit an Initial Enrollment form (CMS-310). Both forms are available through your agency GIR.

Please submit this completed form and appropriate documentation (e.g., proof of loss of other coverage, documentation required to add dependent coverage), along with the Benefit Choice Election form or Initial Enrollment form to your agency Group Insurance Representative (GIR).

GIR/P Use Only

Check the appropriate Opt In eligibility period:

☐ Benefit Choice (attach completed Benefit Choice Election form, CMS-350)

☐ Qualifying Change in Status*: Reason Code:_____ (attach completed Initial Enrollment form, CMS-310)

Proof of Qualifying Change in Status attached? ☐

* ***Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Divorce/Legal Separation/Annulment (60)
Marriage (32)
Medicaid or Medicare Eligibility Loss (64)
Retirement (63)
Spouse Loses Employment (33)
Death of Spouse (61)
Coordination of Spouses Annual Election Period (47)
Member Returns to Work from Non-Pay Status (63)
Spouse Loses Eligibility for Group Insurance Coverage (34)
Premium Increase 30% or Greater: Employees Non-State Health Insurance (45)
Premium of Spouse's Employer Increases 30% or Greater, or Coverage Significantly Decreases (45)
Member Loses Eligibility of Non-State Group Insurance Coverage (for reason other than non-payment) (68)

_____ _____
Group Insurance Representative Signature/Date Telephone Number

_____ _____
Agency Name Organizational Processing Code

GIR must send completed form and documentation to the CMS Group Insurance Division

For questions call: (217) 558-4978

CMS Only

Coverage documentation submitted: ☐ Approved ☐ Denied

Opt In Effective Date: _____ **GID Signature/Date**: _____

State of Illinois
Group Insurance Program

Domestic Partnership Affidavit

I. DECLARATION

We, _____ and _____
(Member – PRINT NAME) (Domestic Partner – PRINT NAME)

certify and declare that we are domestic partners in accordance with the following criteria and are eligible for Medical, Pharmacy, Dental and Vision benefits under the State of Illinois Employees Group Insurance Program. We understand that life coverage for a Domestic Partner is not an option under the State of Illinois Employees Group Insurance Program.

II. DOMESTIC PARTNER CRITERIA

1. We are each other's sole domestic partner and intend to remain so indefinitely.
2. We understand that if the Domestic Partner's coverage is terminated due to non-payment of premium, the Member cannot re-enroll the Domestic Partner until the next Benefit Choice Period.
3. Neither of us is currently married or legally separated.
4. We are at least nineteen (19) years of age and mentally competent to consent to this affidavit.
5. We have continuously resided together in the same residence for at least twelve (12) months and intend to do so indefinitely.
6. We are unrelated and share a committed and mutually dependent relationship with each other that is consistent with that of a married couple.
7. We are the same sex and for this reason are unable to marry each other under Illinois law.
8. We are jointly responsible for each other's common welfare and share financial obligations, which may be demonstrated by the existence of at least two of the documents from Section V <u>or</u> a Cook County Domestic Partnership Certificate.

III. TAX CONSEQUENCES OF DOMESTIC PARTNER AS A DEPENDENT

We understand that it is our responsibility to consult a tax advisor before certifying that the Domestic Partner is a dependent as defined by the Internal Revenue Code. We understand that by answering "YES, my Domestic Partner qualifies as my dependent for Federal income tax purposes" on the Domestic Partner Enrollment form, contributions made for the Domestic Partner's coverage will be on a pre-tax basis and will not be reported as imputed income on the Member's W2. We understand that by answering "No, my Domestic Partner does not qualify as my dependent for Federal income tax purposes," contributions made for the Domestic Partner's coverage will be on a post-tax basis and will be reported as imputed income on the Member's W2.

IV. CHANGE IN DOMESTIC PARTNERSHIP

1. We understand that we are required to notify the State of Illinois within thirty-one (31) days of a change in our status as domestic partners as required by submitting a Termination of Group Insurance Coverage for Domestic Partner form to the agency Group Insurance Representative (GIR).

2. We understand that if we elect to terminate the Domestic Partner's coverage for such reasons as the Domestic Partner becoming eligible for other coverage, or the Domestic Partner becomes ineligible for the State of Illinois Group Insurance Program (for example, relationship terminates, either partner marries, etc.), coverage under the Program will be terminated as of the signature date on the Termination of Group Insurance Coverage for Domestic Partner form.

V. DOMESTIC PARTNER DOCUMENTATION

Supporting Documentation - ***Please check two boxes and attach the supporting documents OR, if you have registered with the Cook County Registry and have received a Cook County Domestic Partnership Certificate, you need only check that box and submit a copy of the Certificate.***

The documentation requirements below are in addition to either the Birth Certificate or Driver's License/State ID of the Domestic Partner.

- ❑ **Cook County Domestic Partnership Certificate** - Chicago members eligible to register with the Cook County Registry for same-sex couples may submit the Cook County Domestic Partnership Certificate in lieu of providing two of the items listed below.

- ❑ Bank statement indicating joint ownership of a bank account
- ❑ Ownership of a joint credit card
- ❑ Same-sex marriage certificate
- ❑ A joint mortgage or lease
- ❑ Evidence of a joint obligation on a loan
- ❑ Mutually granted durable power of attorney
- ❑ Joint ownership of a residence
- ❑ Affidavit by a creditor able to testify to the partner's financial interdependence
- ❑ Evidence of a common household (e.g. utility bills, joint public assistance, telephone bills)
- ❑ Joint ownership or lease of a motor vehicle
- ❑ Evidence of other joint responsibility, such as child care (e.g., school documents, guardianship)
- ❑ Designation of one partner as the representative payee for the other's government benefits
- ❑ Mutually granted authority to make health care decisions (e.g., health care power of attorney)
- ❑ Authorized signatory authority on the partner's bank account, credit card or charge card
- ❑ Other proof establishing economic interdependence
- ❑ Beneficiary designation under the other's life insurance policy, retirement benefits account, or will, or executor of each other's will

VI. ACKNOWLEDGEMENTS

1. We understand that any person/employer/insurer/claims administrator who suffers any loss due to false statements contained in this Affidavit may bring civil action against either or both of us to recover their losses, including reasonable attorney's fees.

2. We have provided the information in this Affidavit for use by the Group Insurance Division of the State of Illinois for the sole purpose of determining eligibility for domestic partner benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, pursuant to a court order or if there is a compelling-business need to have access to the information.

3. We understand that this Affidavit may have legal implications relating to, for example, our ownership of property or taxability of benefits provided, and that before signing this Affidavit, it is our responsibility to seek competent legal and accounting advice concerning such matters.

4. We agree to reimburse the State of Illinois for any and all liability including, without limitation, taxes, penalties or losses (including reasonable attorney's fees), that the State of Illinois may incur arising out of its reliance on this affidavit if it is untrue in any respect or if the required notice of termination is not filed.

We declare, under penalty of perjury under the laws of the State of Illinois that the assertions in this Affidavit are true to the best of our knowledge.

Member and Domestic Partner's Address _____

_____

_____

Member Signature	Date
Member Date of Birth	Member SSN
Domestic Partner Signature	Date
Domestic Partner Date of Birth	Domestic Partner SSN

BENEFITS STAFF USE ONLY

GIR Name:_____ Date:_____

❑ Birth Certificate attached Or Driver's License/State ID attached

Documentation Meets Requirements	❑ YES	❑ NO

If documentation does not meet requirements, indicate reason on lines below: _____

_____

GID Signature:_____ Approval Date:_____

State of Illinois Group Insurance Program

Domestic Partner Enrollment Form

Member Information (please print):

Name: _____ SSN: _____ Date Partnership Began:_____

Domestic Partner Information:

Name: _____ SSN: _____ Date of Birth: _____ Health PCP: _____
(complete if enrolled in a managed care plan)

Other Coverage:

Is the Domestic Partner covered by any other health insurance? ☐ Yes ☐ No Effective Date: _____

If yes, name of Insurance Company:_____ Insurance Company Policy Number _____

Is the Domestic Partner currently covered under a State of Illinois medical plan? ☐ Yes ☐ No

Medicare Information:

Is the Domestic Partner receiving Medicare? ☐ Yes ☐ No (if yes, a copy of the Domestic Partner's Medicare card must be provided to your agency GIR)

If yes, check one: ☐ Part A Eff. Date: _____ ☐ Part B Eff. Date: _____
☐ Part A & B Eff. Date: _____ ☐ Part D Eff. Date: _____

On what is the Domestic Partner's Medicare eligibility based? ☐ Age ☐ Disability ☐ End Stage Renal Disease

IRS Dependent Tax Status:

Please consult a tax advisor before you certify that the Domestic Partner is a dependent as defined by the Internal Revenue Code. If your answer is YES, you will not be taxed on imputed income for the Domestic Partner's premiums paid by the State of Illinois and contributions made for the Domestic Partner's coverage will be on a pre-tax basis.

Please check one:

☐ No, my Domestic Partner does not qualify as my dependent for Federal income tax purposes.

☐ Yes, my Domestic Partner qualifies as my dependent for Federal income tax purposes (member must provide a copy of the most recent year's tax statement indicating the domestic partner as a dependent with this enrollment form).

Member Signature:_____ Date:_____ Day Time Phone: (_____) _____

BENEFITS STAFF USE ONLY

GIR Signature:_____ Date:_____ Agency Org Proc Code:_____

☐ Benefit Choice ☐ Initial Enrollment ☐ Qualifying Change in Status, Reason _____

GID Signature:_____ Date:_____ Effective Date:_____ Rel. Code: _____

State of Illinois
Group Insurance Program

Termination of Group Insurance Coverage for Domestic Partner

Termination of Domestic Partnership Affidavit

I, _____, submit this Termination of Domestic
(Member)

Partnership Affidavit in order to terminate the Domestic Partnership Affidavit previously filed with respect to _____.
(Domestic Partner)

I understand that the effect of filing this Termination of Domestic Partnership Affidavit is that my Domestic Partner will no longer be covered under the State of Illinois Employees Group Insurance Program.

Signature: _____ Date: _____

Termination of Group Insurance Coverage

I wish to terminate my Domestic Partner's enrollment in the State of Illinois Employees Group Insurance Program due to my Domestic Partner (check one):

- ❑ Becoming eligible for other group insurance coverage on _____.
- ❑ Getting married on _____.
- ❑ Death that occurred on _____.
- ❑ Other – Please specify reason:_____
  _____.

I understand that the effect of filing this Termination of Domestic Partner's Group Insurance Coverage is that my Domestic Partner will no longer be covered under the State of Illinois Employees Group Insurance Program.

Signature: _____ Date: _____

BENEFITS STAFF USE ONLY	
GIR Name:_____	Date:_____
Effective Date of Termination:_____	Termination Code:_____

CMS-512 IL401-1640 (06/06)

Appendix E contains samples of all the Flexible Spending Accounts (FSA) forms.

The FSA forms include:

Index	Appendix E - 1
Medical Care Assistance Program COBRA Form (CMS-334)	Appendix E - 2
Medical Care Assistance Program Enrollment Form (CMS-332)	Appendix E - 3
Dependent Care Assistance Program Enrollment Form (CMS-333)	Appendix E - 5
Medical Care Assistance Program Change in Status Form (CMS-330M)	Appendix E - 7
Dependent Care Assistance Program Change in Status Form (CMS-330D)	Appendix E - 8

FSA Form Descriptions:

- ***MCAP COBRA Election form:*** This form should be used by members who wish to continue making contributions to their MCAP account while they are off payroll (i.e., either due to termination of employment or a unpaid leave of absence). Payments are made directly to the FSA Unit.

- ***MCAP Enrollment form:*** This form should be used by members to enroll or re-enroll in MCAP upon initial enrollment, during the annual Benefit Choice election period or upon experiencing a qualifying change in status.

- ***DCAP Enrollment form:*** This form should be used by members to enroll or re-enroll in DCAP upon initial enrollment, during the annual Benefit Choice election period or upon experiencing a qualifying change in status.

- ***MCAP Change in Status form:*** This form should be used when a mid-year change results in a change in deduction amount or a revocation for MCAP.

- ***DCAP Change in Status form:*** This form should be used when a mid-year change results in a change in deduction amount or a revocation for DCAP.

Obtaining and Printing Forms:

To obtain FSA account information and/or MCAP and DCAP reimbursement forms, go to the FBMC website at: www.fbmc-benefits.com and click on the 'Download Forms' tab. You will be prompted to log in to the website. After you have logged in, you can select and print the desired forms.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MCAP COBRA Election Form

SECTION I: PARTICIPANT INFORMATION

Social Security Number	Last Name	First Name	M.I.
— —			
Date for Employment Termination, Unpaid LOA, or Retirement:			

SECTION II: CURRENT STATUS OF ACCOUNT

Current Account Balance as of ____/____/_____ : $ _____

1) Annual Elected Amount ..... $ _____
2) Current Year-To-Date Contributions (last deposit on _____/_____/_____) ..... $ _____
3) Additional Regular Payroll Contributions, if any ..... $ _____
4) Total Plan Year-To-Date Contributions upon Final Regular Payroll (add lines 2 and 3) ..... $ _____
5) **Balance Due to Meet Annual Elected Amount** (subtract line 4 from line 1) ..... $

SECTION III: PARTICIPATION/PAYMENT OPTIONS (for assistance contact the FSA Unit)

If the employee does not wish to continue participation, they must elect to terminate Plan Participation on this form. To continue plan participation, the employee must indicate their choice in the appropriate section and specify the payment option. The payment agreement must be honored in order to continue participation. **The employee must sign and date this form.**

☐ **I elect to continue participation** for the balance of the Plan Year by making my MCAP contributions by the method marked below. I understand that if I do not honor my payment agreement, my participation in the Plan will be terminated and I will not be eligible to file claims for expenses incurred after my period of participation and that I will not be eligible to resume participation if I am rehired by the State during the current Plan Year. **I understand that it is my sole responsibility to make any payments** by personal check or money order that are required **by the due date**, payable to the Flexible Spending Accounts Program and that I will not receive any notice of payments due or of non-payment.

☐ a) Full payment of Balance Due of $ _____ (from line 5) made on a pretax basis from any lump sum vacation or sick pay. If these funds are not sufficient to pay the balance due, I authorize payment of the full amount available, up to the amount listed in this option and will pay the difference by personal check or money order **within 45 calendar days** of my leave payment processing date.

☐ b) **Partial payment of $ _____ ($ _____ minimum)** made on a pretax basis from my annual or sick leave payment. The **Remaining Balance of $ _____** will be paid by personal check or money order **within 45 days** of the signature date on this form, or the processing of my leave payment, whichever occurs first. If leave funds are not sufficient to cover the designated partial payment, I authorize payment of the full amount available, up to the partial payment amount listed in this option. I will meet my Remaining Balance Payment by personal check or money order accordingly.

☐ c) **Full payment of $ _____** paid by personal check or money order within 45 calendar days of the signature date on this form.

☐ d) **Monthly payments** by personal check or money order due on the **first day of each month**.

Number of payments ____ of $ _____ beginning ___/___/_____

Payments are due on the first day of each month.

☐ **I elect to terminate Plan Participation.** I understand that any claims for expenses incurred after my period of participation will not be eligible for reimbursement.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

GROUP INSURANCE REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

CMS-334 (4/02) IL 401-1612

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MEDICAL CARE ASSISTANCE PLAN
ENROLLMENT FORM **FY___**

Section A – Type of Enrollment

☐ Benefits Choice Enrollment

☐ New Hire Date of Hire _____ / _____ / _____

☐ Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on _____/_____/_____

Section B – Employee Information

Social Security Number *Last Name* *First* *Initial*

( )

Street Address *City* *State* *Zip Code* *Home Phone*

( )

Agency *Work Phone*

Section C – Deduction Information, Authorization and EZ REIMBURSE® Card Request

Deduction Information and Authorization - ***I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my MCAP account.***

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
The number of deductions for monthly payrolls is 12 (university employees could have less than 12)

$_____ X _____ = $_____
Deduction Amt Per Pay Number of Deductions Total Annual MCAP Expenses *
(Minimum = $240.00; Maximum = $5000.00)

* If you elect to receive the EZ REIMBURSE® card (below), you must include the non-refundable $20.00 card fee in your annual deduction calculation. To figure the amount that will be deducted each pay period, divide the annual deduction amount by the number of deductions remaining in the plan year. The total annual MCAP deduction amount cannot be greater than $5000.00. The amount eligible for reimbursement is the total annual deduction amount less the $20.00 fee.

EZ REIMBURSE Card

☐ Yes! I want the EZ REIMBURSE® card. I understand there is a non-refundable annual fee of $20.00 per plan year that will be deducted from my MCAP account.

~ OVER ~

Section D - Change in Status Code Chart

01	Birth or adoption of dependent
02	Marriage
03	Divorce, legal separation or annulment *
07	Change of county of residence/worksite for employee or spouse *
08	Judgment, decree or court order *
10	Employee commences employment

11	Employee returns to payroll (from being on a leave of absence)
13	Employee changes employment status from Part-time less than 50% to Full-time
15	Spouse or dependent terminates employment
17	Spouse or dependent changes employment status from Full-time to Part-time
20	Spouse enters leave of absence and loses FSA enrollment
24	Coordination of spouse's annual benefit election period

*** Reviewed case-by-case**

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period, September 30th.*
- *I understand that deductions must continue during any paid leave of absence.*
- *I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.*
- *If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period for which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.*

Employee Signature: _____ **Date** ____/____/_____

Please return the signed, completed form to your agency Group Insurance Representative.

Section F – Agency Approval *(To be completed by Group Insurance Representative)*

Effective Date: _____/_____/_____ Deduction Start Date: _____/_____/_____

If University Enrollment, Enter End Date of Last Deduction: _____/_____/_____

Organizational Processing Code: _____ _____ _____ Pay Code: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If a university enrollment, also enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DEPENDENT CARE ASSISTANCE PLAN
ENROLLMENT FORM FY___

Section A – Type of Enrollment

☐ Benefits Choice Enrollment

☐ New Hire Date of Hire _____ / _____ / _____

☐ Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on _____/_____/_____

Section B – Employee Information

Social Security Number *Last Name* *First* *Initial*

( )

Street Address *City* *State* *Zip Code* *Home Phone*

( )

Agency *Work Phone*

Section C – Deduction Information and Authorization

Deduction Information and Authorization - ***I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my DCAP account.***

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
The number of deductions for monthly payrolls is 12 (university employees could have less than 12)

$_____ X _____ = $_____

Deduction Amt Per Pay | Number of Deductions | Total Annual DCAP Expenses

(Minimum = $240.00; Maximum = $5000.00)

Section D - Change in Status Code Chart

01	Adoption of dependent *
02	Marriage
03	Divorce, legal separation or annulment *
08	Judgment, decree or court order *
10	Employee commences employment
11	Employee returns to payroll (from being on a leave of absence)

13	Employee changes employment status from Part-time <50% to Full-time
14	Spouse commences employment
16	Spouse returns from leave of absence
18	Spouse changes employment status from Part-time to Full-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

*** Reviewed case-by-case**

~ OVER ~

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period, September 30th.*
- *I intend to participate in DCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.*

Employee Signature: _____ **Date** ____/____/_____

Please return the signed, completed form to your agency Group Insurance Representative

Section F – Agency Approval ***(To be completed by Group Insurance Representative)***

Effective Date: _____/_____/_____ Deduction Start Date: _____/_____/_____

If University Enrollment, Enter End Date of Last Deduction: _____/_____/_____

Organizational Processing Code: _____ _____ _____ Pay Code: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If a university enrollment, also enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

CMS 333 (REV 03/06) IL 401-1611

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MCAP CHANGE IN STATUS FORM for FY_____

Section 1 – Employee Information

_____	_____	_____	_____
Social Security Number	*Last Name*	*First*	*Initial*

Section 2 – Complete the section which applies to your requested change.

