

LOCAL GOVERNMENT HEALTH PLAN Benefits Handbook



Illinois Department of Central Management Services

Bureau of Benefits

January 1, 2006

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

IMPORTANT
Do not throw away

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

This Benefits Handbook is intended to assist Plan Participants in the Local Government Health Plan (LGHP) understand and become familiar with the benefits available under various Local Government Health Plan-sponsored programs.

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

Chapter 2 provides information regarding **health, dental, vision and other special programs**.

Chapter 3 provides **reference information** such as the **glossary and index**.

IMPORTANT
Do not throw away

Notes

Chapter 1: Enrollment and Eligibility Information

Introduction	7
Member Responsibilities	9
Information for Annuitants and Survivors	11
Eligibility Requirements	13
Enrollment	17
◆ Qualifying Changes in Status	22
◆ Documentation Requirements and Time Limits	24
Termination of Coverage	27
COBRA – Continuation of Coverage	29

Chapter 2: Health, Dental, and Vision: Options and Plan Information

Health Plan Options	33
Local Care Health Plan (LCHP)	
◆ Local Care Health Plan (LCHP)	37
◆ Plan Year Deductibles and Out-of-Pocket Maximums	43
◆ Medical Benefits Summary	45
◆ Preventive Services	57
◆ Prescription Drug Plan	61
◆ Behavioral Health Services	65
◆ Exclusions and Limitations	69
◆ Claim Filing Deadlines and Procedures	73
Local Care Dental Plan (LCDP)	75
◆ Exclusions and Limitations	77
◆ Claim Filing Deadlines and Procedures	79
Vision Plan	81
Coordination of Benefits	83
Medicare	85
Smoking Cessation Program	89
Subrogation and Reimbursement	91
Claim Appeal Process	93

Chapter 3: Reference

Glossary	97
Index	103

Notes

Chapter 1

Enrollment and Eligibility Information

SECTION	PAGE
Introduction	7
Member Responsibilities	9
Information for Annuitants and Survivors	11
Eligibility Requirements	13
Enrollment	17
◆ Qualifying Changes in Status	22
◆ Documentation Requirements and Time Limits	24
Termination of Coverage	27
COBRA Continuation of Coverage	29

Notes

Your Local Government Health Plan (LGHP) Benefits

Please read this handbook carefully as it contains vital information about your benefits.

The Department of Central Management Services (Department) is the agency that administers the Local Government Health Plan (Plan) as set forth in the State Employees Group Insurance Act of 1971 (Act). You have the opportunity to review your choices and change your coverage for each Plan Year during the annual Benefit Choice Period.

Health Plan Representative (HPR)

A Health Plan Representative (HPR) is your employing unit's liaison to the Department. HPRs are valuable resources for answering questions you may have about your eligibility for coverage, (including leave of absence, termination or COBRA), and to assist you in enrolling or changing the benefits you have selected. To identify your HPR, call your unit's personnel office, or visit the Local Government Health Plan link at www.benefitschoice.il.gov.

Where To Get Additional Information

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

- Each individual Plan Administrator can provide you with specific information on plan coverage inclusions/exclusions.
- The Department's website contains the most up-to-date information regarding benefits and links to Plan Administrators' websites. Visit the Local Government Health Plan link at www.benefitschoice.il.gov for information.
- Annual Benefit Choice Options booklet. This booklet contains the most current information

regarding changes for the Plan Year. New benefits and changes in Plan Administrators are included in the booklet. **Read this booklet carefully as it contains important eligibility and benefit information that may affect your coverage.**

The Department can answer your benefit questions or refer you to the appropriate resource for assistance. They can be reached at:

**Department of Central Management
Services (DCMS)
Group Insurance Division
201 E. Madison Street
P.O. Box 19208
Springfield, IL 62794-9208
(800) 442-1300 or (217) 782-2548
TDD/TTY: (800) 526-0844**

ID Cards

The Plan Administrators produce ID Cards at the time of enrollment and cards are mailed to the Member's address. To obtain additional cards, contact the Plan Administrator(s) listed in the current Benefit Choice Options booklet or visit the website at www.benefitschoice.il.gov for links to current Plan Administrators.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The State contracts with Business Associates (health plan administrators, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits.

If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective Plan Administrator. If you are a Plan Participant in the Local Care Health Plan (LCHP), refer to the annual Benefit Choice Options booklet for the Notice of Privacy Practices.

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

Notify your Health Plan Representative (HPR) at your employing unit immediately when any of the following occurs:

- **Change of address.** When you and/or your Dependents move.

NOTE: Your address may be updated based upon a forwarding order from the United States Post Office.

- **Life changing events.** Failure to **timely** notify the HPR of a life-changing event, such as a birth or marriage, will prevent you from being able to change coverage until the next Benefit Choice Period. See the Enrollment section in this chapter for a complete listing of Qualifying Changes in Status.
- **Dependent loss of eligibility.** Dependents who are no longer eligible under the Local Government Health Plan (Plan) (including divorced Spouses) must be reported to your HPR **immediately**. Failure to report an ineligible Dependent is considered a fraudulent act and will result in the termination of Dependent coverage under the Plan and potentially the loss of COBRA continuation rights. (Effective February 1, 2006).

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

- **Other Coverage.** If you have group coverage provided by a plan other than the Local Government Health Plan, or if you or your Dependents gain other coverage during the

Plan Year, you must provide that information to your HPR **immediately** in order for claims to be processed correctly.

- **Leave of Absence.** You must notify your HPR when you go on and/or return from a leave of absence.
- **Change in Medicare Status.** You must provide a copy of your and/or your Dependent's Medicare card to your HPR when a change in Medicare status occurs.

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

If You Live or Spend Time Outside Illinois

Members who move out of state or the country will most likely need to enroll in the Local Care Health Plan (LCHP). For those in certain areas contiguous to the State of Illinois, some managed care health plan options may be available. Refer to the current Benefit Choice Options booklet or contact the managed care health plan directly for information on plans available. Changing your address does not automatically change your health plan.

Penalty for Fraud

Falsifying information/documentation in order to obtain/continue coverage under the Plan is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, expenses incurred by the Plan.