A Change in Status which is **on account of and consistent with the nature of the qualifying event** must occur in order to change your current MCAP account. Requests to change your deduction amount or revoke your enrollment must be initiated within 60 days of the qualifying event. Changes in Status indicated with an '*' must be reviewed and approved by the FSA Unit on a case-by-case basis. You may contact the FSA Unit at 1-800-442-1300 if you have any questions.

☐ **Increase in Deduction Amount** **Change in Status Code _____** **New Deduction Amount Per Pay Period $_____**

01	Birth or adoption of dependent
02	Marriage
03	Divorce, legal separation or annulment *
07	Change of county of residence/worksite for employee or spouse *

08	Judgment, decree or court order *
15	Spouse or dependent terminates employment
17	Spouse or dependent changes employment status from Full-time to Part-time
20	Spouse enters leave of absence and loses FSA enrollment
24	Coordination of spouse's annual benefit election period

☐ **Decrease in Deduction Amount** **Change in Status Code _____** **New Deduction Amount Per Pay Period $_____**

03	Divorce, legal separation or annulment *
04	Death of dependent or spouse
05	Dependent becomes ineligible
06	Dependent becomes eligible for coverage
07	Change of county of residence/worksite for employee or spouse *

08	Judgment, decree or court order *
09	Entitlement to Medicare or Medicaid
14	Spouse or dependent commences employment
18	Spouse or dependent changes employment status from Part-time to Full-time
20	Spouse enters leave of absence and loses FSA enrollment
24	Coordination of spouse's annual benefit election period

☐ **Revocation of Enrollment** **Change in Status Code _____**

03	Divorce, legal separation or annulment *
04	Death of dependent or spouse
05	Dependent becomes ineligible
08	Judgment, decree or court order *
09	Entitlement to Medicare or Medicaid

12	Employee changes employment status from Full-time to Part-time working less than 50%
19	Employee enters leave of absence
22	Employee termination of employment, retirement or death
24	Coordination of spouse's annual benefit election period

Section 3 – Certification

I certify that the above eligible change in status event occurred on _____/_____/_____.

Employee Signature: _____ Date _____/_____/_____

Section 4 – Agency Approval (To be completed by Group Insurance Representative)

GIR Signature: _____ Date: _____/_____/_____

GIR INSTRUCTIONS	• Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

Return the completed form to your Group Insurance Representative

CMS-330M (REV 04/05) IL401-1367

04/2005

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DCAP CHANGE IN STATUS FORM for FY_____

Section 1 – Employee Information

_____	_____	_____	_____
Social Security Number	*Last Name*	*First*	*Initial*

Section 2 – Type of Transaction

A Change in Status which is **on account of and consistent with the nature of the qualifying event** must occur in order to change your current DCAP account. Requests to change your deduction amount or revoke your enrollment must be initiated within 60 days of the qualifying event. Changes in Status indicated with an '*' must be reviewed and approved by the FSA Unit on a case-by-case basis. You may contact the FSA Unit at 1-800-442-1300 if you have any questions.

☐ **Increase in Deduction Amount** **Change in Status Code _____** **New Deduction Amount Per Pay Period $_____**

01	Adoption of dependent *
02	Marriage
03	Divorce, legal separation or annulment *
08	Judgment, decree or court order *

14	Spouse commences employment
18	Spouse changes employment status from Part-time to Full-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

☐ **Decrease in Deduction Amount** **Change in Status Code _____** **New Deduction Amount Per Pay Period $_____**

03	Divorce, legal separation or annulment *
04	Death of dependent *
05	Dependent becomes ineligible (e.g. age)
08	Judgment, decree or court order *

17	Spouse changes employment status from Full-time to Part-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

☐ **Revocation of Enrollment** **Change in Status Code _____**

03	Divorce, legal separation or annulment *
04	Death of only dependent
05	Dependent becomes ineligible
08	Judgment, decree or court order *
12	Employee changes employment status from Full-time to Part-time less working than 50%

15	Spouse terminates employment
19	Employee enters leave of absence
20	Spouse enters leave of absence
21	Change in the cost of care
22	Employee termination of employment, retirement or death
24	Coordination of spouse's annual benefit election period

Section 3 – Certification

I certify that the above eligible change in status event occurred on _____/_____/_____.

Employee Signature: _____ Date _____/_____/_____

Section 4 – Agency Approval (To be completed by Group Insurance Representative)

GIR Signature: _____ Date: _____/_____/_____

GIR INSTRUCTIONS	• Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

Return the completed form to your Group Insurance Representative

CMS-330D (REV 04/05) IL401-1636

04/2005

The listing below indicates the various life insurance workflow procedures, along with the corresponding page number.

Minnesota Life Optional Life Deduction Report (CMS-320)	Appendix F - 2
Optional Life Matrix	Appendix F - 3
Beneficiary Designation Form (CMS-617)	Appendix F - 4
Optional Life Coverage Overview	Appendix F - 5
Medical Underwriting Workflow	Appendix F - 6
Death Claim Workflow	Appendix F - 7
Dismemberment Claim Workflow	Appendix F - 8
Election of Portability Workflow	Appendix F - 9
Conversion of Insurance Workflow	Appendix F - 10
Accelerated Benefit Claim Workflow	Appendix F - 11
Transfer of Ownership Workflow	Appendix F - 12

Online Status Inquiries – Statement of Health and Life Claims: GIR/Ps can inquire on the status of Statement of Health applications, life claim applications, beneficiary designations of members, as well as order any of the Life Plan Administrator forms, via a free service offered by the life plan administrator. This service is provided through the use of an Extranet database. Agencies must have internet capability in order to utilize the database. An access agreement must be signed by the GIR/P prior to utilizing the database. If interested in gaining access to this database, contact the life plan administrator.

Agencies who have been granted access to the Extranet can utilize the website at: **www.lifebenefitsextra.minnesotamutual.com.**

For life insurance questions, needs, or concerns, please contact Minnesota Life:

Phone Numbers:		**Mailing Address:**	**Office Location:**
Toll-free	1-888-202-5525	Minnesota Life	1 North Old Capitol Plaza
Local	217-523-7899	Springfield Branch Office	Suite 305
Fax	217-523-7898	PO Box 2327	Springfield IL 62701
TDD/TYY	*1-800-526-0844*	Springfield IL 62705-9806	

CMS ILLINOIS DEPARTMENT OF
CENTRAL MANAGEMENT SERVICES

ILLINOIS STATE EMPLOYEES GROUP INSURANCE PROGRAM

MINNESOTA LIFE OPTIONAL LIFE DEDUCTION REPORT

University _____ Payroll Code(s) _____

Date of Transmittal Listing _____ Prepared by _____

Phone # _____ Date _____

Date of Check (1)	Check Number (2)	Dollar Amount (3)	Type of Payroll (S/M, Monthly) (4)	Coverage Period (5)	Remarks (6)

Total of Transmittal $ _____

CMS-320 (3/00)

OPTIONAL LIFE MATRIX																				
Member Optional Life	X	X	X	X	X	X	X	X	X	X	X	X								
Dependent Life-Spouse		X	X	X	X	X	X						X	X	X	X				
Dependent Life-Child			X	X	X			X	X	X				X	X		X	X		
AD & D - Basic				X		X			X		X				X	X		X	X	
AD & D – Combined					X		X			X		X								
Life Deduct Code to be entered in Payroll	A*	B*	C*	D*	E*	F*	G*	H*	J*	K*	L*	M*	N0	P0	R0	S0	T0	W0	X0	00

Second Character of 'Life Deduct Code':

*** - Denotes number of times (1 - 8) Optional Life Coverage the member has elected. Example, member electing 3 times their basic life coverage amount would be coded 'A3' for optional life.**

0 (zero) – Denotes no Optional Life coverage elected (i.e., zero times optional life). Example, member electing no optional life would be coded 'O0' (letter O, number zero).

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS GROUP LIFE INSURANCE PROGRAM BENEFICIARY DESIGNATION

MEMBERS MAY DESIGNATE PRIMARY CONTINGENT BENEFICIARIES. **Beneficiaries will receive equal shares, unless specific percentages are indicated.** Contingent beneficiaries become effective only when all primary beneficiaries have died prior to the member's death. A beneficiary may be a person, trust, estate, or other legal entity. You may designate as many primary or contingent beneficiaries as you feel necessary. If you need more space, please copy this sheet or attach another form CMS-617.

Beneficiary designations may be changed by the member at any time by submitting a new form.

If a beneficiary has not been designated, or all designated beneficiaries have died prior to the member's death, any proceeds payable shall be paid according to the Facility of Payment section of the State of Illinois Group Life Insurance Program book. Call Minnesota Life at 888-202-5525 if you would like assistance completing this form.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE EMPLOYED	MEMBER STATUS (Check all that apply) ☐ FULL TIME EMPLOYEE ☐ PART TIME EMPLOYEE ☐ IMMEDIATE ANNUITANT ☐ DEFERRED ANNUITANT ☐ SURVIVOR				

Transaction Type

☐ Initial Designation ☐ Change of Beneficiary ☐ Change of Address of Beneficiary

Primary *or* Contingent Percent

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

☐ P ☐ C _____ %
Last Name | First Name | MI | Relationship | Date of Birth
Street | City, State, Zip | Social Security Number

I hereby designate the above-named beneficiary(ies). I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions. The above designation supersedes all prior designations of beneficiaries I have made.

Form must be signed and filed with Minnesota Life Insurance Company to validate designation.
Minnesota Life Insurance Company ▪ 1 North Old Capitol Plaza #305 ▪ Springfield, IL 62701

MEMBER SIGNATURE	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	DATE
X	( )	( )	

CMS-617 (Rev 1/03) IL 401-1116 F. 57549 1-2003

Optional Life Coverage Overview

Child Life and Spouse Life:

- Coverage may be *added* anytime throughout the plan year; however, the member must complete and submit a Statement of Health application to the Life Plan Administrator for the affected dependent. ***Note:*** The situations in which a Statement of Health application **is not required** are:
  - Adoption, if coverage is requested within 60 days of the adoption
  - Birth, if coverage is requested within 60 days of the birth
  - Marriage, if coverage is requested within 60 days of the marriage
  - Adjudicated child, if coverage is requested within 60 days of the court order
- Coverage may be *dropped* anytime throughout the plan year. A Qualifying Change in Status is not required.

Member AD&D:

- Coverage may be *added, increased, dropped, or decreased* anytime throughout the plan year. A Qualifying Change in Status is not required, nor is a Statement of Health application.

Member Optional Life:

- If adding or increasing Optional Life coverage, Statement of Health approval <u>is required</u>. If dropping or decreasing coverage, no Statement of Health is necessary.

  Note: Optional Life coverage for 1 – 4 times Basic may be *added* <u>without</u> a Statement of Health application only during the member's 10-day initial enrollment period into the Group Insurance Program. Optional Life coverage for 5 – 8 times Basic during the 10-day initial enrollment period requires Statement of Health approval. Outside the initial enrollment period, Optional Life coverage may be *added, increased, dropped, or decreased* in the following situations:

  a) When a Qualifying Change in Status occurs (see Consistency Matrix, Appendix A).

  b) During the Benefit Choice Period: May 1 – May 31.

  c) Anytime throughout the plan year ***if*** the member's current Basic Life and Optional Life coverage is equal to, or greater than, $50,000. If dropping or decreasing Optional Life coverage, the combined Optional and Basic Life must not decrease to an amount less than $50,000.

Effective Dates of Coverage:

- In situations where evidence of insurability **is required** (i.e., increasing member Optional Life, adding Spouse or Child Life), the effective date of additional coverage will be the first day of the pay period following Statement of Health approval.
- In situations where evidence of insurability **is not required** (i.e., adding AD&D) the effective date of additional coverage will be the first day of the pay period following the written request.

Medical Underwriting Workflow

Medical underwriting is the process used to determine an applicant's insurability under the plan. Approval for insurance is dependent upon written proof (based on medical information) that the person is insurable. Evidence of insurability is required when adding spouse and/or child life, and when increasing member optional life. After the initial underwriting review, many applicants are approved or denied without the need for any additional information. However, additional information is sometimes required to get a better understanding of an applicant's health. Additional information may include historical medical records, or a paramedical exam.

- The Group Insurance Representative (GIR) completes all fields in the "For GIR Use Only" section on the *Statement of Health* form. The GIR then provides the member with the form and a postage paid return envelope. It is the member's responsibility to complete and mail the form to the Minnesota Life Springfield Branch Office.

- Upon receipt of application, Minnesota Life will approve, decline, or request additional information from the member, or medical provider(s), that is deemed necessary for making an underwriting decision.

- If additional information requested has not been received within 14 calendar days, Minnesota Life will send a reminder to the member.

- The member's file will be closed if Minnesota Life does not receive the requested information within 45 days from the date of the request. Notification of the decision to close the file will be sent to the member. Files that have been closed will also be shown on a notification statement mailed to the member's agency.

- The medical underwriting process is complete when the Statement of Health is approved, declined, or closed.

- A notification statement containing final decisions will be mailed to the member's agency.

- If a member wishes to appeal a denial, the appeal should be made directly to the Medical Underwriting Unit at Minnesota Life. Upon receipt of a request for reconsideration, a consulting underwriter will review the entire file and render a decision. Notification of the final decision will be sent to the member, and if approved, a copy of the decision will be mailed to the appropriate agency.

- Status information regarding Medical Underwriting is available on Minnesota Life's Extranet site, lifebenefitsextra.minnesotamutual.com.

  To obtain access to the site, please contact the Minnesota Life Springfield Branch Office at 1-888-202-5525 or 217-523-7899.

Death Claim Workflow

- Upon notification of the death of an insured, the GIR completes an *Agency Notice of Death* form.

- The GIR faxes or mails *the Agency Notice of Death* form to Minnesota Life.

- Upon receipt of the Agency Notice of Death form, Minnesota Life mails a *Claimant Notice of Death* form to each designated beneficiary shown on the beneficiary form on file.

- If no beneficiary form is on file, Minnesota Life will contact the GIR to see if a beneficiary form is in the agency's file.

- The claimant(s) complete the necessary information and returns the form to Minnesota Life with any other claim-related documents.

- Minnesota Life will send a copy of the death certificate to the GIR.

- Minnesota Life is responsible for all necessary follow-up and communication regarding the claim. All inquiries received by the GIR regarding the claim should be referred to the Minnesota Life Springfield Branch office.

- If the claim is approved, payment will be made to the claimant. If the claim is denied, the claimant will be notified by mail.

- Status information (date claim was paid and the amount) regarding death claims is available on Minnesota Life's Extranet site, lifebenefitsextra.minnesotamutual.com.

  To obtain access to the site, please contact the Minnesota Life Springfield Branch Office at 1-888-202-5525 or 217-523-7899.

Dismemberment Claim Workflow

- Upon notification of an injury, the GIR completes Section I of the *Notice of Dismemberment or Loss of Sight* claim form and sends the form to the member.

- The member completes Section II and provides the form to his/her physician to complete.

- The physician then sends the completed form and all medical records directly to the Springfield Branch Office of Minnesota Life. (This form and the medical records do not flow back through the GIR. These documents are submitted directly to Minnesota Life.)

- If the claim is approved, payment will be made to the member. If the claim is denied, the claimant will be notified by mail.

- Status information is available on Minnesota Life's Extranet site, lifebenefitsextra.minnesotamutual.com.

  To obtain access to the site, please contact the Minnesota Life Springfield Branch Office at 1-888-202-5525 or 217-523-7899.

Election of Portability Workflow

Upon termination or retirement from State employment, a member has the option of porting their optional life insurance coverage in force at the time of their termination or retirement.

Members who elect portability cannot also elect conversion of their optional coverage.

NOTE! The GIR must provide the *Election of Portability for Optional Term Life* form, the portability information sheet, and a postage paid return envelope to the member before, or at the time of, retirement or termination.

Members must return the completed form to Minnesota Life within 31 days of the date of termination or retirement. Minnesota Life will not accept forms that are received more than 46 days after the date of retirement or employment termination.

- The GIR completes the "To Be Completed by Agency" section of the *Election of Portability for Optional Term Life* form and gives/sends the form to the member with a postage paid return envelope, on or prior to, the member's employment termination date.

- The member completes the form and promptly sends it to Minnesota Life's Springfield Branch Office using the envelope provided.

- Minnesota Life processes the completed form.

- Coverage will begin on the day following the coverage termination date indicated on the form.

- The member should retain their life certificate booklet titled "State of Illinois Group Life Insurance Program," as members who have ported their coverage are still insured under this certificate.

Conversion of Insurance Workflow

Upon termination of State employment or retirement, a member may convert their basic and/or optional insurance to an individual life insurance policy.

If an insured dependent wishes to convert their insurance to an individual life insurance policy, the insured dependent may do so within 60 days of the member's death, or within 31 days of the date the dependent ceases to qualify for insurance under the policy.

Members who elect conversion of their optional coverage cannot also elect portability.

NOTE! The GIR must provide the *Enrollment Form for Conversion of Group Life Insurance*, the conversion information sheet, and a return envelope to the member before, or at the time of, retirement or termination.

Members must return the completed form to Minnesota Life within 31 days of the date of termination or retirement. Minnesota Life will not accept forms that are received more than 46 days after the date of retirement or employment termination.

- The GIR completes the "To Be Completed by GIR" section of the *Enrollment Form for Conversion of Group Life Insurance* and gives/sends the form to the member with a postage paid return envelope, on or prior to, the member's employment termination date.

- The member or dependent completes the form and promptly sends it to Minnesota Life's Springfield Branch Office using the envelope provided by the GIR.

- Minnesota Life processes the completed form. A bill will then be mailed to the member or dependent indicating the premium due.

- The individual policy will take effect 31 days after the coverage termination date indicated on the form. (Note: The member/dependent retains their basic and optional coverage during the 31 day conversion period).

Accelerated Benefit Claim Workflow

- Upon notification of an accelerated benefit claim by a member, the GIR (or Retirement System) completes Section I of the *Notice of Accelerated Benefit* form.

- The GIR then forwards the form to the member.

- The member completes Section II and provides the form to his/her physician to complete.

- The physician then sends the completed form and all medical records directly to the Springfield Branch Office of Minnesota Life. (This form and the medical records do not flow back through the GIR. These documents are submitted directly to Minnesota Life.)

- Minnesota Life will send written notification to the applicant and the GIR that the claim is being processed.

- If the claim is approved, payment will be made to the member. If the claim is denied, the member and the GIR will be notified by mail.

Transfer of Ownership Workflow

A Transfer of Ownership request transfers the ownership rights in a group life insurance contract from the member to another entity or person. Completion of this form transfers all ownership rights and is irrevocable by the member, although the new owner can, in turn, transfer ownership rights to another entity or person. Members should be advised to seek legal advice prior to requesting a transfer of ownership.

- Upon request, the GIR provides the member with a *Transfer of Ownership* form and a postage paid return envelope.

- The member completes the top section of the form titled Transfer of Ownership and forwards the form and envelope to the new owner.

- The new owner completes the middle sections of the form titled Notice and mails the completed form to the Springfield Branch Office of Minnesota Life in the envelope provided.

- Minnesota Life completes the bottom section of the form titled Endorsement and keeps the document on file.

- A copy of the Transfer of Ownership form, the Beneficiary Designation form, and a confirmation letter are mailed to the new owner. Copies are sent to CMS, or the Retirement System in the case of retirees. The new owner will receive all future certificates and mailings from Minnesota Life.

Various Group Insurance publications and/or Plan Administrator Directories may be placed in this section.

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Appendix H includes all codes necessary for entering and deciphering the Membership and Group Insurance Financial Control (GIFCS) Systems.

Included are:

Index	Appendix H - 1
County Codes	Appendix H - 2
Group Insurance Division (GID) Acronyms	Appendix H - 3
Membership Screen Codes (Smart User Feature)	Appendix H - 4
Group Insurance Financial Control System (GIFCS) Codes	Appendix H - 5
Payroll Eligibility Codes	Appendix H - 6
Membership Codes	Appendix H - 7
Type Enrollee Codes	Appendix H - 11
Membership Address Formatting Codes	
1. Abbreviations	Appendix H - 13
2. Special Characters/Punctuation	Appendix H - 14
3. Unnecessary Words	Appendix H - 14
4. Address Type Examples	Appendix H - 15
5. US State Abbreviations	Appendix H - 16
6. US Territory Codes	Appendix H - 17
7. Canadian Province Codes	Appendix H - 17
8. Foreign Country Codes	Appendix H - 18

COUNTY CODES

001 Adams
002 Alexander
003 Bond
004 Boone
005 Brown
006 Bureau
007 Calhoun
008 Carroll
009 Cass
010 Champaign
011 Christian
012 Clark
013 Clay
014 Clinton
015 Coles
016 Cook
017 Crawford
018 Cumberland
019 DeKalb
020 Dewitt
021 Douglas
022 DuPage
023 Edgar
024 Edwards
025 Effingham
026 Fayette
027 Ford
028 Franklin
029 Fulton
030 Gallatin
031 Greene
032 Grundy
033 Hamilton
034 Hancock
035 Hardin
036 Henderson
037 Henry
038 Iroquois
039 Jackson
040 Jasper
041 Jefferson
042 Jersey
043 Jo Daviess
044 Johnson
045 Kane
046 Kankakee
047 Kendall
048 Knox
049 Lake
050 LaSalle
051 Lawrence
052 Lee
053 Livingston
054 Logan
055 McDonough
056 McHenry
057 McLean
058 Macon
059 Macoupin
060 Madison
061 Marion
062 Marshall
063 Mason
064 Massac
065 Menard
066 Mercer
067 Monroe
068 Montgomery
069 Morgan
070 Moultrie
071 Ogle
072 Peoria
073 Perry
074 Piatt
075 Pike
076 Pope
077 Pulaski
078 Putnam
079 Randolph
080 Richland
081 Rock Island
082 St. Clair
083 Saline
084 Sangamon
085 Schuyler
086 Scott
087 Shelby
088 Stark
089 Stephenson
090 Tazewell
091 Union
092 Vermilion
093 Wabash
094 Warren
095 Washington
096 Wayne
097 White
098 Whiteside
099 Will
100 Williamson
101 Winnebago
102 Woodford
103 Out-of-State
104 Out-of-Country

GID Acronyms

ARU	Analysis And Resolution Unit
CCDP	College Choice Dental Plan
CCHP	College Choice Health Plan
CIP	College Insurance Program
CMS	Central Management Services
COB	Coordination Of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCAP	Dependent Care Assistance Plan
EAP	Employee Assistance Plan
EOB	Explanation Of Benefits
EOMB	Explanation Of Medicare Benefits
FSA	Flexible Spending Account
FY	Fiscal Year
GIA	Group Insurance Act
GID	Group Insurance Division
GIFCS	Group Insurance Financial Control System
GIPF	Group Insurance Premium Fund
GRF	General Revenue Fund
HIPAA	Health Insurance Portability And Accountability Act
HIRF	Health Insurance Reserve Fund
HMO	Health Maintenance Organization
LGHP	Local Government Health Plan
LGIRF	Local Government Insurance Reserve Fund
MCAP	Medical Care Assistance Plan
NPA	National Prescription Administrator's, Inc.
OAP	Open Access Plan
PCP	Primary Care Physician
PCU	Premium Collection Unit
POS	Point Of Service
PPO	Preferred Provider Organization
QCDP	Quality Care Dental Plan
QCHP	Quality Care Health Plan
RTW	Return To Work
SEGIA	State Employees Group Insurance Act
SERS	State Employees Retirement System
SURS	State University Retirement System
TCHP	Teachers' Care Health Plan
TRIP	Teachers' Retirement Insurance Program
THIS	Teachers' Health Insurance Security Fund
TRS	Teachers' Retirement System
VSP	Vision Service Plan

MEMBERSHIP SCREEN CODES

Smart User Feature

Screen Name	Menu Option	SmartUser Option
Agency Inquiry Menu	n/a	00
Name / SSN Cross Reference	01	01
Member Current Profile	02	02
Member Type Enrollee	03	03
Current Medicare Status of Member and Dependents	04	04 or 4A
Medicare Detail	4B	4B
Insurance Benefit Statement Plan / Cost	05	05 or 5A
Life Benefit Summary	5B	5B
Deduction Calculation	5C	5C
Insurance Benefit Statement – Dependent Information	06	06
Member COBRA Information	07	07
Coverage Summary of Member and Dependents	08	08 or 8A
Carrier History	8B	8B
Recert / Relationship History	8C	8C
View Messages	09	n/a
GIFCS Menu	10	n/a
Member Biographical	11	MB
Member Group	11	MG
Member Address	11	MA
Member Other Address	11	MO
Member Health	11	MH
Member Dental	11	MD
Member Vision	11	MV
Member Life	11	ML
Dependent Biographical	11	DB
Dependent Group	11	DG
Dependent Address	11	DA
Dependent Other Address	11	DO
Dependent Health	11	DH
Dependent Dental	11	DD
Dependent Vision	11	DV
Dependent Life	11	DL

The “Smart User” feature is accessible from the Inquiry mode in the Membership System.

Group Insurance Financial Control System Codes (GIFCS)

Refund Reason Codes		
Code	**Reason**	**Explanation**
1	COLL IN ERROR	Collected in error – should not use this code if another applies
2	MBM TERM/DIED	Member terminated or died
3	SRS PICKUP	Member picked up by retirement system
4	DISCHARGE REV	Discharge reversal – member made whole
5	NEVER ON LOA	Member never on a leave of absence
6	TERM NON PAY	Member terminated for nonpayment of premium
7	MBR RTW	Member returned to work
8	MBRSHP LIAB CHG	Membership liability change
9	COBRA/LOA EXP	COBRA or leave of absence time period expired
10	VOL COBRA TERM	Voluntary termination of COBRA coverage

Refund Type Codes		
Code	**Type**	**Description**
1	Payroll	This option is used when premium are overpaid on payroll and must be refunded to the member via the GIFCS system. Reasons for refunding via GIFCS may include the member terminated or agency does not have the capability to refund on payroll.
2	Direct Payment from Agency	This option is used when premiums are overpaid in GIFCS based on an Agency Direct Pay report submitted by the agency to CMS. This payment is usually submitted due to an underpayment of premiums for a payroll period that cannot be collected on payroll due to a member terminating employment or being on an extended leave of absence.
3	Direct Payment from Premium Collection Unit	This option is used when premiums are overpaid to the Special Payment Programs Unit. Reasons for these overpayments include member returned from leave of absence but had paid an entire month of premium or member's liability changed.
4	COBRA	This option can only be used by ARU to refund COBRA overpayments to a member.
5	Management Directive	This option can only be used by ARU to process a refund for overpayments which occurred in a previous fiscal year that must have CMS management approval.
6	Direct Payment for Domestic Partner	This option may only be used by ARU to refund a member for an overpayment of premiums made to the Special Payment Programs Unit for domestic partner coverage.

Group Insurance Financial Control System Codes (GIFCS)

PAYROLL ELIGIBILITY CODES

CODE	DESCRIPTION
A	Active Employee
B	Inactive Employee
C	No Insurance
D	Immediate Annuitant
E	Deferred Annuitant
F	Retiree
G	Survivor
H	Survivor of Deferred Annuitant
I	Non-certified Survivor
J	Survivor of Retiree
K	Disability Recipient
L	Survivor Employee Immediate Ann.
M	Active Part-time Employee
N	Inactive Part-time Employee
O	COBRA Dependent
P	Part-time Health/Dental
Q	Survivor Employee Immediate Ann.

CODE	DESCRIPTION
R	Life Full-time/Part-time/Opt Out
S	Ineligible State Paid
T	Health/Dental Full-time/Part-time
U	Life Part-time
V	Seasonal Leave
W	COBRA Member
X	Permanent Layoff
Y	Life
Z	Health/Dental
7	COBRA Dependent
8	Active Life
9	COBRA Disability
#	Inactive Full-time/Part-time
@	Part-time Health/Dental
$	Permanent Layoff
%	Layoff Health/Dental
&	Layoff Life

RECORD TYPES

Type of pay record represented.

- C – COMPPAY (Comptroller Pay)
- P – PCUDPAY (Special Payment Programs Unit/Agency Direct Pay)
- L – LOCAL (Local Payroll from universities)
- R – REVERSAL (Pay record reversal)
- F – REFUND (Refund processed through GIFCS)
- A – ADDPAYREC (Added pay record)
- T – TRANSFER (Member paid premium transfer)
- O – OFFSETADJ (Offsetting adjustment processed by GID)
- I – IPPADD (Insurance pay period add record from payroll voucher)

MEMBERSHIP CODES

Qualifying Change Reason Codes (Member Group Section)	
20	Address Change
31	Adoption or placed for adoption
10	Benefits Choice
30	Birth
41	Change in Dependent health coverage in the 2+ category
42	Change in life insurance coverage > $50,000
40	Change in Managed Care provider network
63	Change in member's employment status
64	Change in Public Aid or Medicare Status
43	Change in Spouse, child and/or AD&D life coverage
47	Coordination of spouse's annual election period
67	Adjudicated child - court order establishing member's financial responsibility
66	Custody - court order resulting in member gaining/losing
61	Death of dependent or spouse
65	Dependent becomes eligible for coverage
35	Dependent becomes ineligible for coverage
60	Divorce of employee
32	Marriage
63	Member retiring
68	Member loses other coverage (due to other than non-payment of premium)
44	Reinstatement of coverage terminated due to nonpayment of premium
62	Spouse gaining employment
33	Spouse losing employment
34	Spouse's employer discontinues all coverage
45	Spouse's employer makes premium increase greater than 30%
46	Spouse's employer offers insurance for the first time

Carrier Change Reason Codes (Plan Section)	
02	Address Change
01	Benefits Choice
06	Change in Family Status
04	Other Special Circumstances
03	Special Enrollment Periods
07	Terminate Coverage

Salary Change Reason Codes (Member Health Section)	
4	Annual salary change
6	Opt Out
1	Retirement
3	Return to Employment
2	Voluntary Reduction

Medicare Codes (Biographical Section)	
5	End Stage Renal
4	Medicare Disability
2	Medicare Eligible 65+
3	Medicare Ineligible 65+
1	Non- Medicare

Dependent Relationship Codes (Dependent Group Section)					
07	Adjudicated Child	02	Natural Child	04	Stepchild
03	Adopted Child	10	Other	08	Student
09	Handicapped	05	Recognized Child		
06	Legal Guardian	01	Spouse		

Other Addressee Relationship Codes (Biographical Section)	
1	Custodial parent
4	Guardian
3	Power of Attorney
2	Trustee

MEMBERSHIP CODES

Member Term/Waive Reason Codes (Member Plan Section – Except, Member Death – Biographical)	
14	Change to less than 50% part-time
06	COBRA loss of eligibility
05	COBRA Medicare entitlement
09	Dependent of another member
12	Gross misconduct
04	Max COBRA coverage
11	Max LOA coverage
01	Member death
07	Never eligible
10	Non-payment of premium
16	Non-state paid LOA waiver
33	Opt Out – no health/dental/vision/life
34	Opt Out – life only
13	Part-time employee waived
15	Perm layoff without state-paid benefits
02	Survivor rights expire
03	TEFRA waiver
17	Term employment no COBRA
08	Terminate employment

Dependent Term Reason Codes (Dependent Plan Section)	
52	Death of dependent
66	Dependent becomes ineligible (loss of student status) *
58	Dependent child turns 19 *
59	Dependent child turns 23 *
60	Dependent DEFRA waiver
55	Dependent marriage *
65	Dependent never eligible
56	Divorce/Legal Sep *
50	Dependent voluntary term
62	Dual enrollee death (GID only)
54	Enrolled as a member
57	Failure to recertify *
61	Member in life only
53	Military service
63	Not elected
69	Opt Out Dependent without life
51	Transfer to another member

* These termination codes will generate COBRA letters

Survivor Relationship Codes (to deceased members) (Member Group Section)	
C	Child
P	Parent
S	Spouse

Dependent Type Enrollee Codes (Dependent Group Section)	
10	Active Dependent
40	COBRA Active Dependent
80	Terminated Dependent

Dental Carrier Codes (Plan Section)	
D7	Managed Care Dental Plan – not available 7/1/04
D6	Quality Care Dental Plan
DD	'No Dental' Option

Life Carrier Codes (Plan Section)	
C9	State Life Insurance Plan

12/01/2006

MEMBERSHIP CODES

COBRA Event Codes (Group Section of the Initial Enrollment and Change Forms)	
16	COBRA Employee Dies – Dependent not Spouse
17	COBRA Employee Dies – Spouse <55
18	COBRA Employee Dies – Spouse 55+
21	COBRA Member Loss Eligibility – 18 months
22	COBRA Member Loss Eligibility – 29 months
07	Dependent Loss of Eligibility
08	Disability
04	Divorce/Legal Separation – Dependent not Spouse
05	Divorce/Legal Separation – Ex-Spouse < 55
06	Divorce/Legal Separation – Ex-Spouse age 55+
13	Employee <50% part-time
01	Employee Death – Dependent not Spouse
02	Employee Death - Spouse <55
03	Employee Death - Spouse 55+
14	Employee Permanent Layoff
15	Employee/Retirement Max Coverage Expires
19	Medicare Eligible after COBRA
10	Member Medicare Entitled, Medicare Eligible 18 months from Separation
09	Member Medicare Entitled, Medicare Eligible Prior Sep. 36 months from Medicare Entitlement
20	Pending Survivor Benefits
11	Survivor Rights Expire
12	Termination of Employment

Membership Source Codes	
10	Group Insurance Division personnel
11	Analysis and Resolution Unit
12	Premium Collection Unit
13	Management Directive
14	CMS Report
20	Agency personnel
30	COBRA personnel
60	Telephone enrollment change
70	System mass update

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TYPE ENROLLEE CODES

(for additional details, see Appendix J, Type/Subtype Chart)

Active Members

1001 Full-time Employee

1003 Public Official *(General Assembly State Officers)*

1004 Emergency Appointment

1005 Former General Assembly Member *(GARS Only)*

1006 U of I Foundation *(U of I Urbana Only)*

1007 Full-time Emp on Payroll w/ Life Only *(GID Only)*

1008 Part-time Emp on Payroll w/ Life Only *(GID Only)*

1009 Full-time IDFA

1010 Part-time IDFA

1016 Permanent Part-time Employee

1017 Employee Part-time - Direct pay *(CSU, NEIU, GSU and State Police only) (prev. 1011)*

1018 Univ PT Faclty <6 months *(Universities Only)*
(Not eligible for Seasonal Leave)

1019 Univ. PT FAC >6 months *(Universities Only)*
(Seasonal *Leave code 6024)*

1020 Univ. PT NFAC >730 Hrs. *(Universities Only)*
(Seasonal Leave code 6037)

1021 Agency/University Seasonal 6 – 11 mo.
(Seasonal Leave code 6007)

Active Members *(Opt Out)*

1051 Opt Out – Actively Working – Life Only

1053 Opt Out – Public Official

1056 Opt Out – U of I Foundation *(U of I Urbana Only)*

Certified Survivor *(U of I Urbana Only)*

2017 U of I CES Member *(U of I Urbana Only)*

2027 U of I Athletic Assoc. *(U of I Urbana only)*

Retiree *(U of I Urbana Only)*

5006 U of I Coop Ext. Service *(U of I Urbana only)*

5014 U of I Urbana Athletic Assoc. *(U of I Urbana only)*

Leaves of Absence

6001 Non. Occ. Disability With Retirement Benefits (FT)

6002 Non. Occ. Disability No Retirement Benefits (FT)

6003 Occupational Disability (FT) *(Workers' Comp)*

6004 LOA Conversion *(Need to change code)*

6006 Educational/Sabbatical (FT)

6008 Perm. Layoff w/ State Paid

6009 Personal Leave (FT)

6010 Family Responsibility Leave (FMLA) (FT)

6011 Dock/Suspension <= 30 Days (FT)

6012 Dock/Susp. > 30 Days (FT)

6013 Perm. Layoff - Life Only

6014 FMLA RTW PT Direct Pay (FT)

6015 Plans Termed Non-Pay *(GID only)*

6018 Furlough *(ISD, ISVI only)*

6019 Military Call up – Payroll

6020 Military Call up – Direct Pay

6021 Occupational Disability – Previous PT

6022 Univ. Pd Acdmc Yr Break *(SIU-C only)*

6023 Univ. FT Faculty and "Acdmc Yr" Non-Faculty Annual Break *(Universities only) (Active code 1001)*

6026 Non-Occupational Disability with Ret. Benefits (PT)

6027 Non-Occupational Disability – No Ret. Benefits (PT)

6028 Educ/Sabattical (PT)

6029 Agency/Univ Seasonal Leave (PT) *(Active code 1015)*

6030 Personal Leave (PT)

6031 Family Responsibility Leave (FMLA) (PT)

6032 Dock/Suspension <= 30 (PT)

6033 Dock/Suspension > 30 Days (PT)

6034 FMLA RTW Part-time (PT)

6035 Plans Termed Non-Pay (PT) *(GID only)*

6036 Univ. PT Faculty Acdmc Yr Break
(Universities only) (*Active code 1013)*

6037 Univ. PT Non-Fac Acdmc Yr Brk
(Universities only) (*Active code 1014)*

6039 Military Leave *(prev. 6016/6017)*

6040 Return To Work PT Non-Occupational Dis. (FT)

6041 Return To Work PT Occupational Disability (FT)

TYPE ENROLLEE CODES

(for additional details, see Appendix J, Type/Subtype Chart)

Opt Out Leaves of Absence

6051 Non-Occ. Dis. With Ret. Benefits (FT) Opt Out
6052 Non-Occ. Disability No Ret. Benefits (FT) Opt Out
6053 Occupational Dis. (FT) *(Workers' Comp)* **Opt Out**
6056 Educational/Sabbatical (FT) Opt Out
6058 Perm. Layoff w/State Paid Opt Out
6059 Personal Leave (FT) Opt Out
6060 Family Responsibility Leave (FMLA) (FT) Opt Out
6061 Dock/Suspension <= 30 Days (FT) Opt Out
6062 Dock/Suspension > 30 Days (FT) Opt Out
6064 FMLA RTW Part-time Direct Pay (FT) Opt Out
6068 Furlough *(ISD, ISVI only)* **Opt Out**
6069 Military Call up – Payroll Opt Out
6070 Military Call up – Direct Pay Opt Out
6071 Occupational Disability - Previously PT Opt Out
6072 Univ. Paid Acdmc Yr Break *(SIU-C only)* **Opt Out**
6073 Univ. FT Faculty and "Acdmc Yr" Non-Faculty Annual Break *(Universities only)* **Opt Out**
6090 Return To Work PT Non-Occupational Opt Out
6091 Return To Work PT Occupational Opt Out

Termination

8001* Member Death
8002* Survivor Rights Expired
8003 TEFRA Waiver
8007 Never Eligible
8008* Terminate Employment
8009 Dependent of another Member
8010 Non-Pay of Premium
8011* Max. Leave of Absence Coverage Period
8012 Gross Misconduct
8013 Part-time Employee Waived
8014* Changing to < 50% PT
8015* Permanent Layoff w/o 6 Month
8016 Non State Paid Leave of Absence Waiver
8017 Termination - No COBRA
8022 COBRA Voluntary Term *(GID ONLY)*
8024 Waiver at Retirement *(Retirement System Only)*
8025* Dual Enrollee Death *(GID ONLY)*
8026* Term Benefit Ended *(Retirement System Only)*
8027* Term Loss of Eligibility
8033 Term Opt Out No Life Coverage
8036* Ben End IME (Independent Medical Evaluation)
8037* Ben End ½ Time (Disability Benefit Exhausted)
8038* Ben End Gain Emplymt (Obtained Other Employment)
8039* Ben End Fail to Coop (Failure to Cooperate)
8040* Ben End WC Stopped (Workers' Comp Benefit Stopped)

*These termination codes will generate COBRA letters

Membership Address Formatting

1. Abbreviations

If the last word of an address line is any of those listed below, replace the word with the standard abbreviation.