Notes

Information for Annuitants and Survivors

Annuitants and Survivors who are receiving pension benefits from their unit's retirement system may be eligible to participate in the Local Government Health Plan (Plan). See the Eligibility Requirements section in this Chapter or contact your employing unit for information.

Coverage Options

Annuitants and Survivors have the same health, dental and vision benefit options as active Employees, including the same annual Benefit Choice Period. See the Enrollment section in this Chapter for specific coverage options.

Upon retirement, Plan Participants not wishing to participate in the Plan may elect to:

- Waive coverage and/or become a Dependent of a Spouse with coverage through the Plan.

NOTE: Plan Participants electing to waive coverage upon retirement cannot re-enroll in the Plan.

If You Live or Spend Time Outside Illinois

Annuitants and Survivors who move out of state or the country will most likely need to enroll in the Local Care Health Plan (LCHP). For those in certain areas contiguous to the State of Illinois, some managed care health plan options may be available. Refer to the current Benefit Choice Options booklet or contact the managed care health plan directly for information on plans available. Changing your address does not automatically change your health plan.

ID Cards

Annuitants who elect a different health carrier at the time of enrollment or upon experiencing a break in coverage will receive a new health ID Card from the appropriate Plan Administrator.

Power of Attorney

Annuitants and Survivors should consider having a Power of Attorney on file with the employing unit. A Power of Attorney is considered a representative to act on the member's behalf.

Medicare

Refer to the Medicare section in Chapter 2 for important information regarding Medicare.

Survivors

Contact the employing unit immediately upon becoming a Survivor to determine eligibility and begin the application process.

Notes

This section contains benefit eligibility information which applies to all **health, dental and vision** plans.

Eligibility Requirements

Eligibility is defined by the State Employees Group Insurance Act of 1971 (Act) (5 ILCS 375/1 et seq.) or as hereafter amended and by such policies, rules and regulations as shall be promulgated thereunder.

Eligible As Members

Employees

- **In order to be eligible as an Employee, the following criteria must be met:**
 - Eligible to participate in an employer sponsored retirement system.
 - Receive compensation from the unit in order to participate in the Plan.
 - Receive benefits comparable to others in the same unit.
- **Full-time Employees** - Participation is required under the Local Government Health Plan.
 - **Employees of the Unit** - Full-time employees who work more than 90% of the unit's normal work period must be enrolled in the Plan, or attest to Dependent coverage under a Spouse enrolled in the Plan or another group plan.
- **Part-time Employees** - Part-time employees who work 50% to 90% of the unit's normal work period may enroll in the Plan if the unit allows part-time Employee participation.
- **Others considered as eligible Employees are:**
 - Elected officials and the employees under

their jurisdiction who meet the standards as Employees.

- 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.
- Persons on approved leaves of absence.

COBRA Participants

Qualified individuals (see COBRA - Continuation of Coverage in this chapter for eligibility requirements) who elect to participate in the health, dental and vision plans under the Plan in accordance with the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

Annuitants

Annuitants are eligible as Members on the effective date of the commencement of their retirement or annuity benefits, or the first of the month following their application for retirement, **whichever is later**. Annuitants must satisfy the minimum vesting requirements of the appropriate retirement system sponsored by the unit and receive pension benefits from the unit's retirement system to be eligible as Members. Annuitants should contact their unit and confirm, prior to actual retirement, that they will be eligible for continuation of coverage.

Survivors

A Spouse or child(ren) of the deceased Member who is certified as eligible to receive an annuity from the unit's retirement system as a result of the death of a Member in one of the above categories.

Ineligible As Members

- Employees who work less than 50% of a normal work period, measured yearly.
- Contractual employees.
- Temporary employees.
- Employees who are ineligible to participate in and contribute to the employing unit's retirement systems.

Eligible As Dependents

Eligible Dependents of a Member participate in the same health, dental and vision plans as the Member. Eligible Dependents of the Member include:

- **Spouse** (does not include ex-spouses, common-law spouses or those not legally married).
- **Unmarried child from birth to age 19, including:**
 - Natural child.
 - Adopted child.
 - Stepchild who lives with the Member in a parent-child relationship at least 50% of the time.
 - Child for whom Member has permanent legal guardianship.

At age 19, an unmarried child may only continue eligibility under one of the following options: Full-time student, handicapped or other.

- **Unmarried child age 19 to 23 who meets ALL of the following conditions:**

- 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.
- **Unmarried child age 19 to 25 who meets ALL of the following conditions qualifies for additional eligibility equal to the amount of time spent in the U.S. Armed Services, including National Guard, up to a maximum age of 25:**
 - Member of the U.S. Armed Services, including National Guard, on or after January 1, 2002.
 - 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.
- **Unmarried child age 19 and older who is mentally or physically handicapped and meets ALL of the following conditions:**
 - Financially dependent upon the Member.
 - Eligible to be claimed as a Dependent for income tax purposes by the Member.
 - Continuously disabled as determined by the Social Security Administration from a cause originating prior to age 19 (age 23 if enrolled as a full time student).
- **Other Dependents** - A Dependent who has received an Organ Transplant after June 30, 2000, and is financially dependent upon the Member and eligible to be claimed as a Dependent for income tax purposes by the Member.

Recertification of Dependent Coverage

NOTE: Dependents of COBRA participants must also recertify eligibility for coverage.

Birth Date Recertification - Members must verify continued eligibility for Dependents turning age 19 or 23. Members with Dependents turning age 19 or 23 will receive notification from the Department several weeks prior to the birth month that the Dependent must be recertified in order to continue coverage. The Member must provide the required documentation to the Department prior to the Dependent's birth date. Failure to recertify the Dependent's eligibility will result in the Dependent's coverage being terminated effective the end of the birth month.

Student Category - The Plan requires Members to recertify continued eligibility for Dependents age 19 or older enrolled as full-time students. Recertifications are required twice per year, in the fall and in the spring. Failure to recertify a Dependent will result in the Dependent's coverage being terminated.