Word	Abbreviation
Alley	ALY
Avenue	**AVE**
Bluff	BLF
Boulevard	**BLVD**
Bypass	BYP
Causeway	CSWY
Circle	CIR
Commons	CMNS
Corner	COR
Course	CRSE
Court	CT
Creek	CRK
Crossing	XING
Drive	**DR**
Estates	**ESTS**
Expressway	EXPY
Forest	FRST
Freeway	FWY
Garden	GDN
Glen	GLN
Green	GRN
Heights	HTS
Highway	HWY
Hill	HL
Hollow	HOLW
Island	IS
Isle	ISLE
Junction	JCT
Lake	LK
Lakes	LKS
Landing	LNDG
Lane	LN
Loop	LOOP
Manor	MNR

Word	Abbreviation
Meadows	MDWS
Mills	MLS
Mount	**MT**
Orchard	ORCH
Park	PARK
Place	PL
Plains	PLNS
Port	PRT
Ranch	RNCH
Ridge	RDG
Road	**RD**
Route	**RTE**
Skyway	SKWY
Square	SQ
Station	STA
Street	**ST**
Terrace	TER
Throughway	TRWY
Trail	TRL
Tunnel	TUNL
Turnpike	TPKE
Underpass	UPAS
Union	UN
Valley	VLY
View	VW
Village	VLG
Ville	VL
Vista	VIS
Way	WAY
Apartment	**APT**
Basement	**BSMT**
Room	**RM**
Suite	**STE**
Unit	**UNIT**

- **The most commonly used abbreviations are in bold.**

Membership Address Formatting

2. Special Characters/Punctuation

Except for a hyphen in name, all punctuation must be omitted. The following are some examples of punctuation which must be omitted.

Symbol	Character
	Double spaces/blanks change to single space or blank, except between state abbreviations and ZIP Codes or Zip+4 codes.
*	Asterisks
,	Commas
( )	Parentheses
“ “	Quotations
:	Colons
;	Semi-colons
-	Hyphens, except in a name
@	At
&	Ampersand

3. Unnecessary Words

Replace or remove certain words as listed below. However, the use of standard business word abbreviations (see a list of standard abbreviations above) is preferred over removal of words.

- Replace *and* with *space*.
- Replace *space & space* with *space*.
- Replace number words with numeric symbols: *first* with *1st*.
- Remove *etc., i.e., in care of,* and *et al*.
- Remove words like *the, of, by, for, at, also*.
- Remove *ATTENTION, ATTN:*.
- Remove gender words like *MS, MRS, MISS, MR, SIR*.
- Remove title words like *DR, PHD, DDS, RN*.

Membership Address Formatting

4. Address Type Examples

JAMES JONES 4417 BROOKS ST NE WASHINGTON DC 20019-4649	H E BROWN RR 3 BOX 9 CANTON OH 44730-9521
JANICE SMITH PO BOX 34 DULUTH MN 55803-0034	HELEN SAUNDERS 1010 CLEAR ST OTTAWA ON K1A 0B1 CANADA

Membership Address Formatting

5. US State Abbreviations

State	*Abbreviation*
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO

State	*Abbreviation*
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Membership Address Formatting

6. US Territory Codes

UNITED STATES TERRITORIES	
Territory	***Code***
American Samoa	AS
Federated States of Micronesia	FM
Marshall Islands	MH
Northern Mariana Islands	NP
Palau	PW
Puerto Rico	PR
Virgin Islands	VI

Note: These are countries that are U.S. territories, such as Puerto Rico, Virgin Islands, etc. A two-digit territory code must be entered in the 'State' field for these countries (see list of US territory codes in Appendix H, 'System Codes'). When the Membership system encounters an address for a 'Territory', the address must be entered as a domestic, rather than a foreign, address.

7. Canadian Province Codes

CANADIAN PROVINCES	
Province	***Code***
Alberta	AB
British Columbia	BC
Manitoba	MB
New Brunswick	NB
Newfoundland	NF
Northwest Territories	NT
Nova Scotia	NS
Ontario	ON
Prince Edward Island	PE
Quebec	QC
Saskatchewan	SK
Yukon Territory	YT

Note: Canada is divided into provinces, much like the United States is divided into states. A two-digit province code may only be entered in the STATE field when Canada is entered in the COUNTRY field.

Membership Address Formatting

8. Foreign Country Codes

A list of all foreign countries will appear on the Membership System when a **'?'** is in the 'Country' field and the F1 (PF1)/Help key is pressed.

FOREIGN COUNTRIES		
Country Name	***Expanded Country Name***	***Code***
Afghanistan	Afghanistan	AFG
Albania	Peoples Socialist Republic Of Albania	ALB
Algeria	Peoples Democratic Republic Of Algeria	DZA
American Samoa	American Samoa	ASM
Andorra	Principality Of Andorra	AND
Angola	Republic Of Angola	AGO
Anguilla	Anguilla	AIA
Antartica	Antarctica (The Territory South Of 60 Deg S)	ATA
Antigua And Barbuda	Antigua And Barbuda	ATG
Argentina	Argentina	ARG
Armenia	Armenia	ARM
Aruba	Aruba	ABW
Australia	Commonwealth Of Australia	AUS
Austria	Republic Of Austria	AUT
Azerbaijan	Republic Of Azerbaijan	AZE
Bahamas	Commonwealth Of Bahamas	BHS
Bahrain	Kingdom Of Bahrain	BHR
Bangladesh	Peoples Republic Of Bangladesh	BGD
Barbados	Barbados	BRB
Belarus	Belarus	BLR
Belgium	Kingdom Of Belgium	BEL
Belize	Belize	BLZ
Benin	Peoples Republic Of Benin (Was Dahomey)	BEN
Bermuda	Bermuda	BMU
Bhutan	Bhutan	BTN
Bolivia	Republic Of Bolivia	BOL
Bosnia And Herzegovina	Bosnia And Herzegovina	BIH
Botswana	Republic Of Botswana	BWA
Bouvet Island	Bouvet Island (Bouvetoya)	BVT
Brazil	Federative Republic Of Brazil	BRA
British Indian Ocean	British Indian Ocean Territory (Chagos Archipelago)	IOT
British Virgin Islands	British Virgin Islands	VG
Brunei Darussalam	Brunei Darussalam	BRN
Bulgaria	Peoples Republic Of Bulgaria	BGR

Membership Address Formatting

Mail To Country Name	Expanded Country Name	CODE
Burkina Faso	Burkina Faso (Was Upper Volta)	BFA
Burundi	Republic Of Burundi	BDI
Cambodia	Kingdom Of Cambodia (Was Khmer Republic/Kampuchea, Democratic)	KHM
Cameroon	United Republic Of Cameroon	CMR
Canada	Canada	CAN
Cape Verde	Republic Of Cape Verde	CPV
Cayman Islands	Cayman Islands	CYM
Central African Republic	Central African Republic	CAF
Chad	Republic Of Chad	TCD
Chile	Republic Of Chile	CHL
China	Peoples Republic Of China	CHN
Christmas Island	Christmas Island	CXR
Cocos Islands	Cocos Islands (Keeling)	CCK
Colombia	Republic Of Colombia	COL
Comoros	Federal And Islamic Republic Of Comoros	COM
Congo	Democratic Republic Of Congo	COD
Congo	Peoples Republic Of Congo	COG
Cook Islands	Cook Islands	COK
Costa Rica	Republic Of Costa Rica	CRI
Cote D'ivoire	Republic Of Cote D'ivoire, Ivory Coast	CIV
Croatia	Croatia (Local Name: Hrvatska)	HRV
Cuba	Republic Of Cuba	CUB
Cyprus	Republic Of Cyprus	CYP
Czech	Czech Republic	CZE
Denmark	Kingdom Of Denmark	DNK
Djibouti	Republic Of Djibouti (Was French Afars And Issas)	DJI
Dominica	Common Wealth Of Dominica	DMA
Dominican Republic	Dominican Republic	DOM
East Timor	Democratic Republic Of East Timor	TLS
Ecuador	Republic Of Ecuador	ECU
Egypt	Arab Republic Of Egypt	EGY
El Salvador	Republic Of El Salvador	SLV
Equatorial Guinea	Republic Of Equatorial Guinea	GNQ
Eritrea	Eritrea	ERI
Estonia	Estonia	EST
Ethiopia	Ethiopia	ETH
Falkland Islands	Falkland Islands (Malvinas)	FLK
Faroe Islands	Faroe Islands	FRO
Fiji	Fiji	FJI
Finland	Finland	FIN
France	France	FRA
France	France, Metropolitan	FXX
French Guiana	French Guiana	GUF
Mail To Country Name	**Expanded Country Name**	**CODE**

Membership Address Formatting

French Polynesia	French Polynesia	PYF
French Southern Territories	French Southern Territories	ATF
Gabon	Gabonese Republic Of Gabon	GAB
Gambia	Republic Of Gambia	GMB
Georgia	Georgia	GEO
Germany	Germany	DEU
Ghana	Republic Of Ghana	GHA
Gibraltar	Gibraltar	GIB
Greece	Hellenic Republic Of Greece	GRC
Greenland	Greenland	GRL
Grenada	Grenada	GRD
Guadeloupe	Guadeloupe	GLP
Guam	Guam	GUM
Guatemala	Republic Of Guatemala	GTM
Guinea	Revoluntionary Peoples Repc Of Guinea	GIN
Guinea-Bissau	Republic Of Guinea-Bissau (Was Portuguese Guinea)	GNB
Guyana	Republic Of Guyana	GUY
Haita	Republic Of Haita	HTI
Heard And Mc Donald Islands	Heard And Mc Donald Islands	HMD
Honduras	Republic Of Honduras	HND
Hong Kong	Spec Admin Region Of China, Hong Kong	HKG
Hungary	Hungarian Peoples Republic Of Hungary	HUN
Iceland	Republic Of Iceland	ISL
India	Republic Of India	IND
Indonesia	Republic Of Indonesia	IDN
Iran	Islamic Republic Of Iran	IRN
Iraq	Republic Of Iraq	IRQ
Ireland	Ireland	IRL
Israel	State Of Israel	ISR
Italy	Italian Republic Of Italy	ITA
Jamaica	Jamaica	JAM
Japan	Japan	JPN
Jordan	Hashemite Kingdom Of Jordan	JOR
Kazakhstan	Republic Of Kazakhstan	KAZ
Kenya	Republic Of Kenya	KEN
Kiribati	Republic Of Kiribati (Was Gilbert Islands)	KIR
Korea	Democratic Peoples Republic Of Korea	PRK
Korea	Republic Of Korea	KOR
Kuwait	State Of Kuwait	KWT
Kyrgyzstan	Kyrgyz Republic	KGZ
Lao	Peoples Democratic Republic Of Lao	LAO
Latvia	Latvia	LVA
Lebanon	Lebanon	LBN
Mail To Country Name	**Expanded Country Name**	**CODE**
Lesotho	Lesotho	LSO

Membership Address Formatting

Liberia	Liberia	LBR
Libyan Arab Jamahiriya	Libyan Arab Jamahiriya	LBY
Liechtenstein	Liechtenstein	LIE
Lithuania	Lithuania	LTU
Luxembourg	Luxembourg	LUX
Macau	Macau	MAC
Macedonia	Macedonia, The Former Yugoslav Republic Of	MKD
Madagascar	Madagascar	MDG
Malawi	Malawi	MWI
Malaysia	Malaysia	MYS
Maldives	Maldives	MDV
Mali	Mali	MLI
Malta	Malta	MLT
Marshall Islands	Marshall Islands	MHL
Martinique	Martinique	MTQ
Mauritania	Mauritania	MRT
Mauritius	Mauritius	MUS
Mayotte	Mayotte	MYT
Mexico	United Mexican States	MEX
Micronesia	Federated States Of Micronesia	FSM
Moldova	Republic Of Moldova	MDA
Monaco	Principality Of Monaco	MCO
Mongolia	Mongolian Peoples Republic	MNG
Montserrat	Montserrat	MSR
Morocco	Kingdom Of Morocco	MAR
Mozambique	Peoples Republic Of Mozambique	MOZ
Myanmar	Mayanmar (Was Burma)	MMR
Namibia	Namibia	NAM
Nauru	Republic Of Nauru	NRU
Nepal	Kingdom Of Nepal	NPL
Netherlands Antilles	Netherlands Antilles	ANT
Kingdom Of Netherlands	Kingdom Of The Netherlands	NLD
New Caledonia	New Caledonia	NCL
New Zealand	New Zealand	NZL
Nicaragua	Republic Of Nicaragua	NIC
Niger	Republic Of The Niger	NER
Nigeria	Federal Republic Of Nigeria	NGA
Niue	Republic Of Niue	NIU
Norfolk Island	Norfold Island	NFK
Northern Marianna Islands	Northern Marianna Islands	MNP
Norway	Kingdom Of Norway	NOR
Oman	Sultanate Of Oman (Was Muscat And Oman)	OMN
Pakistan	Islamic Republic Of Pakistan	PAK
Palau	Palau	PLW
Mail To Country Code	**Expanded Country Code**	**CODE**
Palestinian Territory	Occupied Palestinian Territory	PSE
Panama	Republic Of Panama	PAN

Membership Address Formatting

Papua New Guinea	Papua New Guinea	PNG
Paraguay	Republic Of Paraguay	PRY
Peru	Republic Of Peru	PER
Philippines	Republic Of Philippines	PHL
Pitcairn Island	Pitcairn Island	PCN
Poland	Polish Peoples Republic Of Poland	POL
Portugal	Protuguese Republic Of Portugal	PRT
Puerto Rico	Puerto Rico	PRI
Qatar	State Of Qatar	QAT
Reunion	Reunion	REU
Romania	Socialist Republic Of Romania	ROU
Russian Federation	Russian Federations	RUS
Rwanda	Rwandese Republic Rwanda	RWA
Saint Helena	St Helena	SHN
Saint Kitts And Nevis	St Kitts And Nevis	KNA
Saint Lucia	St Lucia	LCA
Saint Pierre And Miquelon	St Pierre And Miquelon	SPM
Saint Vincent And The Grenadines	St Vincent And The Grenadines	VCT
Samoa	Independent State Of Samoa (Was Western Samoa)	WSM
San Marino	Republic Of San Marino	SMR
Sao Tome And Principe	Democratic Republic Of Sao Tome And Principie	STP
Saudi Arabia	Kingdom Of Saudi Arabia	SAU
Senegal	Republic Of Senegal	SEN
Serbia and Montenegro	Former Socialist Federal Republic Of Yugoslavia	YUG
Seychelles	Republic Of Seycheles	SYC
Sierra Leone	Republic Of Sierra Leone	SLE
Singapore	Republic Of Singapore	SGP
Slovakia	Slovak Republic Slovakia	SVK
Slovenia	Slovenia	SVN
Solomon Islands	Solomon Islands (Was British Solomon Islands)	SLB
Somalia	Somali Republic Of Somalia	SOM
South Africa	Republic Of South Africa	ZAF
S Georgia And S Sandwhich Isls	South Georgia And The South Sandwhich Islands	SGS
Spain	Spanish State Of Spain	ESP
Sri Lanka	Democratic Socialist Republic Of Sri Lanka (Was Ceylon)	LKA
Sudan	Democratic Republic Of Sudan	SDN
Suriname	Republic Of Suriname	SUR
Svalbard And Jan Mayen Islands	Svalbard And Jan Mayen Islands	SJM
Mail To Country Code	**Expanded Country Code**	**CODE**
Swaziland	Kingdom Of Swaziland	SWZ
Sweden	Kingdom Of Sweden	SWE
Switzerland	Swiss Confederation Of Switzerland	CHE

Membership Address Formatting

Syrian Arab Republic	Syrian Arab Republic	SYR
Taiwan	Taiwan, Province Of China	TWN
Tajikistan	Tajikistan	TJK
Tanzania	United Republic Of Tanzania	TZA
Thailand	Kingdom Of Thailand	THA
Togo	Togolese Republic Of Togo	TGO
Tokelau	Tokelau (Tokelau Islands)	TKL
Tonga	Kingdom Of Tonga	TON
Trinidad And Tobago	Republic Of Trinidad And Tobago	TTO
Tunisia	Republic Of Tunisia	TUN
Turkey	Republic Of Turkey	TUR
Turkmenistan	Turkmenistan	TKM
Turks And Caicos Islands	Turks And Caicos Islands	TCA
Tuvalu	Tuvalu (Was Part Of Gilbert And Ellice Islands)	TUV
Uganda	Republic Of Uganda	UGA
Ukraine	Ukraine	UKR
United Arab Emirates	United Arab Emirates (Was Trucial States)	ARE
United Kingdom	United Kingdom Of Great Britain And N Ireland (Use For England)	GBR
United States Minor Outlying Islands	United States Minor Outlying Islands	UMI
United States	United States Of America	USA
Uruguay	Eastern Republic Of Uruguay	URY
Us Virgin Islands	Us Virgin Islands	VIR
Uzbekistan	Uzbekistan	UZB
Vanuatu	Vanuatu (Was New Herbrides)	VUT
Venezuela	Bolivarian Republic Of Venezuela	VEN
Viet Nam	Socialist Republic Of Viet Nam (Was Democratic Republic Of And Republic Of)	VNM
Wallis And Futuna Islands	Wallis And Futuna Islands	WLF
Western Sahara	Western Sahara (Was Spanish Sahara)	ESH
Yemen	Yemen	YEM
Zambia	Republic Of Zambia	ZMB
Zimbabwe	Zimbabwe (Was Southern Rhodesia)	ZWE

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Appendix I includes sample letters the Group Insurance Representatives and Preparers must copy onto agency letterhead for their use. Also included are sample notices which are sent to members when certain situations occur, such as the COBRA Rights Notification letter which is sent to new members upon enrollment in the Membership System.

Index	Appendix I - 1
Sample – Agency Billing Letter	Appendix I - 2
Sample – COBRA Initial Notice Letter	Appendix I - 3
Sample – Certificate of Creditable Coverage Sample Letter	Appendix I - 4
Sample – Opt Out Notice	Appendix I - 5
Sample – Medicare ‘Member Turning Age 65’ Letter	Appendix I - 6
Sample – Medicare ‘Dependent Turning Age 65’ Letter	Appendix I - 7
Sample – Verification Form	Appendix I - 8

Your Agency Letterhead

Date

Member's Name
Member's Address

Dear Mr./Ms. _____:

It has come to my attention that there is an underpayment regarding your group insurance premium. The following is an itemization of your coverage and the premium now due:

Health Insurance	$ 0.00
Dental Insurance	$ 0.00
Total	$ 0.00

You now owe for Pay Periods dd/mm/yy through dd/mm/yy, which is a total of $0.00. To ensure that your coverage is not terminated for non-payment of premium, please remit your check or money order made payable to the (Agency Name) to the address below by (date after 10 business days after generating the letter). If you have any questions regarding this matter, feel free to contact (GIR name and phone number).

Very Truly Yours,

GIR Name and Address

201 E. Madison, Suite 2B, P.O. Box 19208, Springfield, IL, 62794-9208

(Date)

(Member Name) and All Covered Dependents
(Address)
(City, State, Zip)

RE: Initial Notification of Continuation of Health Insurance Coverage Under COBRA

The State Employees Group Insurance Program wishes to welcome you to employment with the State of Illinois. Please take a few minutes to read this notice of your rights under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) pertaining to the continuation of health insurance coverage. It is intended to inform you, and your covered dependents, if any, of your rights and obligations under COBRA in the event you (or your dependents) should lose health insurance coverage under the State Group Insurance Plan.

COBRA provides covered employees and covered family members the opportunity for a temporary extension of health insurance coverage at group rates when coverage under the health plan would otherwise end due to certain qualifying events. The qualifying events and associated length of coverage are included in the table below.

Qualifying Events	**Continuation Period**
Employee	
Termination of employment for any reason except gross misconduct	18 months
Loss of eligibility due to reduction in work hours	18 months
Dependent	
Employee's termination of employment for any reason	18 months
Employee's loss of eligibility due to reduction in work hours	18 months
Employee's death, divorce or legal separation	
-spouse or ex-spouse, under age 55	36 months
-spouse or ex-spouse, age 55 or older	Until date of Medicare entitlement
COBRA member's Medicare entitlement	Up to 36 months
Loss of dependent status	36 months

When a qualifying event occurs which affects continued eligibility for insurance coverage, it is your responsibility to notify the Group Insurance Representative at your agency within 60 days of the event. Central Management Services will then send to you, or the dependent who experiences the qualifying event, specific COBRA information and an election notice to the address on the Group Insurance Membership System. If this information is not received within 15 days from the qualifying event, the Group Insurance Representative at your agency should be contacted to ensure that they have processed the eligibility change.

It is extremely important that you provide your agency Group Insurance Representative with current address information for yourself or for any covered dependent that does not reside with you.

COBRA also provides:

- 60 days to elect coverage from the date of the COBRA notification
- An additional 45 days to pay all premium due (105 days total)
- Retroactive coverage to the date benefits were terminated
- Extension of original 18 months of coverage in the event of disability or the occurrence of a second qualifying event
- Addition of coverage for a child born to or adopted by a COBRA member
- Coordination with other group health plans that impose a pre-existing condition

Additional information regarding COBRA continuation coverage is available in your State of Illinois Benefits Handbook.

If you have any questions about COBRA for employees of the State of Illinois, please contact the COBRA Administration Unit of the Illinois Department of Central Management Services at the number below.

Sincerely,
COBRA Administration Unit

COBRA Administration
1-800-442-1300 (select Group Insurance, then Participant, then COBRA)

619 Stratton Office Building, 401 South Spring Street, Springfield, IL 62706

STATE OF ILLINOIS - DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you or your dependents become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

This certifies that the participant listed below was covered for health insurance in the State of Illinois Group Insurance Program:

Certificate Issue Date: 06/06/2002 **Waiting Period: (None)**

Member SSN and Name: 333-44-5555 Pollyanna R. McCracken

Participant SSN and Name: 333-44-5556 Jimmy S. McCracken

Participant Birth Date: 12/22/1959 **Health Plan Termination Effective Date:** 06/01/2002

Group	Active Coverage Period		# Mo.	COBRA Coverage Period	# Mo.
STATE	05/17/1999	05/31/2002	037		

If you have any questions regarding the information provided or require other information, please contact:

Department of Central Management Services
Group Insurance Division Membership Unit
201 East Madison, Suite 2B, P.O. Box 19208
Springfield, IL 62794-9208

Telephone Number: 1-800-442-1300, or (217) 782-2548, or TDD/TTY 1-800-526-0844.

04/23/2004

Opt Out Notice

In accordance with Public Act 92-0600 and Public Act 94-0109, this notice is provided to State of Illinois Group Insurance Program (Program) Members regarding the requirements and limitations for electing not to participate in the Program of health, dental and vision coverage and for re-enrolling in the Program.

Enclosed with this notice is a Group Insurance Membership Verification Form confirming that you have recently elected to not participate in the health, dental and vision plans.

As indicated on the Opt Out Election Certificate, Members continue to be enrolled in the state-paid basic life insurance plan and may elect voluntary optional life coverage.

Members who opt out of the Program are not eligible for free influenza immunizations offered annually by the Department of Central Management Services.

The State of Illinois is not responsible for any expenses incurred for the Member or their dependents on or after the termination date from the Program. The Member and any covered dependents are not eligible for COBRA continuation coverage as a result of opting out of the Program.

Re-enrollment in the Program can be done only during the annual Benefit Choice Period (May 1-31 each year) or within 60 days of experiencing an eligible Qualifying Change in Status. Members and their dependents who re-enroll are subject to possible health benefit limitations for pre-existing conditions. A Certificate of Creditable Coverage from the previous insurance carrier must be provided to reduce the pre-existing conditions waiting period.

Employees who opt out of the Program are eligible to participate in the Flexible Spending Account (FSA) Program and the Commuter Savings Program (CSP). Employees opting out of the Program continue to have the paid maternity/paternity leave of absence benefit available, as well as access to either of the two separate Employee Assistance Programs (EAP).

There are no financial considerations or incentives available for opting out of the Program under Public Act 92-0600.

Please contact the Group Insurance Representative at your employing agency or retirement system for additional information.

MEMBER TURNING AGE 65
STATE OF ILLINOIS
May xx, xxxx

Dear JOE SMITH: Birth Date: 10/12/1942

Our Group Insurance records indicate that within the next five months you will turn age 65. During the next few months, you should receive information from the Social Security Administration regarding your eligibility for Medicare. If you do not receive this information, please contact your local Social Security office as soon as possible.

Medicare is a federal insurance program separated into Part A (Hospital Care) and Part B (Medical Care). Part A is a premium free program, if Medicare taxes were deducted from your earnings. Part B coverage requires the individual to pay a monthly premium, regardless of Medicare tax contribution.

Each member who becomes eligible for Medicare needs to submit a copy of his or her Medicare card to his or her Group Insurance Representative (GIR). Your representative's name, address and phone number are provided on the back of this letter for your convenience.

The following is important information relating to Medicare and your State group insurance coverage based on employment status.

If you are actively employed: The State group insurance program will remain your primary insurance. To reduce possible out-of-pocket expenses, you are encouraged to enroll in Medicare Part A and/or Part B as a secondary insurance.

If you are retired and eligible for Medicare Part A and Part B: You must enroll in the Medicare Program. If you are eligible for premium free Part A of Medicare, failure to enroll in Part B will result in the reduction of benefits under your group insurance coverage and require additional out-of-pocket expenditure for medical care (Part B).

If you are retired and ineligible for premium free Medicare Part A: You should contact the Social Security Administration and request written verification of your ineligibility for free Part A benefits. Upon receipt, this letter is to be forwarded to your GIR. Although your benefits for Part B coverage will not be reduced if you are ineligible for premium free Part A, you are encouraged to enroll in Medicare Part B to reduce possible out-of-pocket expenditures.

Note*:** *If you do not notify your Group Insurance Representative of your enrollment in Medicare by the end of your birth month, CMS will assume you are enrolled in both Parts A and B of Medicare and update our file accordingly.* ***You must also notify your GIR if your date of birth is incorrectly listed above.

Quality Care Health Plan (QCHP) Participants: If you are enrolled in Part B and Medicare is primary for your coverage, Medicare Part B claims can be automatically forwarded to CIGNA, the Medical Plan Administrator, for consideration of secondary benefits. We strongly encourage you to participate in this process known as Medicare Crossover. In order to initiate Medicare Crossover for Part B claims, contact CIGNA toll-free at 1-800-962-0051.

DEPENDENT TURNING AGE 65
STATE OF ILLINOIS
December xx, xxxx

Re: JOE SMITH

Dear JOETTA SMITH: Birth Date: May 12, 1942

Our Group Insurance records indicate that within the next five months, your dependent will be turning age 65. During the preceding six months, information should have been received from the Social Security Administration regarding your dependent's eligibility for Medicare. If this information has not been received, please contact your Social Security office as soon as possible.

Medicare is a federal insurance program separated into Part A (Hospital Care) and Part B (Medical Care). Part A is a premium free program, if Medicare taxes were deducted from your dependent's earnings. Part B coverage requires the individual to pay a monthly premium, regardless of Medicare tax contribution.

Each member whose dependent enrolls in Medicare needs to submit a copy of the dependent's Medicare card to his or her Group Insurance Representative. Your Representative's name, address and phone number are provided on the back of this letter for your convenience.

The following is important information relating to your dependent's Medicare and State group insurance coverage based on employment status.

If you are actively employed: The State group insurance program will remain primary insurance for your dependent. To reduce possible out-of-pocket expenses, your dependent is encouraged to enroll in Medicare Part A and/or Part B as a secondary insurance.

Retired and your dependent is retired and eligible for Medicare Part A and Part B: Your dependent must enroll in the Medicare Program. If he/she is eligible for premium free Part A of Medicare, failure to enroll in Part B will result in the reduction of benefits of your dependent's group insurance coverage and require additional out-of-pocket expenditure for medical care (Part B).

Retired and your dependent is ineligible for premium free Medicare Part A: You should contact the Social Security Administration and request written verification of your dependent's ineligibility for free Part A benefits. Upon receipt, this letter is to be forwarded to your retirement system. Although your dependent's benefits for Part B coverage will not be reduced if he/she is ineligible for premium free Part A, you are encouraged to enroll in Part B to reduce possible out-of-pocket expenditures.

Note: If you do not notify your Group Insurance Representative of your dependent's enrollment in Medicare by the end of his/her birth month. CMS will assume he/she is enrolled in both Parts A and B of Medicare and update our file accordingly. ***You must also notify your dependent's GIR if your date of birth is incorrectly listed above.***

Quality Care Health Plan (QCHP) Participants: If you are enrolled in Part B and Medicare is primary for your coverage, your Medicare Part B claims can be automatically forwarded to CIGNA, the Medical Plan Administrator, for consideration of secondary benefits. We strongly encourage you to participate in this process known as Medicare Crossover. In order to initiate Medicare Crossover for your Part B claims, just call CIGNA toll-free at 1-800-962-0051.

CMS GROUP INSURANCE DIVISION – STATE PLAN VERIFICATION FORM

>>>UNDERLINED INFORMATION HAS BEEN CHANGED<<<

MEMBER'S PERSONAL INFORMATION – Effective 01 01 2004

SSN: 111-11-1111 Name: Jim Jones

Marital Status: Married Birthdate: 04 01 1965

Medicare Status: NON MEDICARE
Part A Effective: End: Part A Free:
Part B Effective: End:

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MEMBER RESIDENTIAL ADDRESS – Effective 01 01 2004

123 GRANT BLVD Resident County: SANGAMON
SPRINGFIELD IL 62702-0000

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ENROLLMENT INFORMATION – Effective 01 01 2004

Type Enrollee: EMPLOYEE FULL TIME Type Eff Date: 01 01 2004

MEMBER PLAN INFORMATION Health Pre-existing Months Applied: 0

	A=Active T=Term'd	Code	Carrier Name	Effective Date	Provider Code	# of Active Dependents
Health:	A	D3	QUALITY CARE HEALTH	01 01 2004		00
Dental:	A	D6	QUALITY CARE DENTAL	01 01 2004		00
Vision:	A	VS	VISION SERVICE PLAN	01 01 2004		00
Life:	A	C9	STATE LIFE INSUR.	01 01 2004		00

Life Insurance Coverage:	Basic:	$30,000	Spouse	$0
	Opt 0X	$0	Child(each)	$0
	AD&D	$0		

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Your Insurance Representative is: CONNIE CHUNG Phone #: 217-976-7825

(INS REP COPY)

Appendix J includes the type/subtype chart which is used to determine which type enrollee code a member should be coded depending on the circumstances of employment.

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	ACTIVELY WORKING MEMBERS		
1001	FULL TIME EMPLOYEE	HEALTH, DENTAL, VISION AND LIFE REQUIRED	YES – 1051
1003	PUBLIC OFFICIAL ***(GENERAL ASSEMBLY STATE OFFICERS)***	HEALTH, DENTAL, VISION AND LIFE REQUIRED	YES – 1053
1004	EMERGENCY APPOINTMENT	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; HEALTH, DENTAL AND VISION; OR LIFE ONLY - MEMBER DIRECT PAYS ENTIRE COST	NO PAYS 100%
1005	FORMER GENERAL ASSEMBLY MEMBER ***(GENERAL ASSEMBLY RET. SYST. ONLY)***	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; HEALTH, VISION AND DENTAL; OR LIFE ONLY - MEMBER DIRECT PAYS ENTIRE COST	NO PAYS 100%
1006	U OF I FOUNDATION ***(U OF I URBANA ONLY)***	HEALTH, DENTAL, VISION AND LIFE REQUIRED - MEMBER PAYS ENTIRE COST	YES – 1056
1007	FULL TIME EMP ON PAYROLL W/ LIFE ONLY ***(GID ONLY)***	LIFE INSURANCE REQUIRED - HEALTH, DENTAL AND VISION TERMED FOR NON PAY - PROCESSED BY CMS/GID ANALYSIS & RESOLUTION UNIT	NO LIFE ONLY
1008	PART TIME EMP ON PAYROLL W/ LIFE ONLY ***(GID ONLY)***	LIFE INSURANCE REQUIRED - MEMBER PAYS A PORTION OF THE STATE COST BASED ON PERCENTAGE OF TIME WORKED - HEALTH, DENTAL AND VISION TERMED FOR NON PAY - PROCESSED BY CMS/GID ANALYSIS & RESOLUTION UNIT	NO LIFE ONLY
1009	IL DEVEL FINANCE AUTH (FULL TIME)	HEALTH, DENTAL AND VISION REQUIRED - NOT ELIG FOR LIFE - PREMIUM REPORTED THROUGH DIRECT PAYMENT	YES 8033 TERM
1010	IL DEVEL FINANCE AUTH (PART TIME)	HEALTH, DENTAL AND VISION REQUIRED - NOT ELIG FOR LIFE - MEMBER PAYS A PORTION OF THE STATE COST BASED ON PERCENTAGE OF TIME WORKED - PREMIUM REPORTED THROUGH DIRECT PAYMENT	NO PAYS %

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	ACTIVELY WORKING MEMBERS		
1016 (prev 1002)	PERM PT EMPLOYEE	MEMBER WORKS A SET SCHEDULE (DOES NOT INCLUDE SEASONAL WORKERS OR UNIVERSITY ACADEMIC YEAR PART TIME). MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED	NO PAYS %
1017 (prev 1011)	PART TIME EMPLOYEE DIRECT BILLED BY SPECIAL PAYMENT PROGRAMS UNIT ***(CSU, NEIU, GSU, STATE POLICE)***	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED - AGENCY UNABLE TO PAYROLL DEDUCT FOR PT EMPLOYEES	NO PAYS %
1018 (prev 1012)	UNIV PT FACLTY <6 MO ***(UNIVERSITIES ONLY)***	MEMBER WORKS A MINIMUM OF 4.5 MONTHS BUT LESS THAN 6 MONTHS. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED. NOT ELIGIBLE FOR SEASONAL LEAVE OF ABSENCE.	NO PAYS %
1019 (prev 1013)	UNIV PT FAC >6 MO ***(UNIVERSITIES ONLY)***	UNIVERSITY FACULTY SEASONAL EMPLOYEE WORKING A MINIMUM OF 6 MONTHS. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED. ELIGIBLE FOR A MAXIMUM OF 6 MONTHS OF SEASONAL LEAVE OF ABSENCE.	NO PAYS %
1020 (prev 1014)	UNIV PT NFAC >730 HRS ***(UNIVERSITIES ONLY)***	UNIVERSITY NONFACULTY SEASONAL EMPLOYEE WORKING AT LEAST 730 HOURS OVER A 9 MONTH PERIOD. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED. ELIGIBLE FOR A MAXIMUM OF 6 MONTHS OF SEASONAL LEAVE OF ABSENCE.	NO PAYS %

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	ACTIVELY WORKING MEMBERS		
1021 (prev 1015)	AGY/UNIV SEASNL 6-11 MO	AGENCY AND UNIVERSITY SEASONAL SERVICE EMPLOYEES WORKING A MINIMUM OF 6 MONTHS BUT LESS THAN 12 MONTHS. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED. ELIGIBLE FOR A MAXIMUM OF 6 MONTHS OF SEASONAL LEAVE OF ABSENCE.	NO PAYS %
	ACTIVELY WORKING MEMBERS – OPTING OUT OF HEALTH, DENTAL AND VISION		
1051	FULL TIME EMPLOYEE	LIFE REQUIRED	CURRENTLY OPTING OUT
1053	PUBLIC OFFICIAL ***(GENERAL ASSEMBLY STATE OFFICERS)***	LIFE REQUIRED	CURRENTLY OPTING OUT
1056	U OF I FOUNDATION ***(U OF I URBANA ONLY)***	LIFE REQUIRED - MEMBER PAYS ENTIRE COST	CURRENTLY OPTING OUT

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	CERTIFIED SURVIVORS		
2017	OF U OF I CES MEMBER ***(U OF I URBANA ONLY)***	HEALTH, DENTAL, AND VISION REQUIRED - NOT ELIG FOR LIFE – STATE PAID BASIC HEALTH AND DEP SUPPLEMENT. MEMBER PAYS FOR OPTIONAL COVERAGE	YES 8033 TERM
2027	OF U OF I ATHLETIC ASSOC ***(U OF I URBANA ONLY)***	HEALTH, DENTAL, AND VISION REQUIRED – NOT ELIG FOR LIFE – MEMBER PAYS ENTIRE COST	YES 8033 TERM
	RETIREES		
5006	U OF I COOPERATIVE EXT. SERVICE ***(U OF I URBANA ONLY)***	HEALTH, DENTAL, AND VISION REQUIRED - NOT ELIG FOR LIFE – CES PAYS BASIC HEALTH. STATE PAYS DEP SUPPLEMENT. MEMBER PAYS FOR OPTIONAL COVERAGE	YES 8033 TERM
5014	U OF I URBANA ATHLECTIC ASSOC. ***(U OF I URBANA ONLY)***	HEALTH, DENTAL, AND VISION REQUIRED - NOT ELIG FOR LIFE - MEMBER PAYS ENTIRE COST	YES 8033 TERM