Handicapped and Other Dependent Categories - Annual recertification of Dependents age 19 or older enrolled in the Handicapped or Other categories as defined in the Enrollment section of this chapter is required. Failure to recertify a Dependent will result in the Dependent's coverage being terminated.

Reinstatement - If coverage for the Dependent is terminated for failure to recertify and the Member provides the required documentation within 30 days from the date the termination is processed, coverage will be reinstated retroactive to the date of termination. If the documentation is not provided within the 30-day period, coverage will be reinstated effective the date of request, but not retroactive to the date of termination.

Contact your HPR for questions regarding recertification of a Dependent.

Notes

Enrollment Periods

Members may enroll or change benefit selections with supporting documentation (see Documentation Requirements chart in this chapter) during the following periods:

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

Initial Enrollment

A “new” Member is one who has not previously been enrolled in the Local Government Health Plan (Plan) or one who has had greater than a 10-day break in coverage. Members with a break in coverage of less than 10 days must be re-enrolled with the same coverage they had in effect prior to the break in coverage.

Members have 10 calendar days from their initial eligibility date to make health, dental and vision insurance coverage elections. All Members, including part-time Employees, who fail to make benefit elections (including the election of Dependent coverage), within the 10-day initial eligibility period must wait for the next Benefit Choice period or Qualifying Event, to enroll.

Members must provide a Social Security Number to enroll in the Plan.

New Members have the following options:

- Elect a health plan.
- Enroll eligible Dependents.

Dependents must be enrolled within 10 calendar

days of the Member’s eligibility date.

Documentation is required for Dependent coverage and must be provided within 15 days of the eligibility date. If the documentation is not provided within 15 days, the coverage will be defaulted to Member-only coverage. See the Documentation Requirements and Time Limits charts in this chapter for specific requirements.

Effective Date of Coverage:

- Coverage for new Employees becomes effective 12:01 A.M. on the date of eligibility.
- Coverage for Annuitants becomes effective the first day of the month following their application for annuity or the effective date of the annuity, **whichever is later**.

Annual Benefit Choice Period

The Benefit Choice Period is normally held annually May 1st through May 31st. During this 31-day period, Members may change their coverage elections. All health changes become effective July 1st.

Documentation is required when adding Dependent coverage. See Documentation Requirements chart later in this chapter.

Plan Participants may make the following changes during the annual Benefit Choice Period:

- Change health plans.
- Add or drop Dependent coverages.

Qualifying Change in Status

Pursuant to Section 125 of the Internal Revenue Code, your premiums for health and dental

coverage may be tax exempt. The tax exemption applies only to premiums that are payroll deducted. The Internal Revenue Code requires units that provide the tax-exempt premium to prohibit changes in the Member's deduction during the plan year unless there is a Qualifying Change in Status. This is referred to as the Irrevocability Rule. See the section in this Chapter entitled Enrollment Periods. If the unit is not in compliance with the Irrevocability Rule, the unit 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 or dropping Dependents from the health coverage.

Consistency Rule

Federal regulations require that all mid-year changes in coverage be consistent with the Qualifying Change in Status event the Member experiences.

Qualifying Change in Status events include, but are not limited to:

- Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation or annulment.
- Events that change an Employee's number of Dependents, including birth, death, adoption or placement for adoption.
- Events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent. Events include termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite or change in the individual's

employment when they cease to be eligible for the Plan.

- Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage based on age, student status, marital status or any similar circumstance.
- A change of residence for the Employee, Spouse or Dependent.

Members experiencing a Qualifying Change in Status have 60 days to change certain benefit selections. Members must submit proper supporting documentation to their Health Plan Representative (HPR) within the 60-day period in order for the change to become effective. See Effective Dates later in this section.

See the Qualifying Changes in Status chart in this chapter for a complete list of qualifying changes and corresponding options.

Changes in Dependent health coverage in the two-or-more Dependent category not affecting the premium may be made at any time.

Effective Dates

Health, dental and vision coverage changes are effective the later of:

- The date the request for change was signed.
- The date the event occurred.

There are exceptions to the effective dates for newborns and adopted children. If the request for change is made within 60 days, coverage may be retroactive to the date of birth or placement for adoption.

Pre-existing Conditions and Creditable Coverage

New Members and new Dependents (excluding newborns and adoptees) are subject to possible health benefit limitations based on Pre-existing Conditions. 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 Plan. No benefits are payable for any services relating to the Pre-existing Conditions that are incurred during the first six months of a new Member or Dependent coverage. After the initial six months, the Pre-existing Condition exclusion no longer applies, even if the Member changes from one plan to another.

The Pre-existing Condition time period may be reduced by the amount of coverage Members or Dependents had with another insurance plan prior to enrollment with one of the unit's plans, provided there was not a break in coverage of more than 63 days. This is called Creditable Coverage. A Certificate of Creditable Coverage from the prior plan must be provided to the employing unit to reduce the Pre-existing Condition time period. In the Health Insurance Portability and Accountability Act (HIPAA), federal law requires all health insurance plans to provide Certificates of Creditable Coverage upon termination from a plan.

HIPAA also provides that coverage for newborn children and adopted children is not subject to Pre-existing Condition limitations. Pregnancy is not subject to Pre-existing Condition exclusions. 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.

When Both Spouses are Members

When both spouses are Members, the following applies:

- If a Spouse terminates eligibility as an Employee, that Spouse may be enrolled as a Dependent of the other Member. If requested within 10 days of termination, no break in coverage occurs.

Dependent Enrollment:

- The Member and all Dependents enrolled under that Member must be in the same health Plan.
- The same Dependent cannot be enrolled under both Members.
- Not all Dependents are required to be enrolled under the same Member.

Dependent Enrollment

Members must contact their HPR to obtain the required enrollment forms. Documentation is always required to enroll Dependents (see Documentation Requirements chart later in this chapter). Failure to provide the required documentation in a timely manner will result in denial of Dependent coverage. However, the eligible Dependent may be added during the next Benefit Choice Period or upon the Member experiencing a Qualifying Change in Status.