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6001	NON OCC. DISABILITY WITH RETIREMENT BENEFITS (FULL TIME)	RECEIVING A DISABILITY CHECK FROM A RETIREMENT SYSTEM. HEALTH, DENTAL, VISION AND LIFE REQUIRED - NO MAXIMUM # MONTHS	YES – 6051
6002	NON OCC. DISABILITY NO RETIREMENT BENEFITS (FULL TIME)	NOT RECEIVING A DISABILITY CHECK FROM A RETIREMENT SYSTEM. HEALTH, DENTAL, VISION AND LIFE REQUIRED - 24 MONTH MAXIMUM FROM LAST DATE ON PAYROLL	YES – 6052
6003	OCCUPATIONAL DISABILITY (Receiving Workers Compensation)	HEALTH, DENTAL, VISION AND LIFE REQUIRED - NO MAXIMUM NUMBER OF MONTHS	YES – 6053
6006	EDUCATIONAL/SABBATICAL (FULL TIME)	HEALTH, DENTAL, VISION AND LIFE REQUIRED - 24 MONTH MAXIMUM	YES – 6056
6008	PERMANENT LAYOFF ST.PD. (Elimination of position) ***(GID ONLY)***	STATE PAID HEALTH, DENTAL, VISION AND LIFE FOR A MINIMUM OF 6 MONTHS UP TO A MAXIMUM OF 24 MONTHS BASED UPON YEARS OF SERVICE; INCLUDES BASIC AND OPTIONAL COVERAGE; APPLIES TO COVERAGE IN FORCE JUST PRIOR TO LAYOFF	YES – 6058
6009	PERSONAL LEAVE (FULL TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; HEALTH, DENTAL AND VISION; OR LIFE ONLY. MEMBER PAYS ENTIRE COST – 24 MONTHS MAXIMUM	YES – 6059
6010	FMLA (FULL TIME) (Family and Medical Leave Act)	HEALTH, DENTAL, VISION AND LIFE REQUIRED – MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS	YES – 6060
6011	DOCK/SUSPENSION <= 30 DAYS (FULL TIME)	HEALTH, DENTAL, VISION AND LIFE REQUIRED – 30 DAY MAXIMUM CUMULATIVE PER PLAN YEAR	YES – 6061

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6012	DOCK/SUSPENSION > 30 DAYS (FULL TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; HEALTH, DENTAL AND VISION; OR LIFE ONLY - MEMBER PAYS ENTIRE COST – COVERAGE TERMINATED AFTER 23 MONTHS – MUST EXHAUST INITIAL 30 DAYS UNDER 6011 PRIOR TO USING 6012	YES – 6062
6013	PERMANENT LAYOFF – LIFE ONLY	LIFE ONLY – 12 MONTHS MAXIMUM; HEALTH, DENTAL AND VISION TERMED – MEMBER PAYS ENTIRE COST	NO LIFE ONLY
6014	FMLA RETURN TO WORK PART TIME – DIRECT PAY PREMIUM (FULL TIME)	HEALTH, DENTAL, VISION AND LIFE REQUIRED – MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS CUMULATIVE INCLUDING TIME UNDER 6010. FULL TIME EMPLOYEE ON FMLA RETURNS TO WORK PART TIME BUT IS STILL CONSIDERED ON LEAVE OF ABSENCE AND MUST DIRECT PAY PREMIUM	YES – 6064
6015	PLANS TERMED FOR NON-PAY (FULL TIME) ***(GID ONLY)***	HEALTH, DENTAL AND VISION TERMINATED FOR NON-PAY OF PREMIUM. ONLY BASIC LIFE ACTIVE – PROCESSED BY CMS/GID SPECIAL PAYMENT PROGRAMS UNIT – MAXIMUM MONTHS ALLOWED IN THIS CODE ARE DETERMINED BY THE LEAVE SUB-TYPE CODED PRIOR TO THE 6015 (I.E., 6002 MAX 24 MONTHS; 6017 MAX 48 MONTHS; 6001 – NO MAXIMUM MONTHS)	NO LIFE ONLY
6016	MIL WITH BENEFITS <= 30 DAYS	HEALTH, DENTAL, VISION AND LIFE REQUIRED – 30 DAYS MAXIMUM	YES – 6066
6017	MIL WITH BENEFITS > 30 DAYS	LIFE ONLY – UP TO 4 YEARS MAXIMUM; HEALTH, DENTAL AND VISION TERMED; MUST EXHAUST 30 DAYS UNDER 6016 PRIOR TO USING 6017	NO LIFE ONLY
6018	FURLOUGH (IL School for the Deaf & IL School for the Visually Impaired)	STATE PAID HEALTH, DENTAL, VISION AND LIFE FOR 4 MONTHS - INCLUDES BASIC AND OPTIONAL COVERAGE ; APPLIES TO COVERAGE IN FORCE IMMEDIATELY PRIOR TO FURLOUGH	YES – 6068

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6019	MILITARY CALL UP – PYRL	LIFE REQUIRED - MAY ELECT HEALTH, DENTAL AND VISION; NO MAXIMUM MONTHS; DEDUCTIONS TAKEN ON PAYROLL	YES – 6069
6020	MILITARY CALL UP – DIRECT PAY	LIFE REQUIRED - MAY ELECT HEALTH, DENTAL AND VISION - NO MAXIMUM MONTHS - PREMIUM PAID VIA DIRECT PAY	YES – 6070
6021	OCC DISAB – PREV PT	MEMBER MAY HAVE THE SAME COVERAGE AS WHEN ACTIVELY WORKING: HEALTH, DENTAL, VISION AND LIFE; HEALTH DENTAL; OR LIFE ONLY. NO MAXIMUM NUMBER OF MONTHS	YES – 6071
6022	UNIV PD ACDMC YR BRK ***(SIU-C ONLY)***	SAME AS TYPE 6023 EXCEPT THE UNIVERSITY PAYS EMPLOYEE (ONLY FOOD SERVICE WORKERS PER UNION CONTRACT) HEALTH AND DENTAL PREMIUMS; MAXIMUM 3 MONTHS. AUTOMATIC TERMINATION 9/1.	YES – 6072
6023	UNIV FT ACDMC YR BRK ***(UNIVERSITIES ONLY)***	HEALTH, DENTAL, VISION AND LIFE REQUIRED; MAXIMUM 3 MONTHS. AUTOMATIC TERMINATION 9/1.	YES – 6073
6026 (prev 6001)	NON OCC. DISABILITY WITH RETIREMENT BENEFITS (PART TIME)	RECEIVING A DISABILITY CHECK FROM A RETIREMENT SYSTEM. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - PAYS PERCENTAGE OF STATE COST OF HEALTH AND DENTAL BASED ON % OF TIME WORKED UNTIL RETIREMENT SYSTEM PICKS UP- NO MAXIMUM # MONTHS	NO PAYS %
6027 (prev 6002)	NON OCC. DISABILITY NO RETIREMENT BENEFITS (PART TIME)	NOT RECEIVING A DISABILITY CHECK FROM A RETIREMENT SYSTEM. MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED - 24 MONTH MAXIMUM FROM LAST DATE ON PAYROLL	NO PAYS %

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6028 (prev 6006)	EDUCATIONAL/SABBATICAL (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY. MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED - 24 MONTH MAXIMUM	NO PAYS %
6029 (prev 6007)	AGENCY/UNIV SEASONAL LEAVE / LAYOFF (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY. MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON PERCENTAGE OF TIME WORKED - 6 MONTH MAXIMUM PER CONTRACT YEAR	NO PAYS %
6030 (prev 6009)	PERSONAL LEAVE (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY. MEMBER PAYS ENTIRE COST - 24 MONTHS MAXIMUM	NO PAYS 100%
6031 (prev 6010)	FMLA (PART TIME) (Family and Medical Leave Act)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON THE PERCENTAGE OF TIME WORKED - MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS	NO PAYS %
6032 (prev 6011)	DOCK/SUSPENSION <= 30 DAYS (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON THE PERCENTAGE OF TIME WORKED - 30 DAYS MAXIMUM CUMULATIVE PER PLAN YEAR	NO PAYS %
6033 (prev 6012)	DOCK/SUSPENSION > 30 DAYS (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY - MEMBER PAYS ENTIRE COST – COVERAGE TERMINATED AFTER 23 MONTHS – MUST EXHAUST INITIAL 30 DAYS UNDER 6032 PRIOR TO USING 6033	NO PAYS 100%

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6034 (prev 6014)	FMLA RETURN TO WORK PART TIME – DIRECT PAY PREMIUM (PART TIME)	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY. MEMBER PAYS PART TIME % OF HEALTH AND DENTAL – MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS CUMULATIVE INCLUDING TIME UNDER 6010. PART TIME EMPLOYEE ON FMLA RETURNS TO WORK PART TIME BUT IS STILL CONSIDERED ON LEAVE OF ABSENCE AND MUST DIRECT PAY PREMIUM.	NO PAYS %
6035 (prev 6015)	PLANS TERMED FOR NON-PAY (PART TIME) ***(GID ONLY)***	HEALTH, DENTAL AND VISION TERMINATED FOR NON-PAY OF PREMIUM. ONLY BASIC LIFE ACTIVE - PROCESSED BY CMS/GID SPECIAL PAYMENT PROGRAMS UNIT – MAXIMUM MONTHS ALLOWED IN THIS CODE ARE DETERMINED BY THE LEAVE SUB-TYPE CODED PRIOR TO THE 6035 (I.E., 6027 MAX 24 MONTHS; 6017 MAX 48 MONTHS; 6026 – NO MAXIMUM MONTHS).	NO LIFE ONLY
6036 (prev 6024)	UNIV PT FAC ACDMC YR BRK ***(UNIVERSITIES ONLY)***	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY – MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON THE PERCENTAGE OF TIME WORKED. MAXIMUM 6 MONTHS. AUTOMATIC TERMINATION 9/1.	NO PAYS %
6037 (prev 6025)	UNIV PT NFAC ACDMC YR BRK ***(UNIVERSITIES ONLY)***	MEMBER MAY CHOOSE HEALTH, DENTAL, VISION AND LIFE; OR LIFE ONLY – MEMBER PAYS A PORTION OF THE STATE COST OF HEALTH AND DENTAL BASED ON THE PERCENTAGE OF TIME WORKED. MAXIMUM 6 MONTHS. AUTOMATIC TERMINATION 9/1.	NO PAYS %

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	LEAVE OF ABSENCE		
6040	RETURN TO WORK PART TIME NON-OCCUPATIONAL DISABILITY (FULL TIME)	HEALTH, DENTAL, VISION AND LIFE REQUIRED – MAXIMUM OF 3 MONTHS. FULL-TIME EMPLOYEE ON NON-OCCUPATIONAL DISABILITY RETURNS TO WORK PART TIME PER DOCTOR'S ORDERS. EMPLOYEE IS DIRECT BILLED BY SPPU AS IF WERE WORKING 100%.	YES – 6090
6041	RETURN TO WORK PART TIME OCCUPATIONAL DISABILITY (FULL TIME)	HEALTH, DENTAL, VISION AND LIFE REQUIRED – NO MAXIMUM NUMBER OF MONTHS. EMPLOYEE ON OCCUPATIONAL DISABILITY LEAVE OF ABSENCE RETURNS TO WORK PART TIME PER DOCTOR'S ORDERS AND RECEIVE SA PARTIAL BENEFIT FROM WORKERS' COMPENSATION. EMPLOYEE IS DIRECT BILLED BY SPPU AS IF WERE WORKING 100%.	YES – 6091

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	MEMBERS ON LEAVE OF ABSENCE – OPTING OUT OF HEALTH, DENTAL AND VISION		
6051	NON-OCC DISABILITY WITH RETIREMENT BENEFITS OPT OUT	LIFE REQUIRED; RECEIVING DISABILITY CHECK FROM A RETIREMENT SYSTEM; NO MAXIMUM NUMBER OF MONTHS	CURRENTLY OPTING OUT
6052	NON-OCC DISABILITY WITHOUT RETIREMENT BENEFITS OPT OUT	LIFE REQUIRED; NOT RECEIVING A DISABILITY CHECK FROM A RETIREMENT SYSTEM; 24 MONTH MAXIMUM FROM LAST DATE ON PAYROLL	CURRENTLY OPTING OUT
6053	OCCUPATIONAL DISABILITY OPT OUT	LIFE REQUIRED; NO MAXIMUM NUMBER OF MONTHS	CURRENTLY OPTING OUT
6056	EDUCATIONAL SABBATICAL OPT OUT	LIFE REQUIRED; 24 MONTH MAXIMUM	CURRENTLY OPTING OUT
6058	PERMANENT LAYOFF OPT OUT ***(GID ONLY)***	LIFE REQUIRED FOR A MINIMUM OF 6 MONTHS UP TO A MAXIMUM OF 24 MONTHS BASED UPON YEARS OF SERVICE. APPLIES TO COVERAGE IN FORCE JUST PRIOR TO LAYOFF.	CURRENTLY OPTING OUT
6059	PERSONAL LEAVE OPT OUT	LIFE REQUIRED; 24 MONTH MAXIMUM	CURRENTLY OPTING OUT
6060	FMLA OPT OUT	LIFE REQUIRED; MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS	CURRENTLY OPTING OUT

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	MEMBERS ON LEAVE OF ABSENCE – OPTING OUT OF HEALTH, DENTAL AND VISION		
6061	DOCK/SUSPENSION <= 30 DAYS OPT OUT	LIFE REQUIRED; 30 DAY MAXIMUM PER PLAN YEAR	CURRENTLY OPTING OUT
6062	DOCK/SUSPENSION > 30 DAYS OPT OUT	LIFE REQUIRED; MEMBER PAYS ENTIRE COST	CURRENTLY OPTING OUT
6064	FMLA RETURN TO WORK PART TIME OPT OUT	LIFE REQUIRED; MAXIMUM NUMBER OF MONTHS VARIES PER AGENCY BUT CANNOT BE GREATER THAN 6 MONTHS	CURRENTLY OPTING OUT
6066	MILITARY WITH BENEFITS <= 30 DAYS OPT OUT	LIFE REQUIRED; 30 DAY MAXIMUM	CURRENTLY OPTING OUT
6068	FURLOUGH (IL School for the Deaf & IL School for the Visually Impaired) OPT OUT	LIFE REQUIRED; 4 MONTH MAXIMUM	CURRENTLY OPTING OUT
6069	MILITARY CALL UP ON PAYROLL OPT OUT	LIFE REQUIRED; DEDUCTIONS TAKEN ON PAYROLL; NO MAXIMUM MONTHS	CURRENTLY OPTING OUT
6070	MILITARY CALL UP ON DIRECT PAY OPT OUT	LIFE REQUIRED; PREMIUMS PAID VIA DIRECT PAY; NO MAXIMUM MONTHS	CURRENTLY OPTING OUT
6071	OCCUPATIONAL DISABILITY PREV. PT – OPT OUT	LIFE REQUIRED; NO MAXIMUM MONTHS	CURRENTLY OPTING OUT

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	MEMBERS ON LEAVE OF ABSENCE – OPTING OUT OF HEALTH, DENTAL AND VISION		
6072	UNIVERSITY PAID ACADEMIC BREAK – OPT OUT	LIFE REQUIRED; MAXIMUM 3 MONTHS	CURRENTLY OPTING OUT
6090	RETURN TO WORK PART TIME NON-OCCUPATIONAL - OPT OUT	LIFE REQUIRED; MAXIMUM 3 MONTHS	CURRENTLY OPTING OUT
6091	RETURN TO WORK PART TIME OCCUPATIONAL - OPT OUT	LIFE REQUIRED; NO MAXIMUM NUMBER OF MONTHS	CURRENTLY OPTING OUT

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	TERMINATED MEMBERS	***Letter Produced For All COBRA Eligible Terminations***	
8001	MEMBER DEATH	DEPENDENTS ELIGIBLE FOR COBRA	N/A
8002	SURVIVOR RIGHTS EXPIRED	COBRA ELIGIBLE	N/A
8003	TEFRA WAIVER	INELIGIBLE FOR COBRA - 65 OR OVER, MEDICARE ENTITLED AND WAIVING STATE COVERAGE	N/A
8007	NEVER ELIGIBLE	INELIGIBLE FOR COBRA - ADDED TO THE MEMBERSHIP FILE IN ERROR	N/A
8008	TERMINATE EMPLOYMENT	COBRA ELIGIBLE	N/A
8009	DEPENDENT OF ANOTHER MEMBER	INELIGIBLE FOR COBRA – MEMBER BECOMES DEPENDENT OF ANOTHER STATE MEMBER	N/A
8010	NON-PAY OF PREMIUM	INELIGIBLE FOR COBRA	N/A
8011	MAXIMUM LEAVE OF ABSENCE COVERAGE PERIOD	COBRA ELIGIBLE - MAXIMUM NUMBER OF MONTHS UNDER LOA EXHAUSTED	N/A
8012	GROSS MISCONDUCT	MEMBER INELIGIBLE FOR COBRA - DEPENDENTS ELIGIBLE FOR COBRA	N/A
8013	PART TIME EMPLOYEE WAIVED	INELIGIBLE FOR COBRA - PT MEMBER WAIVING ALL COVERAGE	N/A
8014	CHANGING TO < 50% PART TIME	COBRA ELIGIBLE	N/A
8015	PERMANENT LAYOFF WITHOUT STATE PAID	COBRA ELIGIBLE - LAYOFF DOES NOT QUALIFY FOR STATE PAID COVERAGE	N/A

TYPE/SUBTYPE COMMENTS - STATE GROUP
(Opt Out does not apply to shaded types)

Note: As of July 1, 2004, members may elect not to participate in the dental plan; therefore, the dental participation requirement does not apply.

TYPE/ SUBTYPE	TYPE ENROLLEE	COMMENTS	ELIGIBLE FOR OPT OUT?
	TERMINATED MEMBERS		
8016	NON-STATE PD LEAVE OF ABSENCE WAIVER	INELIGIBLE FOR COBRA - EXAMPLE: MEMBER ON PERSONAL LEAVE ELECTING TO WAIVE ALL COVERAGE	N/A
8017	TERM EMP NO COBRA	INELIGIBLE FOR COBRA - USED WHEN POSTING A TERMINATION ON TOP OF A TERMINATION SUCH AS TERM FOR NONPAY FOLLOWED BY TERM OF EMPLOYMENT	N/A
8027	TERM LOSS OF ELIGIBILITY	COBRA ELIGIBLE	N/A
8033	TERM OPT OUT NO LIFE COV	MEMBER TERMINATED AFTER OPTING OUT OF HEALTH, DENTAL & VISION; MEMBER EITHER WAIVED ALL LIFE COVERAGE OR WAS NOT ELIGIBLE FOR LIFE COVERAGE; INELIGIBLE FOR COBRA	N/A

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I L L I N O I S Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Michael M. Rumman, Director

STATE GROUP INSURANCE MANUAL RELEASE 05-1

DATE: **January 14, 2005**

SUBJECT: **Table of Contents Added to Online GI Manual**

As you may recall from Manual Release 04-2, dated October 6, 2004, all changes to the online manual will be indicated in colored text. The text of the changes for this Manual Release is blue.

The Table of Contents have been added to the online Group Insurance Manual located on the GIR/P website at www.state.il.us/cms/2_servicese_ben/gir.htm. This section is bookmarked as the first option before Section 1 in the manual.

Additionally, the Table of Contents page which corresponds to each section of the manual is bookmarked. For example, when viewing the bookmarks for Section 5, each sub-section will be displayed. The Table of Contents page for Section 5 is the first bookmark.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Section 3: Enrollment	3.2.D	▪ Removes first paragraph which has references to terminating State employment, retiring and becoming a dependent of a member as the statement is confusing the 'transfer' issue.
Section 7: GIFCS Administration	7.11.E	▪ Updates the ARU Cutoff Schedule column heading from 'CFT Reports Available on MOBIUS' to 'Monthly Reports on MOBIUS' as well as updates the column description. Deletes the 'Member Receiving Warning Letter' column as it does not appear on the schedule.
Section 8: Flexible Spending Accounts	8.1.A	▪ Deletes the statement under the FSA Change in Status Certification FY form referring to the "addition/deletion of a dependent" since that information is no longer kept on file.
Section 8: Flexible Spending Accounts	8.1.C	▪ Clarifies the criteria for the effective date of enrollment in MCAP/DCAP.
Section 8: Flexible Spending Accounts	8.1.D	▪ Clarifies the criteria for the effective date of re-enrollment in MCAP/DCAP upon returning to work from an unpaid leave of absence.
Section 8: Flexible Spending Accounts	8.2.B	▪ Clarifies that the first deduction for MCAP or DCAP must be taken during the pay period indicated in the chart.