Unmarried Children 18 and Under

Natural Children are not required to live with the Member to be eligible. These Dependents may be enrolled if the request is received within 60 days of the qualifying event. A copy of the birth certificate is required. If the Member is not listed on the birth certificate, a copy of the Public Aid order or court order establishing a **Member's** financial responsibility for the child's medical, dental or other

health care is required.

Newborn Dependents may be enrolled if the request to add the child is received within 60 days of birth. The effective date of coverage may be retroactive to the date of birth.

Stepchildren must live with the Member in a parent-child relationship at least 50% of the time in order to be eligible. These Dependents may be enrolled if the request is received within 60 days of the qualifying event.

Documentation required to enroll a stepchild is proof/evidence the child resides with the Member (e.g., copies of records, such as school, child care, social services or medical, etc.), **and** a birth certificate indicating that the Member's Spouse is the child's natural parent, **and** a marriage certificate indicating the child's parent is the Member's current Spouse.

Adopted newborns may be enrolled if the request is received within 60 days of birth. The effective date of coverage may be retroactive to the date of birth. A copy of the petition or court order is required. If the court order is from a foreign court, a copy of the translation must accompany the document.

Adopted children, other than newborns, may be enrolled if the request is received within 60 days of the final court order or filing of the petition for adoption. Coverage may be effective the date of the placement, or the date of the filing of the petition. A copy of the petition or court order is required. If the court order is from a foreign court, a copy of the translation must accompany the document.

Children for whom the Member has legal custody or permanent guardianship and who live with the Member in a parent-child relationship may be enrolled if the request is received within

60 days of the judge's signature date on the court order awarding custody or establishing permanent guardianship. A copy of the court order is required.

Dependents Age 19 and Older

Dependents age 19 and older may be eligible for health, dental and vision insurance coverage provided they meet the eligibility requirements.

These Dependents must be:

- eligible to be claimed for income tax purposes by the Member, **and**
- financially dependent upon the Member.

The Member must provide a completed Dependent Coverage Certification Statement (CMS-138), as well as the appropriate supporting documentation, to enroll a Dependent age 19 or older in one of the following categories:

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

Dependents turning age 19 in June, July or August may continue coverage during the summer months if the Dependent intends to enroll as a full-time student during the Fall semester. The Member must complete the "turning age 19" Dependent Certification Statement attesting to the intent to enroll in the Fall. The Dependent will then be required to verify enrollment during the Fall re-certification period.

Military Student: Unmarried Dependents, up to, but not including age 25, may qualify for additional eligibility equal to the amount of time spent in the U.S. Armed Services, including the National Guard, on or after January 1, 2002. The Military Student must provide verification of military time served, verification of full-time Military Student status in an accredited school, or, if enrolling the following semester, a letter from the Member advising of the Military Student's "intent to enroll."

Handicapped: Unmarried Dependents may be enrolled if they have been continuously disabled from a cause originating prior to age 19 (age 23 if enrolled as a full-time student). Initial enrollment in the Handicapped category requires a diagnosis from a physician with an ICD-9 diagnosis code, a letter from the doctor detailing the Dependent's limitations, capabilities and onset of condition, and either a disability statement from the Social Security Administration or a court order adjudicating the disability.

Other Dependents: Dependents, age 19 and older, may be enrolled with proof the Dependent has received an organ transplant after June 30, 2000.

Penalty for Fraud

Falsifying information/documentation in order to obtain/continue coverage under the Plan is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, expenses incurred by the Plan.

The Internal Revenue Code requires Units that provide the tax-exempt premium to prohibit changes to the Member’s deductions during the Plan Year unless there is a Qualifying Change in Status. The notations on the charts indicate the changes Members are allowed to make which are consistent with a Qualifying Change in Status.

Member Qualifying Changes in Status							
Changes affecting the Member	Corresponding HEALTH & DENTAL Options						
	Enroll or Re-Enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dependent Coverage (other than Spouse)	Terminate Spouse Coverage	Change Health Carrier
Adoption (or placement for adoption)		X					
Birth of Child		X					
Custody awarded and requires Dependent coverage (court ordered)		X	X				
Custody loss (court ordered) / Court order expires					X		
Divorce / Legal separation / Annulment	X				X	X	
Eligibility: Member loses eligibility (for other than non-payment of premium) of non-LGHP group insurance coverage	X						
Employment Status: Full-time to part-time (part-time = 50% or greater)					X	X	
Employment Status: Part-time to full-time			X	X			
Initial enrollment - within 10 days	X		X	X			
Leave of Absence: Member entering non-pay status					X	X	
Leave of Absence: Member returns to work from non-pay status	X		X	X			
Marriage	X	X		X			
Medicaid or Medicare eligibility gained					X	X	
Medicaid or Medicare eligibility lost	X		X	X			
Military Call-up: Member called-up by executive order					X	X	X
Military Call-up: Member returns to work	X		X	X			X
PCP leaves network							X
Premium increase 30% or greater: Employee's non-LGHP health insurance	X		X	X			
Premium increase 30% or greater: Member's LGHP health insurance					X	X	
Residence/Work location: Member's county changes							X
Retirement			X	X	X	X	X

X = Eligible changes for all Members.

Newly Acquired Child = A child for which the Member gained custody within the previous 60 day period, such as a new stepchild or a child for which the Member gained court-ordered guardianship.

Existing Child = A child for which the Member has custody prior to the previous 60 day period, such as a natural or adopted child, stepchild or a child for which the Member is guardian.

Spouse Qualifying Changes in Status							
Changes affecting the Spouse	Corresponding HEALTH & DENTAL Options						
	Member may Enroll or Re-enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dependent Coverage (other than Spouse)	Terminate Spouse Coverage	Change Health Carrier
Coordination of Spouse's open enrollment period	X		X	X	X	X	
Death of Spouse	X					X	
Eligibility: Spouse loses eligibility for group insurance coverage	X		X	X			
Eligibility: Spouse now provided with group insurance coverage					X	X	
Employment Status: Spouse gains employment					X	X	
Employment Status: Spouse loses employment	X		X	X			
Medicare eligibility: Spouse gains						X	
Medicare eligibility: Spouse loses				X			
Premium of Spouse's employer increases 30% or greater, or Spouse's employer significantly decreases coverage	X		X	X			
Residence/Work location: Spouse's county changes							X

Dependent (other than Spouse) Qualifying Changes in Status							
Changes affecting a Dependent (other than Spouse)	Corresponding HEALTH and DENTAL Options						
	Member may Enroll or Re-Enroll in the Program	Add Newly Acquired Child	Add Existing Child	Add Spouse	Terminate Dependent Coverage (other than Spouse)	Terminate Spouse Coverage	Change Health Carrier
Death of Dependent					X		
Eligibility: Dependent becomes eligible for LGHP group coverage			X				
Eligibility: Dependent loses eligibility for non-LGHP group coverage			X				
Eligibility: Dependent now eligible for non-LGHP group coverage					X		
Medicare eligibility: Dependent gains					X		
Medicare eligibility: Dependent loses			X				
Residence/Work location: Dependent's county changes							X

Documentation Requirements	
Adding Dependent Coverage	
Type of Dependent	Supporting Documentation Required
Dependent Spouse	Marriage Certificate or tax return which indicates the Spouse's name.
Natural Child Birth up to, but not including, age 19	Birth Certificate required, ~ OR ~ Court Order establishing a Member's financial responsibility for the child's medical, dental or other health care, ~ OR ~ Copy of Public Aid Order with the page of the document which has an 'X' indicating that the Member must provide health insurance through the employer.
Adoption or placement for adoption Birth up to, but not including, age 19	Adoption Decree/Order with judge's signature and circuit clerk's file stamp, ~ OR ~ Petition for Adoption with the circuit clerk's file stamp.
Handicapped child Child age 19 or over	Birth Certificate required, ~ AND ~ Letter from licensed physician detailing the Dependent's limitations, ICD-9 diagnosis code, capabilities, date of onset of condition and a statement from the Social Security Administration with the Social Security disability determination, ~ AND ~ Dependent Recertification form (CMS-138).
Stepchild Birth up to, but not including, age 19	Birth Certificate required, ~ AND ~ Marriage Certificate indicating the Member is married to the child's parent, ~ AND ~ Proof of the child's primary residence, such as school records or other documentation verifying the child's address is the same as the Member's address.
Student Child age 19 up to, but not including, age 23	Birth Certificate required, ~ AND ~ Documentation indicating the student is enrolled full time at an accredited school, ~ AND ~ Dependent Recertification form (CMS-138).
Military Student Child age 19 up to, but not including, age 25	Verification of Military time served, documentation indicating student is enrolled full-time at an accredited school, or letter from Member advising of intent to enroll the following semester, ~ AND ~ Dependent Recertification form (CMS-138).
Other Dependent who has received an organ transplant after 6/30/00.	Member's tax return, or other documentation proving financial dependency, ~ AND ~ Dependent Recertification form (CMS-138), proof of transplant.
Note: Birth Certificate from either the State or admitting hospital which indicates the Member is the parent is acceptable.	

Documentation Requirements	
Terminating Dependent Coverage	
Qualifying Event	Supporting Documentation Required
Divorce	Divorce Order filed in a Court – first and last pages with judge’s signature and circuit clerk’s file stamp.
Legal separation or annulment	Court Order with judge’s signature and circuit clerk’s file stamp.
Loss of court-ordered custody	Court Order indicating the Member no longer has custody of the Dependent. The Order must have judge’s signature and circuit clerk’s file stamp.
Dependent becomes ineligible for Group Insurance coverage	Email or signed memorandum from the Member indicating the Dependent’s name, the reason for the termination and the effective date of the termination.
<p>Penalty for Fraud: Falsifying information/documentation in order to obtain/continue coverage under the Plan is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, expenses incurred by the Plan.</p>	

Documentation Time Limits			
<p>Dependent coverage may be added with the corresponding effective date when documentation is provided to your HPR within the allowable time frame as indicated below. If documentation is provided outside the time frames, adding Dependent coverage will not be allowed until the annual Benefit Choice Period or if the Member experiences a Qualifying Change in Status.</p>			
When adding Dependent coverage DUE TO or DURING the:	Dependent coverage will be effective...	IF the coverage is requested...	AND the documentation is provided...
Initial Enrollment Period	Date of eligibility	Day 1–10 after eligibility date	1–15 days after eligibility date
Annual Benefit Choice Period (normally held May 1 – May 31 each year)	July 1st	During Benefit Choice election period	Within 10 days of the Benefit Choice election period ending
Qualifying Change in Status (Exception for birth or adoption – noted below)	Date of the event	Before, or the day of, the event	1– 60 days after the event
	Date of the request	Day 1 – 60 after event	
Birth of Child (Natural or Adopted)	Date of birth	From birth up to 60 days after the birth	From birth to 60 days after the birth
Adopted Children (Other than newborn)	Date of placement of the child or the filing of the petition	Within 60 days of the event	Within 60 days of the event

Notes

Termination of Coverage

This section describes the events and timing of the termination of benefits. In some cases, health, dental and vision insurance coverage can be continued under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Termination of Member Coverage

A Member's coverage terminates at midnight on the date of:

- Termination of employment (e.g., not increased by any type of lump sum payment).
- Change from full-time employment to less than 50% part-time employment.
- Death.
- The end of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid (COBRA ineligible).

Termination of Dependent Coverage

An enrolled Dependent's coverage terminates at midnight:

- Simultaneous with termination of Member's coverage.
- On the last day of the month in which a Dependent loses eligibility.
- On the requested date of a voluntary termination of a coverage in the two or more Dependent category that does not affect premiums (COBRA ineligible).
- On the last day of the month of graduation, cessation of studies or attainment of age 23 (or attainment of age 25 for military student), whichever is earlier.

- On the last day of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid (COBRA ineligible).
- On the date of death.
- On the last day of the month the Dependent child becomes 19 years of age, unless the Dependent qualifies for the Student, Handicapped or Other category.
- The day preceding:
 - Entrance into military service.
 - Enrollment in the Plan as a Member.
 - Marriage of the Dependent.
 - Divorce from the Member.