Due to several changes to the Table of Contents, GIR/Ps who maintain a printed copy of the manual should print the entire Table of Contents (pages 2 through 24 of the online manual).

Reminder: Minnesota Life creates and maintains all life insurance related forms, therefore, please access life insurance forms through the Minnesota Life website at https://web1.lifebenefitsextra.com.

Please continue to watch for GI Notices which will notify of more enhancements to the GIR/P website.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam_dejanovich@cms.state.il.us.

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Michael M. Rumman, Director

STATE GROUP INSURANCE
MANUAL RELEASE 05-02

DATE: **February 7, 2005**

SUBJECT: **Changes to the Part-time Employment and Election of Participation Certificate**

As indicated in the "Forms Release 05-1" dated February 7, 2005, the title of the Part-time Employment and Election of Participation Certificate has been changed to **Part-time Employee Election/Waiver of Group Insurance Participation.** Due to this revision, references to the form in the online Group Insurance Manual are indicated in RED for this Manual Release. All pages which have been updated are bookmarked under the "Manual Release 05-2 Changes" tab. GIR/Ps who maintain a printed copy of the manual may want to print the changed pages.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated to reflect the new form name:

Section	Citation	Online Manual Page
Table of Contents	3 - *ii*	Page 6
Table of Contents	Appendix *i*	Page 23
Section 3: Enrollment	3.0.A.5	Page 64
Section 3: Enrollment	3.0.A.6	Page 66
Section 3: Enrollment	3.0.C.3	Page 72
Section 3: Enrollment	3.2.C	Page 81
Section 3: Enrollment	3.3.B	Page 85
Section 4: Group Insurance Policy	4.1.C.10.e	Page 112
Section 4: Group Insurance Policy	4.1.C.17.b	Page 125
Section 12: Membership Enrollment Procedures	12.8 (pages 12-32 and 12-33)	Page 316/317
Appendix D: Forms Requiring Member's Signature	Page 1	Page 467
Appendix D: Forms Requiring Member's Signature	Page 20	Page 486

Please continue to watch for GI Notices which will notify you of more enhancements to the GIR/P website.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam_dejanovich@cms.state.il.us.

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STATE GROUP INSURANCE
MANUAL RELEASE 05-3

DATE: **July 1, 2005**

SUBJECT: **Opt Out Processing and General Updates**

On June 13, 2005, a GI Notice was sent explaining that Opt Out transactions may now be processed by GIR/P's in the field and that procedures would be forthcoming. Effective with this Manual Release, the Group Insurance Manual has been updated to change/include opt out procedures for GIR/P processing.

A few other changes to the manual have been included with this release, such as the name change of the Qualified Transportation Benefit (QTB) Program to the Commuter Savings Program (CSP). All changes to the online Group Insurance Manual are indicated in BLUE and any updated pages have been book-marked under the "Manual Release 05-3 Changes" tab. GIR/Ps who maintain a printed copy of the manual may want to print the changed pages, including all of the pages in Section 12 since most of those pages have changed.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Section 2: Eligibility Requirements	2.1.C	▪ Clarifies the time limit for the dependent reinstatement policy
Section 3: Enrollment	3.0.A.5	▪ Updates GIR duties #9 and #10 on checklist
Section 3: Enrollment	3.0.A.6	▪ Updates the name of the transit benefit to CSP
Section 3: Enrollment	3.0.B.2	▪ Updates the name of the transit benefit to CSP
Section 3: Enrollment	3.0.C.2	▪ Updates the Opt Out effective date chart
Section 3: Enrollment	3.1.A.3	▪ Changes the adoption policy effective date to be retroactive to the date of placement
Section 3: Enrollment	3.1.B.1	▪ Removes "if applicable" from the handicapped SSA determination statement since SSA determination is now required
Section 3: Enrollment	3.2.A	▪ Updates the Opt Out procedure
Section 3: Enrollment	3.2.C	▪ Clarifies the effective date of part-time waivers

Section 3: Enrollment	3.2.G	▪ Changes the effective date of coverage upon the return to work of members who waived coverage while on a leave of absence
Section 6: Termination and COBRA	6.1.D	▪ Adds the opt out termination type enrollee code 8033 (only used for members without life coverage)
Section 6: Termination and COBRA	6.1.E	▪ Updates the Opt Out process in the "GIR Duties" chart
Section 9: Other Programs	9.0	▪ Updates that Smoking Cessation Program plan administrator information as being located in the most recent Benefit Choice Options booklet
Section 9: Other Programs	9.1.D	▪ Updates that Adoption Benefit Program plan administrator information as being located in the most recent Benefit Choice Options booklet
Section 9: Other Programs	9.4	▪ Updates the transit benefit program name to CSP, as well as gives more instruction to the GIR/P on how the CSP operates, such as effective dates, payroll deductions, monthly reports, etc.
Section 10: Premium Calculation and Coding	10.4	▪ Updates the opt out coding instructions for GIRs to process opt out transactions on the Membership System, as well as gives the appropriate opt out codes for payroll
Section 12: Membership Enrollment Procedures	12	▪ Updates the following procedures: 'Adding A New Member,' 'Terminating Member Coverage,' 'Terminating Dependent Coverage,' 'Member's Employment Changes' (Part-time to Full-time, Active to Leave of Absence and Leave of Absence to Active) ▪ Changes all procedure numbers beginning with 12.5 due to the addition of the new 'Full-time Member Opting Out of Health, Dental and Vision' procedure ▪ Updates the new procedure numbers throughout section 12 where they are referenced within the procedures
Appendix H	Page 8	▪ Updates the Membership codes to include Opt Out
Appendix H	Page 11 and 12	▪ Updates the Type Enrollee summary chart to include opt out active and leave codes
Appendix J	ALL	▪ Updates the Type Enrollee chart with Opt Out codes

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam_dejanovich@cms.state.il.us.

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STATE GROUP INSURANCE
MANUAL RELEASE 05-4

DATE: September 2, 2005

SUBJECT: New Military Codes / Military Policy Change

On July 13, 2005, a GI Notice was sent explaining the revised military benefit that was effective July 1, 2005. The online Group Insurance Manual has been updated (in RED) to reflect the associated type enrollee code and policy changes. The updated pages are book marked under the tab labeled "Manual Release 05-4 Changes". As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Table of Contents	5.10.G	▪ Deleted Codes 6016 and 6017 – Replaced with 6039
Section 5: Leave of Absence/Layoffs	5.10.G	▪ Changes military benefit from 30 days to 24 months
Section 10: Premium Calculation and Coding	10.4	▪ Changes 6066 military opt out code to 6089
Section 12: Membership Enrollment Procedures	12.10	▪ Changes 6016/6017 codes to 6039; changes 6066 opt out code to 6089
Appendix H	Pages 11 - 12	
Appendix J	Pages 6 - 12	

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam_dejanovich@cms.state.il.us.

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STATE GROUP INSURANCE
MANUAL RELEASE 06-01

DATE: **January 18, 2006**

SUBJECT: **FSA Updates**

Extensive changes have been made to the Flexible Spending Accounts (FSA) Program section of the Group Insurance Manual and are outlined in this Manual Release. Among those FSA program changes that have been incorporated into the GI Manual are the MCAP EZ REIMBURSE® MasterCard® program and the new IRS mandated "grace period." Please review Section 8 very carefully, as the entire section has been updated.

As in the past, changes to the online Group Insurance Manual are indicated in color. The changes for this particular Manual Release are indicated in BLUE. Updated pages are book-marked under the "Manual Release 06-1 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print the changed pages in the Table of Contents and Section 11, as well as every page in Section 8.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Table of Contents	Section 8 (all)	▪ Adds, moves, renames section headings for the FSA Section of the GI Manual
	Section 11.0	▪ Adds 'GIP Leaving Agency' to this section (moved from previous section 11.5)
	Section 11.5	▪ Adds the FSA System specifics to the GI Manual
Section 8: Flexible Spending Accounts	All Sections	▪ Incorporates multiple changes into the FSA Section of the GI Manual, including an explanation of the new "grace period" and EZ REIMBURSE® MasterCard® Program
Section 11: Group Insurance System Administration	11.0.C	▪ Moves the 'GIP Leaving Agency' section from its previous location in the manual to section 11.0
	11.5	▪ Adds explanation of FSA System access, FSA Main Menu and FSA Inquiry Menu

Please continue to watch for GI Notices which will notify you of more enhancements to the GIR/P website. If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam.dejanovich@illinois.gov.

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STATE GROUP INSURANCE
MANUAL RELEASE 06-02

DATE: **March 16, 2006**

SUBJECT: **Correction - FSA Grace Period to become effective with FY2007 Plan Year**

THE FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM NEW IRS "GRACE PERIOD" EFFECTIVE DATE IS BEING CHANGED.

The previous Manual Release, 06-01, sent on January 18, 2006, stated that the new IRS "Grace Period" would be effective with the current plan year. Due to technical issues, that effective date has been changed to the upcoming FY2007 plan year. This means that MCAP participants currently enrolled in the program must incur claims for the current plan year before July 1, 2006 in order to be reimbursed. Employees who elect to enroll in MCAP during the upcoming FY2007 Benefit Choice Period will be permitted to incur MCAP claims through September 15, 2007. The run-out period (the last day in which claims MUST be submitted) remains September 30th for both the current and upcoming plan years.

As in the past, changes to the online Group Insurance Manual are indicated in color. The changes for this particular Manual Release are indicated in RED. Updated pages are book-marked under the "Manual Release 06-2 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print the changed page in Section 8.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Section 8: Flexible Spending Accounts	All Sections	▪ Changes the new "grace period" to begin effective with the FY2007 plan year (July 1, 2006 – June 30, 2007)

Please continue to watch for GI Notices which will notify you of more enhancements to the GIR/P website.

If you have questions regarding this release, please contact Grant Brauer at (217) 524-4374 or email him at: grant.brauer@illinois.gov.

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STATE GROUP INSURANCE
MANUAL RELEASE 06-03

DATE: **May 17, 2006**

SUBJECT: **Termination and COBRA Updates**

Extensive changes have been made to the 'Termination and COBRA' section of the Group Insurance Manual and are outlined in this Manual Release. Please review Section 6 very carefully, as the entire section has been updated. Please note, termination and COBRA policies relating to Domestic Partners are not included in this section. A new section will be created in the Group Insurance Manual which will explain all policies, procedures and benefits relating to Domestic Partner coverage. If you have any questions regarding termination and/or COBRA with relation to Domestic Partners, please contact Keri Krager at 217-524-3456.

As in the past, changes to the online Group Insurance Manual are indicated in color. The changes for this particular Manual Release are indicated in RED. Updated pages are book-marked under the "Manual Release 06-3 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print the changed pages in the Table of Contents, as well as every page in Section 6.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Table of Contents	Section 6	▪ Moves COBRA information regarding 'Opt Out', 'Part-time Member Waiving Coverage/Leave of Absence Waiver' and 'Dental Waiver of Coverage' from the 'Termination' section to the 'COBRA' section.
		▪ Incorporates 'Enrolling Dependents' and 'Pre-Existing Conditions' into the 'Additional Provisions' and 'Electing Coverage' sections.
		▪ Adds the COBRA Refund Policy to the COBRA Section 6.2.D.2.
Section 6: Termination and COBRA	All Sections	▪ Incorporates multiple changes into the Termination and COBRA Section of the GI Manual

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam.dejanovich@illinois.gov.

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I L L I N O I S Rod R. Blagojevich, Governor
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STATE GROUP INSURANCE MANUAL RELEASE 06-04

DATE: **July 11, 2006**

SUBJECT: **Domestic Partner Benefit**

This Manual Release outlines the Domestic Partner portion of the State Employees Group Insurance Program. Section 15 in the Group Insurance Manual, formerly the Frequently Asked Questions, has been replaced and now contains an explanation of the Domestic Partner policies, procedures and benefits. Please review Section 15 very carefully as the entire section is new. The information that was contained within the FAQ section will be updated and added to the Group Insurance Website as a link in the near future.

As in the past, changes to the online Group Insurance Manual are indicated in color. The changes for this particular Manual Release are indicated in BLUE. Updated pages are book-marked under the "Manual Release 06-4 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print the changed pages of the Table of Contents, Section 2 and every page in Section 15.

As a reminder, the GI Manual is located on the GI Website at www.state.il.us/cms/2_servicese_ben/gir.htm.

Please use the GI website User Name (gimanual) and Password (1234gi) to login.

The following section(s) of the GI Manual have been updated:

Section	Citation	Change
Table of Contents		▪ Section 15 – replaced all FAQ sections with new Domestic Partner information
Section 2: Eligibility Requirements	2.0.C	▪ Adds "Certain Unrelated, Same-Sex Domestic Partners" as an eligible dependent and refers reader to the new Section 15 "Domestic Partner Coverage" for more specific information
Section 2: Eligibility Requirements	2.0.D	▪ Removes "Same sex partners" from the list of ineligible dependents
Section 15: Domestic Partner Coverage	All	▪ Replaced Section 15 (formerly FAQs) with new Domestic Partner information

Please continue to watch for GI Notices which will notify you of more enhancements to the GIR/P website.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at: pam.dejanovich@illinois.gov.

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Paul J. Campbell, Director

STATE GROUP INSURANCE MANUAL RELEASE 06-05

DATE: **December 7, 2006**

SUBJECT: **Leaves of Absence Section and various other updates**

Extensive changes have been made to Section 5, 'Leaves of Absence/Layoffs,' of the Group Insurance Manual and are outlined in this Manual Release. Please review Section 5 very carefully, **as the entire section has been updated**, including the name of the section which has been changed to 'Direct Billing & Time Away from Work'. The only portion that has not been updated is FMLA, which will be updated in a separate manual release. Additionally, minor changes have been made to Sections 6 and 8, as well as Appendices B and H.

As in the past, changes to the online Group Insurance Manual are indicated in color. The changes for this particular Manual Release are indicated in BLUE. Updated pages are book-marked under the "Manual Release 06-5 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print every page in Section 5, as well as the pages indicated below in other areas of the manual. If you have any questions regarding leave of absence and/or billing procedures, please contact the Special Payment Programs Unit at (217) 558-4783.

As a reminder, the GI Manual is located at www.state.il.us/cms/2_servicese_ben/gir.htm. Please use the GI website User Name (gimanual) and Password (1234gi) to login.

Even though all of Section 5 has been updated, the following indicates the more significant changes for Section 5, as well as the changes to the other sections of the manual:

Section	Citation	Change
Table of Contents	Section 5	▪ Updates the headings in Section 5 as some have changed and/or been moved
Section 5: Leaves of Absence/Layoffs	All	▪ Changes the name of Section 5 to 'Direct Billing & Time Away from Work' ▪ Adds new 'Family Military Leave' as section 5.10.0 ▪ Changes 'Dock/Suspension' policy with regard to effective dates ▪ Clarifies 'Non-Occupational' leave of absence policy with regard to when an employee returns to work on a temporary part-time schedule ▪ Adds Occupational leave of absence policy with regard to when an employee returns to work on a temporary part-time schedule ▪ Adds that, for insurance purposes, a return to work means the physical return of the employee to work ▪ Adds policy change for effective dates following a waiver or termination for non-payment of premium

Section	Citation	Change
Section 6	Section 6	▪ Adds the termination effective date of a spouse who the member has terminated due to a legal separation (6.1.C)
		▪ Changes the Reason Code literal for ‘8056’ to Divorce/Legal Sep (separation) (6.1.D)
		▪ Adds in the ‘Special Note’ section that an 8050 code should only be used for specific voluntary termination reasons (6.1.D)
		▪ Adds the Illinois Spousal Law provision with regard to Medicare coverage and divorce (6.2.G)
Section 8	8.0 8.2.A 8.3.A 8.3.A.2	▪ Corrects the maximum amount that university faculty employees paid over 9 months can elect for their FSA deduction to $555.54 (from $555.55).
Appendix B	Page 5	▪ Corrects the documentation requirement under the ‘Supporting Documentation’ column for ‘Member changes from part time waiving coverage or <50% to full time’ to indicate the documentation must show the change to full-time status (not part time)
Appendix H	Page 5-6	▪ Updates GIFCS Refund Type Codes and adds a ‘Record Type’ section
Appendix H	Page 8	▪ Changes the ‘8056’ Dependent Term Reason Code literal to include legal separation (see GI Notice dated 11/17/2006 for more information)

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her via the link below.

mailto:pam.dejanovich@illinois.gov

CMS

ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 07-01

DATE: **June 29, 2007**

SUBJECT: **Return to Work Part-time with Doctor's Statement – New Codes**

Please review the updated sections on the GI website carefully. **Note: the GI website has a new, easy to remember website address, www.GIResources.illinois.gov.** The User Name and Password have not changed. The previous website address will also work.

User Name: gimanual (must be lower case)
Password: 1234gi (must be lower case)

Changes have been made to Section 5, 'Direct Billing & Time Away From Work,' of the online Group Insurance Manual. Four new type enrollee codes have been added in order to help differentiate between employees on a non-occupational or occupational leave of absence who are not working at all and employees on either a non-occupational or occupational leave of absence who have returned to work part-time due to doctor's orders (see chart below). The Type/Sub-type Chart in Appendix J has been updated to include these new codes.

Literal	Description	Code
RTW PT NON OCC DIS	Return to Work Part Time, Non-Occupational Disability	6040
RTW PT OCC DIS	Return to Work Part Time, Occupational Disability	6041
RTW PT NONOCC OPTOUT	Return to Work Part Time, Non-Occupational Disability, Opting Out	6090
RTW PT OCCDIS OPTOUT	Return to Work Part Time, Occupational Disability, Opting Out	6091

Changes to the online Group Insurance Manual are indicated in color and are book-marked under the "Manual Release 07-01 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print these pages.

Section	Citation	Change
Section 5: Direct Billing & Time Away From Work	5.4 Doctor's Statement to Return to Work Part-time	▪ Renames the section to 'Returning to Work Part time Per Doctor's Statement' ▪ Replaces the type enrollee codes previously used for employees who return to work in a temporary part-time capacity from 6002 to 6040 and 6003 to 6041.
Appendix J	Pages 10 – 13	▪ Adds new type enrollee codes 6040, 6041, 6090 and 6091

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at pam.dejanovich@illinois.gov.

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ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 07-02

DATE: **June 29, 2007**

SUBJECT: **Section 1: Plan Descriptions, Section 2: Eligibility Requirements & Section 3: Enrollment**

Changes have been made to Section 1, 'Plan Descriptions,' Section 2, 'Eligibility Requirements' and Section 3, 'Enrollment' of the online Group Insurance Manual. Please review the updated sections on the GI website carefully. **Note: the GI website has a new, easy to remember website address, www.GIResources.illinois.gov.** The User Name and Password have not changed. The previous website address will also work.

User Name: gimanual (must be lower case)
Password: 1234gi (must be lower case)

Changes to the online Group Insurance Manual are indicated in RED and are book-marked under the "Manual Release 07-02 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print every page in Sections 1, 2 and 3.