NOTE: Members who fail to notify their HPR within 60 days of Dependent ineligibility will not receive a premium refund and could potentially lose COBRA coverage. (Effective February 1, 2006).

Notes

COBRA - Continuation of Benefits

Overview

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides eligible covered Members and their eligible Dependents the opportunity to **temporarily** extend their health coverage when coverage under the health plan would otherwise end due to certain qualifying events. COBRA rights are restricted to certain conditions under which coverage is lost, and the election to continue coverage must be made within a specified election period. If COBRA continuation of coverage is elected, coverage is reinstated retroactive to 12:01 A.M. the date following termination of coverage.

NOTE: Not all units are required to offer COBRA coverage. Contact your HPR for coverage information.

General Provisions

Continuation coverage for COBRA qualified beneficiaries is identical to the coverage provided to active Members.

- COBRA participants may change carriers during the annual Benefit Choice Period or within 60 days of a Qualified Change in Status.
- Qualified beneficiaries electing continuation in their own right are enrolled in COBRA under their own Social Security number.
- The pre-existing conditions limitation does not apply to individuals electing COBRA, unless there is a break in coverage of at least 63 days or they have not previously met the pre-existing period.

COBRA Notifications and Enrollment

Notification of Eligibility After a Qualifying Event

The member or qualified beneficiary must notify the Health Plan Representative within 60 days of the date of the event or the date on which coverage would end, whichever is earlier.

Conversion Privilege for Health Coverage

When COBRA coverage terminates, Members may have the right to convert to an individual health plan without providing Evidence of Insurability. This conversion privilege applies to health coverage only. Members are eligible for this conversion unless group health coverage ended because of:

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

To be eligible for conversion, Members must have been covered by the current COBRA health plan for at least 3 months and requested conversion within 31 days of exhaustion of COBRA coverage. The converted coverage, if issued, will become effective the day after COBRA coverage ended. Contact the appropriate Health Plan Administrator for information on COBRA conversion. The Local Government Health Plan is not involved in the administration or premium rate structure of insurance benefits obtained through conversion.

Notes

Chapter 2

Health, Dental and Vision: Options and Plan Information

SECTION	PAGE
Health Plan Options	33
Local Care Health Plan (LCHP)	37
◆ Plan Year Deductibles and Out-of-Pocket Maximums	43
◆ Medical Benefits Summary	45
◆ Preventive Services	57
◆ Prescription Drug Plan	61
◆ Behavioral Health Services	65
◆ Exclusions and Limitations	69
◆ Claim Filing Deadlines and Procedures	73
Local Care Dental Plan (LCDP)	75
◆ Exclusions and Limitations	77
◆ Claim Filing Deadlines and Procedures	79
Vision Plan	81
Coordination of Benefits	83
Medicare	85
Smoking Cessation Program	89
Subrogation and Reimbursement	91
Claim Appeal Process	93

Notes

Overview

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

Each plan provides medical and behavioral health benefits as well as prescription drugs. However, the Covered Services, benefit levels and exclusions and limitations differ. In making choices, consider the following: health status, coverage needs and service preferences. Dependents have the same health and dental plan as the Member under whom they are enrolled.

Types of Health Plans

There are three types of health plans available:

- Health Maintenance Organizations (HMOs).
- Open Access Plan (OAP).
- Indemnity Plan –
Local Care Health Plan (LCHP).

Managed Care Health Plans

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

Members who enroll in a managed care health plan must select a Primary Care Physician or Provider (PCP) from the managed care health plan

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

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

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

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

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

There may be managed care health plans that are self insured and administered by the State of Illinois, meaning all claims are paid by the Local Government Health Plan even though managed care health plan benefits apply. The plans are not regulated by the Illinois Department of Financial and Professional Regulation, Division of Insurance and are not governed by the Employees Retirement Income Security Act (ERISA).

In order to have the most detailed information regarding a particular managed care health plan,

you may ask to receive a plan's Summary Plan Description (SPD) which describes the Covered Services, benefits levels and exclusions and limitations of the plan's coverage. The SPD may also be referred to as the Certificate of Coverage or the Summary Plan Document.

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

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

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

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

Health Maintenance Organization (HMO)

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

HMOs are restricted to operating only in certain counties and zip codes called service areas.

There is no coverage outside these service areas unless pre-approved by the HMO. When traveling outside of the health plan's service area, coverage is limited to life-threatening emergency services. For specific information regarding out-of-area services or emergencies, call the HMO.

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

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

Open Access Plan (OAP)

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

The OAP allows Plan Participants to mix and match Providers. For example, the Plan Participant can utilize a Tier II Physician and receive care at a Tier I hospital. The OAP Plan Administrator can provide a directory that contains

listings of the Tier I and Tier II networks. The benefit level for services rendered will be the highest if selecting Tier I Providers.

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

The Indemnity Plan - Local Care Health Plan (LCHP)

The Local Care Health Plan (LCHP) is the self-insured indemnity health plan that offers a comprehensive range of benefits. Under the LCHP, Plan Participants are free to utilize any Provider (Physician, specialist or Hospital) of their choice. Benefit enhancements are available by utilizing:

- Preferred Provider Organization (PPO) Hospitals for Inpatient and Outpatient Services.
- The indemnity Health Plan Administrator's nationwide Physician and Hospital network.
- Pharmacy network.
- Behavioral health benefits, through the Behavioral Health Plan Administrator.
- Transplant PPO (TPPO) network.

Notes

Overview

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

Plan Components

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

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

Plan Features

Plan Participant Responsibilities

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

- Any penalties for failure to comply with the **Notification requirements**.
- Any charges NOT covered by the Plan or determined by the Plan Administrator to not be **medically necessary** services.

Plan Year Deductible

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

The Plan Year begins on July 1.

Special Deductibles

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

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

Coinsurance

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

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

Annual Out-of-Pocket Maximum Expenses

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

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

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

Eligible Charges

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

Medical Necessity

- **LCHP covers charges for services and supplies that are medically necessary. Medically necessary services or supplies are those which are:**
 - Provided by a Hospital, medical facility or prescribed by a Physician or other Provider and are required to identify and/or treat an illness or injury.
 - Consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
 - Generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.

- The most appropriate supply or level of service which can be safely provided to the patient.
- Not solely for the convenience of the patient, Physician, Hospital or other Provider.
- Repeated only as indicated as medically appropriate.
- Not redundant when combined with other treatment being rendered.

Pre-Determination of Benefits

Pre-determination is a method to ensure that medical services/stays will meet Medical Necessity criteria and be eligible for benefit coverage.

The Plan Participant's Physician must submit written detailed medical information to the Medical Plan Administrator. For questions regarding a pre-determination of benefits, contact the Plan Administrator.

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

Usual and Customary (U&C) Charges

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

The Plan Participant is responsible for the portion

of the expense that is above U&C. Amounts in excess of U&C are not Eligible Charges and are not applicable to Plan Year Deductible or Out-of-Pocket Maximums.

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

Preferred Provider Organization (PPO) Network

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

Exceptions to the PPO Hospital Network

If a Plan Participant resides within 25 miles of a PPO Hospital, but requires emergency or specialized care not available at the PPO facility, an exception to the non-PPO rate of 65% may be requested. Upon request, the Notification Administrator will evaluate the case, and when appropriate, authorize an exception to utilize a non-PPO Hospital. When an exception is granted, the benefit is 80% of U&C. If an exception is not granted, the non-PPO benefit level of 65% of U&C applies.

If a Plan Participant voluntarily chooses to travel more than 25 miles and a PPO Hospital is available within the same travel distance, a PPO Hospital must be used or the 65% benefit level will apply.

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

Medical Case Management

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

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

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

Upon completing the MCM review, the case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. **Refusal to participate in the MCM Program will result in a reduction of benefits available under the LCHP for treatment of the illness for which the Plan Participant was referred to MCM.**

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

Notification Requirements

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

Notification is required for all Plan Participants including those with Medicare or other insurance as primary payer. Failure to notify the Plan within the required time limits will result in a **financial penalty** and the risk of incurring non-covered charges for services not deemed to be medically necessary.

Notification is the Plan Participant's responsibility. Whenever possible, the Plan Participant should make the initial telephone call to the Notification Administrator, rather than relying on the Facility/Provider or someone else.

- The Notification Administrator will need the following information:
 - Patient's name, address and date of birth.
 - Member's name, address and Social Security Number or alternate Member identifier.
 - Date of Admission, if known, or expected due date for maternity Admission.
 - Diagnosis or procedure.
 - Physician's name, address and telephone number (including area code).
 - Hospital or extended care facility name, address and telephone number (including area code).

A "reference number" will be assigned and should be maintained in the Plan Participant's records. This number serves as a resource should there be any questions regarding Notification.

The Notification Administrator maintains detailed records on every call when the Plan Participant's enrollment status is verified.

After Notification, a medically qualified reviewer will contact the Plan Participant's Physician or Provider to obtain specific medical information, evaluate the setting and anticipated initial length of stay for medical appropriateness and determine whether a second opinion is required.

■ **Notification is required for the following:**

– **Outpatient Surgery & Procedures**

At least seven days before the surgery, the Plan Participant must call the Notification Administrator. Sometimes a second opinion will be required to obtain full benefits under the Plan. Call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), colonoscopy and endoscopy services.

– **Any Elective Inpatient Surgery or Non-Emergency Admission**

At least seven days before Admission, call the Notification Administrator. The Admission and length of stay must be authorized before entering the facility. A second opinion may be required to obtain full benefits under the Plan.

– **Maternity**

It is recommended that the Notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. **Notification of a maternity Admission is not automatic enrollment of the newborn.** Contact your HPR to enroll the newborn.

- **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission**
At least seven days before Admission, call the Notification Administrator. A review of the care being rendered will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission**
The Plan Participant or Physician must phone the Notification Administrator within two business days after the Admission.
- **Hospice Admission**
Plan Participant or Physician must phone the Notification Administrator prior to the Admission.
- **Potential Transplants**
Potential transplant candidates should provide Notification at the first indication of their status to receive benefits under the Plan. Benefits are only available through the LCHP Transplant PPO (TPPO) network of Hospitals/facilities.

■ **Notification is *Not*:**

- **A final determination of Medical Necessity.** Health conditions and need for treatment can change quickly. If the Notification Administrator should determine that the setting and/or anticipated length of stay are no longer Medically Necessary and **NOT** eligible for coverage, the Physician will be informed immediately. The Plan Participant will also receive written confirmation of this determination.
- **A guarantee of benefits.** Regardless of Notification of a procedure or Admission, there will be no benefit payment if the Plan Participant is ineligible for coverage on the date services were rendered or if the charges were ineligible.

- **Enrollment of a newborn for coverage.** Contact your HPR to enroll a newborn within 60 days of birth.
- **Notification of a maternity Admission does not mean the newborn is automatically enrolled in the Program.**
- **A determination of the amount which will be paid for a Covered Service.** Benefits are based upon the Plan Participant's eligibility status and the Plan provisions in effect at the time the services are provided.

Contact information for the Notification Administrator can be found in the Plan Administrator section of the current Benefit Choice Options booklet. The toll-free number is also printed on your identification card. You can call seven days a week, 24 hours a day.

NOTE: For Notification procedures and time limits for Behavioral Health Services, see the Behavioral Health Services section later in this chapter.

Benefits for Services Received While Outside The United States

The Plan covers Eligible Charges incurred outside of the United States for generally accepted medically necessary services usually rendered within the United States.

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

Payment for the services will most likely be required from the Member at the time of services. Plan Participants must file a Claim with the Plan Administrator for reimbursement. When filing a

Claim, enclose the itemized bill with a description of the services translated to English and the dollar amount converted to U.S. currency, along with the name of the patient, date of service, diagnosis, procedure code and the Provider's name, address and telephone number.

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

Hospital Bill Audit Program

The Hospital Bill Audit Program applies to non-PPO Hospital charges. The Program provides that if the Plan Participant should discover an error or overcharge on a 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 \$1,000 per Admission.