Even though most of Sections 1 - 3 have been updated, the following indicates the more significant changes:

Section	Citation	Change
Table of Contents	Section 1, Section 2 and Section 3	▪ Updates the heading names and page numbers for Section 1, 2 and 3
Section 1: Plan Descriptions	Section 1.1 Health	▪ Changes the language from "PPO" hospitals and networks to "QCHP" hospitals and networks ▪ Updates the notification requirements ▪ Adds a new 'QCHP Prescription Drug Plan' subsection
Section 2: Eligibility Requirements	Section 2.0.A Eligible As Members	▪ Adds the coverage options available to the "Eligible As Members" section, including 'Opt Out Financial Incentive' to the "Annuitant" section
	Section 2.0.B Ineligible As Members	▪ Adds the requirement that all employees (including those with a full-time employment status) must work at least 50% of the average hours required of a full-time employee
	Section 2.0.C Eligible As Dependents	▪ Adds the new policy that a full-time student who becomes handicapped due to a cause originating prior to age 23, is eligible for coverage in the 'Handicapped' category ▪ Adds military student to the 'Other' category
	Section 2.1A.1 Dependent Recertification	▪ Changes the unit responsible for processing Birth Date recertifications to the GID Membership Unit

Section 3: Enrollment	Section 3.0.A Initial Enrollment	▪ Moves the stand-alone SSN section to Section 3.0.A.5.
	Section 3.0.B.2 Changes Allowed During Benefit Choice	▪ Adds the option to enroll a Domestic Partner and includes the Opt Out with Financial Incentive option
	3.1.B.1 Documentation Requirements	▪ Adds documentation requirements for a full-time student who becomes handicapped due to a cause originating prior to age 23 ▪ Adds documentation requirements for a military student to be eligible for the 'Other' category
	3.2.A Opting (Out/In)/Waiving/ Transferring/Retiring	▪ Adds a list of the benefits for which a member is eligible and ineligible if they opt out of health coverage
	3.2.E Employee Retiring	▪ Clarifies the retirement system's role when an employee retires with regard to changing org proc codes and the transference of the employee's file
	3.2.G Leave of Absence Waiver Option	▪ Removes this section entirely since the Leave of Absence Waiver form is no longer to be used

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at pam.dejanovich@illinois.gov.

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ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 07-03

DATE: **September 26, 2007**

SUBJECT: **Section 4: Group Insurance Policy & Section 6: Termination and COBRA**

Many changes have been made to Section 4 'Group Insurance Policy' and Section 6, 'Termination and COBRA' of the online Group Insurance Manual. **Section 5 has not yet been updated.**

Please review the updated sections on the GI website carefully. **Note: the GI website has a new, easy to remember website address, www.GIResources.illinois.gov.** The User Name and Password have not changed. The previous website address will also work.

User Name: gimanual (must be lower case)
Password: 1234gi (must be lower case)

Changes to the online Group Insurance Manual are indicated in RED and are book-marked under the "Manual Release 07-03 Changes" tab. GIR/Ps who maintain a printed copy of the manual may wish to print every page in Sections 4 and 6.

Even though most of Sections 4 and 6 have been updated, the following indicates the more significant changes:

Section	Citation	Change
Table of Contents	Section 4 and Section 6	▪ Updates the heading names and page numbers for Section 4 and 6
Section 4: Group Insurance Policy	4.1.C.7 Qualifying Change in Status – Divorce, Legal Separation or Annulment	▪ Emphasizes that untimely notification of an ineligible dependent will result in the member forfeiting any potential premium refund and the dependent will be ineligible for COBRA coverage
	4.1.C.11 & 4.1.C.12 Qualifying Change in Status – Employee Going on a LOA and Employee Returning to Work from a LOA	▪ Clarifies the available options when a member goes on and returns from a leave of absence. **Review this section carefully.**
	4.1.C.17 Qualifying Change in Status – Coordination of Spouse's Annual Election Period	▪ Clarifies that changes to a member's coverage due to coordinating with their spouse's annual election period must be consistent with the changes the spouse requested through their employer.
Section 6: Termination and COBRA	6.1.B.2 Resignation/Separation of University Faculty	▪ Clarifies the policy that university faculty are eligible for group insurance coverage over the summer months; these members have the option to terminate the coverage upon request.
	6.1.B.4 Termination for Non-payment of Premium	▪ Institutes the new policy that coverage terminated for non-payment of premium will be terminated with a current effective date (not retroactive)

Section 6: Termination and COBRA	6.2.C.3	▪ Adds a new section outlining the coverage options available to qualified beneficiaries enrolled with COBRA coverage.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at pam.dejanovich@illinois.gov.

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I L L I N O I S Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 07- 04

DATE: October 17, 2007

SUBJECT: University Faculty Employees

A clarification has been made to the "University Part-time Faculty Employees" policy in Section 2, 'Eligibility Requirements' of the online Group Insurance manual. The clarification impacts university faculty employees hired at the beginning of a spring semester who are given a 9, 10 or 12 month contract, or who have an open-ended contract. In order to comply with the policy, the employment status of the faculty must be considered to be long-term and full-time. These faculty employees can be coded as full-time employees effective the date of employment and would not be considered part-time, one-semester employees.

Please review the updated section on the GI website. **Note: the GI website has a new, easy to remember website address, www.GIResources.illinois.gov.**

The change is indicated in BLUE and is bookmarked under the "Manual Release 07-04 Change" tab. GIR/Ps who maintain a printed copy of the manual may wish to reprint the page.

The following indicates the specific citation of the change:

Section	Citation	Change
Section 2: Eligibility Requirements	2.0.A.2.c	▪ Removes the reference that those who begin employment with a university at the beginning of the spring semester would be considered part-time employees.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at pam.dejanovich@illinois.gov.

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I L L I N O I S Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 08 - 01

DATE: January 31, 2008

SUBJECT: Addition to Section 4, Section 5 Reorganization & Others

Section 4, 'Group Insurance Policy' and Section 5, 'Direct Billing & Time Away From Work,' of the Group Insurance Manual have both been updated. Permanent Layoff was added as a qualifying change in status to Section 4. Section 5 has been completely reorganized and updated. Three sample letters in Appendix I have also been updated.

The first two sections of Section 5 (5.0 and 5.1) apply to all member groups who are billed by the Premium Collection Unit. The remaining four sections (5.2 – 5.5) apply to employee leaves of absence only. The leaves of absence portion of Section 5 describe each type of leave in detail and the procedures the GIR/P must follow when an employee goes on a leave. The leave types are broken into two groups: FMLA protected and not FMLA protected. The return to work portion of Section 5 is also broken into two groups: employee returning to a regular work schedule and employee who returns to work on a reduced schedule.

Please review the entire section carefully as the section has new policies incorporated.

Section 5 is broken into 6 main subheadings:
5.0: General Information
5.1: Billing, Termination and Reinstatement Procedures
5.2: Employee Leaves of Absence
5.3: Employee Returns to Regular Work Schedule
5.4: Employee Returns to Work on a Reduced Schedule
5.5: Reports and Schedules

Go to **www.GIResources.illinois.gov** and enter the User Name and Password.

User Name: gimanual (must be lower case)
Password: 1234gi (must be lower case)

Changes to the online Group Insurance Manual are indicated in RED and are book-marked under the "Manual Release 08-01 Changes" tab. GIR/Ps who maintain a printed copy of the manual will need to print every page in Section 5, as well as pages 35 – 44 of Section 4.

Even though most of Section 5 has been updated, the following indicates the more significant changes:

Section	Citation	Change
Table of Contents	Section 4 & Section 5	▪ Adds a new 4.1.C.23, 'Employment Status Changes: Active Employee to Permanent Layoff.' ▪ Replaces entire Table of Contents page due to reorganization of Section 5.
Section 4: Group Insurance Policy	4.1.C.23	▪ Adds the qualifying change in status reason of changing from active employee to permanent layoff.
Section 5: Direct Billing & Time Away From Work	5.1.A PCU Direct Bill Procedure	▪ Adds the new E-Pay option as another form of payment for premiums. Members may use a debit or credit card to make their payment online.
	5.1.B Non-payment of Premium	▪ Clarifies the new termination for non-payment and involuntary withholding policies and procedures.
	5.1.C Reinstatement of Coverage	▪ Clarifies the reinstatement policies and procedures. Adds that all outstanding premiums, as well as the premiums for the month of July, must be collected from a member prior to coverage being reinstated that was requested during the Benefit Choice Period.
	5.2.C.1.d & 5.2.C.2.c Family Leave	▪ Separates Family Leave into leaves that qualify as FMLA protected from family leaves that are not FMLA protected.
	5.2.C.1.e & 5.2.C.2.b Dock Time	▪ Separates Dock Time into time that qualifies as FMLA protected from dock time that is not FMLA protected.
	5.6 Time Away From Work Chart	▪ Adds a new chart that separates the various time away form work reasons into two groups: FMLA Protected and Not FMLA Protected. This chart may be used as wallpaper for quick reference.
Appendix I: Sample Letters	Page 5	▪ Updates the 'Opt Out Notice' to include the Public Act 94-0109 information.
	Page 6 & Page 7	▪ Changes the language in the 'Member Turning Age 65' letter from notifying the member two months prior to their 65th birthday to five months prior.
		▪ Changes the language in the 'Dependent Turning Age 65' letter from notifying the member two months prior to their 65th birthday to five months prior. Also adds information regarding Medicare Crossover.

If you have questions regarding this release, please contact Pam DeJanovich at (217) 785-8051 or email her at pam.dejanovich@illinois.gov.

CMS

ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

STATE GROUP INSURANCE
MANUAL RELEASE 08 - 02

DATE: June 26, 2008
SUBJECT: Complete update of Section 8: Flexible Spending Accounts (FSA)

All of Section 8, 'Flexible Spending Accounts,' of the Group Insurance Manual has been updated. Many of the changes are with regard to EZ REIMBURSE® Card use, policies and procedures; however, there are other significant changes as well. Please review the entire section to become familiar with the changes. Additionally, one change was made to Section 2.

Go to **www.GIResources.illinois.gov** and enter the User Name and Password.

User Name: gimanual (must be lower case)
Password: 1234gi (must be lower case)

Changes to the online Group Insurance Manual are indicated in RED and are book-marked under the "Manual Release 08-02 Changes" tab. GIR/Ps who maintain a printed copy of the manual will need to print every page in Section 8.

Even though most of Section 8 has been updated, the following table indicates the more significant changes:

Section	Citation	Change
Table of Contents	Section 8	▪ Updates headings and page numbers
Section 2: Eligibility Requirements	2.0.A.5	▪ Removes the references to maintaining basic life coverage for survivors
Section 8: Flexible Spending Accounts	8.2.B Participant Ineligibility	▪ Adds policy that an employee can be off payroll for two weeks or less without having their FSA benefit terminated.
	8.4.B Claims Submission	▪ Adds the FBMC toll-free fax phone number for faxing claims
	8.4.F Checking Claim Status Online	▪ Updates the procedure an employee needs to follow in order to register on the FBMC website to view FSA account information
	8.6.A General Information	▪ Explains what happens if a transaction is processed for an amount greater than the participant's MCAP account balance
	8.6.B EZ REIMBURSE® Card Definitions	▪ Explains auto adjudication more clearly ▪ Adds an explanation of the Inventory Information Approval System (IIAS)
	8.6.E Dental Expenses	▪ Adds that a participant can use their claim information on the CompBenefits website for dental documentation in place of an EOB
	8.6.F Prescription and Over-the-Counter (OTC) Expenses	▪ Explains how the IIAS system auto adjudicates prescription and OTC items at most merchant locations

If you have questions regarding this release, please contact Pam Kogler at (217) 785-8051 or email her at pam.kogler@illinois.gov.

Forms Release 05-1

Two group insurance forms have been revised and are described in this first "Forms Release". The changes that were made to the forms are indicated in red in the online Group Insurance Manual. The chart below indicates the two forms which have been revised and the revisions which were made.

As indicated in the October 22, 2004, GI Notice (subject line: "Group Insurance Forms added to GIR/P Website") a "Forms Release" will be sent whenever a group insurance form is revised. Revised forms will replace the out of date form in both the 'Group Insurance Forms' and 'Group Insurance Manual' sections of the GI website (www.state.il.us/cms/2_servicese_ben/gir.htm).

Form	Changes	GI Manual Page
Part-time Employment and Election of Participation Certificate (now CMS-563)	▪ Changes the name to, "Part-time Employee Election/Waiver of Group Insurance Participation." *Note: Since the name of this form has changed, a Manual Release will be sent to update the references in the Group Insurance Manual.* ▪ Assigns a CMS form number of CMS-563. ▪ Rephrases the first paragraph to include that failure to complete the form will result in automatic default to QCHP and QCDP. ▪ Separates two choices under the "YES" option to participate, indicating employees may only elect not to participate in Dental if they are a new employee or if they are completing the form during the annual BC Period. ▪ Adds a 'GIR/P Use Only' box at the bottom of the form to indicate the effective date and PT percentage.	Appendix D – Page 20
Waiving Annuitant Group Insurance Coverage Notification and Election Form (CMS-565)	▪ Adds #5 which indicates the annuitant must provide a copy of the marriage certificate. ▪ Adds 'Type Enrollee Code,' 'Part-time Percentage,' and 'Basic Life Units' to the GIR/P Use Only box.	Appendix D – Page 22

If you have problems accessing the website, please contact either Pam DeJanovich at (217) 785-8051 or Grant Brauer at (217) 524-4374.

STATE GROUP INSURANCE
FORMS RELEASE 05-02

DATE: **March 10, 2005**

FORM NAME: **Part-Time Employment and Election of Participation Certificate (CMS-563)**

The Part-time Employment and Election of Participation Certificate (CMS-563) group insurance form has once again been revised. The changes are described in this "Forms Release" and are indicated in blue on page 486 of the online Group Insurance Manual. The chart below indicates the revisions which were made.

As indicated in the October 22, 2004, GI Notice (subject line: "Group Insurance Forms added to GIR/P Website") a "Forms Release" will be sent whenever a group insurance form is revised. Revised forms will replace the out of date form in both the 'Group Insurance Forms' and 'Group Insurance Manual' sections of the GI website (www.state.il.us/cms/2_servicese_ben/gir.htm).

Form	Changes	GI Manual Page
Part-time Employment and Election of Participation Certificate (now CMS-563)	▪ Clarifies the Basic and Optional Life options available to the part-time member who waives or elects coverage. ▪ Clarifies that the part-time premium is in addition to the regular member premium payment. ▪ Adds that members have 60 days from a Qualifying Change in Status to elect or waive coverage.	Appendix D – Page 20

If you have problems accessing the website, please contact either Pam DeJanovich at (217) 785-8051 or Grant Brauer at (217) 524-4374.

STATE GROUP INSURANCE
FORMS RELEASE 05-3

DATE: **July 1, 2005**

FORM NAME: MCAP Enrollment Form (CMS-332)
Leave of Absence – Continuation or Waiver of Coverage
Dependent Coverage Certification Statement (CMS-138)
Opt Out & Opt In Election Certificate (CMS-500)

Effective with the FY06 plan year, MCAP participants may elect the EZ REIMBURSE Card anytime throughout the plan year (this is a change from last year in which only new enrollees could elect the card). The form has been updated to reflect this change. In order for participants already enrolled in MCAP to request the card, they must complete the EZ REIMBURSE Mastercard application brochure (available through FBMC). Please begin using the new form immediately. Changes to the other above-named forms are minor and are explained in the chart below.

The forms below have been replaced in both the 'Group Insurance Forms' and 'Group Insurance Manual' sections of the GI website located at: www.state.il.us/cms/2_servicese_ben/gir.htm. The changes are indicated in **GREEN** in the online Group Insurance Manual.

If you have problems accessing the website, please contact either Pam DeJanovich at (217) 785-8051 or Grant Brauer at (217) 524-4374.

Form	Changes	GI Manual Page	Online Manual Page
Leave of Absence – Continuation or Waiver of Coverage	▪ Adds the new coverage effective date policy for members who waive their coverage or have coverage terminated due to non-payment of premium. Effective July 1, 2005, these members will not have coverage reinstated until the first day of the pay period following their physical return to work.	Appendix D – page 4	Page 476
Dependent Coverage Certification Statement (CMS-138)	▪ Removes "if applicable" from the handicapped SSA determination statement since SSA determination is now required for a handicap determination.	Appendix D – page 8	Page 480
Opt Out & Opt In Election Certificate (CMS-500)	▪ Removes the 'CMS Only' section from Side A (Opt Out), incorporates the "Coverage Documentation Submitted" and "Opt Out Effective Date" fields into the 'GIR/P Use Only' section, as these fields must now be completed by the GIR/P and are no longer sent to CMS for processing.	Appendix D – page 23	Page 495
MCAP Enrollment Form (CMS-332)	▪ Removes the policy that only new enrollees can elect the EZ REIMBURSE card; moves the EZ REIMBURSE Card election box to the bottom of Section C.	Appendix E – Page 3/4	Page 499

CMS

I L L I N O I S Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Paul J. Campbell, Director

STATE GROUP INSURANCE
FORMS RELEASE 06-01

DATE: **August 4, 2006**

FORM NAME: MCAP Enrollment Form (CMS-332)
DCAP Enrollment Form (CMS-333)
Leave of Absence – Continuation or Waiver of Coverage (CMS-560)
Domestic Partnership Affidavit (CMS-510)
Domestic Partner Enrollment Form (CMS-511)
Termination of Group Insurance Coverage for Domestic Partner (CMS-512)
Agency Organizational Processing Code File Set-up Form (CMS-139)

Effective with the FY07 plan year were changes to the MCAP and DCAP forms, as well as the addition of three forms for domestic partner coverage.

The MCAP and DCAP forms were changed to include a 'Deduction Start Date' and a 'Date of Last Deduction' field for universities who have employees who are paid over a 9-month period.

With the addition of domestic partner coverage to the state benefits offered, three new forms were developed for enrollment in the program, proof of eligibility and termination of coverage.

The Leave of Absence – Continuation or Waiver of Coverage and the Agency Organizational Processing Code File Set-up Form had minor changes (described in the table below).

Each of the forms below have been replaced or added to both the 'Group Insurance Forms' and 'Group Insurance Manual' sections of the GI website located at: www.state.il.us/cms/2_servicese_ben/gir.htm. The changes to the forms in the online Group Insurance Manual are indicated in **GREEN**.

If you have problems accessing the website, please contact either Pam DeJanovich at (217) 785-8051 or Grant Brauer at (217) 524-4374.

Form	Changes	GI Manual Page	Online Manual Page
Agency Organizational Processing Code File Set-up Form (CMS-139)	Changes the fax number for the Systems Unit; removes references to 'Flex Rep' as this contact is now the agency GIR/P; adds a section to indicate whether the GIR/P should be listed on the Benefits Website as a contact or not	Appendix C – page 3	Pages 459 – 460
Appendix D Title Page	Adds form number to Leave of Absence form and adds the Domestic Partner forms	Appendix D – 1	Page 465
Leave of Absence – Continuation or Waiver of Coverage (CMS-560)	Adds a field for the GIR/P to enter the date the form was provided to the member in the GIR/P Use Only box; adds form number (CMS-560)	Appendix D – page 4	Page 468
MCAP Enrollment Form (CMS-332) & DCAP Enrollment Form (CMS-333)	Includes a 'Deduction Start Date' and the 'Date of Last Deduction' for universities who have employees paid over 9 months	Appendix E – pages 3 – 6	Pages 496 – 499
Domestic Partnership Affidavit (CMS-510) Domestic Partner Enrollment Form (CMS-511) Termination of Group Insurance Coverage for Domestic Partner (CMS-512)	Adds the three new Domestic Partner forms	Appendix D – pages 25 – 29	Pages 488 – 492