■ **Reimbursement documentation required:**

- Original incorrect bill.
- Corrected copy of the bill.
- Member's name and telephone number.

Submit Documentation to:

**Hospital Bill Audit Program
Department of Central Management
Services (DCMS)
Group Insurance Division
201 E. Madison St.
P.O. Box 19208
Springfield, IL 62794-9208**

NOTE: PPO Hospital claims which are paid on a per diem basis are not eligible under the Hospital Bill Audit Program, as the Plan pays based on the negotiated rate, not on actual charges. Related bills such as radiologist, surgeon, etc., are not eligible under the Program.

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

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

LCHP Out-Of-Pocket Maximums	
There are two separate Out-of-Pocket Maximums: a general one and one for non-PPO charges. Coinsurance and Deductibles listed below count toward one or the other, but not both.	
General Out-of-Pocket Maximum: Per Plan Year, Per Individual Family maximum is 2.5 times the individual maximum	Non-PPO Out-of-Pocket Maximum: Per Plan Year, Per Individual Family maximum is 2 times the individual maximum
Plan Year Deductible	Non-PPO Hospital Deductible
Professional & Physician Coinsurance	Non-PPO Inpatient Coinsurance
PPO Inpatient and Outpatient Facility Coinsurance	Non-PPO Outpatient Facility Coinsurance
Ambulatory Surgical Facility	
Transplant Deductible	
Transplant Inpatient and Outpatient Coinsurance	
Standard* Hospital Coinsurance	
Standard* Hospital Admission Deductible	
All Emergency Room Deductibles	
* Applies when the Notification Administrator grants an exception for a non-PPO Admission, or when the Plan Participant does not reside within 25 miles of a PPO Hospital.	
The following do NOT apply toward Out-of-Pocket Maximums:	
<ul style="list-style-type: none"> ▪ Prescription Drug benefits or Copayments. ▪ Notification penalties. ▪ Ineligible charges (amounts over U&C and charges for non-covered services). ▪ After Medicare pays, LCHP pays (80%) of the balance after the LCHP Deductible. 	

Notes

LCHP - Medical Benefits Summary

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

Acupuncture

- 80% of U&C for treatment of diagnosed Chronic Pain with a written referral from a Physician or dentist. Coverage is subject to frequency limitations.
- Must be performed by a licensed Physician trained in acupuncture or a licensed acupuncturist.

Allergy Injections

- Allergy testing is paid at 100% of U&C.
- 80% of U&C for injections and serum, provided the person has had recognized allergy testing to determine hypersensitivity and the need to be desensitized.

Ambulance

- 80% of U&C for transportation charges to the nearest Hospital/facility for emergency medically necessary services for a patient whose condition warrants such service. The Plan Administrator should be notified as soon as possible for a determination of coverage.
- Transportation Services Eligible for Coverage:
 - From the site of the disabling illness, injury, accident or trauma to the nearest Hospital qualified to provide treatment (includes air ambulance when medically necessary).
 - From a remote area, by air, land or water (inside or outside the United States), to

the nearest Hospital qualified to provide emergency medical treatment.

- From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest Hospital equipped to treat the injury, trauma or illness.
- Transportation exclusions include, but are not limited to:
 - Transportation that is not medically necessary.
 - Transportation between health care facilities for preference or convenience.
 - Transportation of patient for office or other outpatient visit.

Blood/Blood Plasma

- 80% of charges for blood and blood plasma in excess of the first 3 pints in a Plan Year.

Breast Implant Removal and Reimplantation

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

Breast Reconstruction Following Mastectomy

- The Plan provides coverage, subject to and consistent with all other Plan provisions, for services following a mastectomy, including:
 - Reconstruction of the breast (including implants) on which the mastectomy was performed.
 - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a Provider covered under the Plan.
- Two mastectomy bras are covered at 80% of U&C following surgery or a change in prosthesis.

Cardiac Rehabilitation

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

Chiropractic Services

- 80% of U&C.
- No coverage for chiropractic services considered to be maintenance in nature, in that medical information does not document progress in the improvement of the condition.
- Effective July 1, 2006, the Plan will cover a maximum of 30 visits per Plan Year.

Christian Science Practitioner

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

Circumcision

- 80% of U&C for professional services.
- Charges for circumcision are considered to be Covered Services, when billed as a separate Claim for the newborn, if performed within the first thirty (30) days following birth and if the newborn is enrolled in the Plan.
- Charges for circumcision performed beyond the 30-day time frame are considered to be Covered Services only when Medical Necessity is documented.

Colonoscopy and Sigmoidoscopy

- 80% of U&C and subject to Plan Deductible.
- Notification is required.

Dental Services

- **Accidental Injury:**
 - 80% of U&C for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within 3 months of original accidental injury. The appropriate facility benefit applies.
- **Non-Accidental:**
 - 80% of U&C for coverage limited to:
 - Anesthesia and facility charges for dependent children age six and under.
 - A medical condition that requires anesthesia and facility charges for dental care (not anxiety or behavioral related conditions). **Professional services are not covered under the medical indemnity plan.**
 - Chronic Disability

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- Dental exclusions include, but are not limited to:
 - Services and appliances related to the diagnosis or treatment of Temporomandibular Joint Disorder or Syndrome (TMJ) and other myofunctional disorders.
 - Internal accidental injury to the mouth caused by biting on a foreign object.
 - Outpatient Services for routine dental care.

Diabetic Coverage

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

Dialysis

- Hemodialysis and Peritoneal Dialysis.
- 80% of U&C.

Durable Medical Equipment (DME)

- **Short-term Rental:**
 - 80% of U&C up to the purchase price for items that temporarily assist an impaired person during recovery. Examples include canes, crutches, walkers, hospital beds and wheelchairs.
- **Purchase:**
 - 80% of U&C to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the

purchase price.

- DME exclusions include, but are not limited to:
 - Repairs or replacements due to negligence or loss of the item.
 - Newer or more efficient models.
 - Items viewed as convenience items such as exercise equipment and non-Hospital type adjustable beds.
 - Environmental items such as air conditioners, humidifiers, dehumidifiers or purifiers.
- DME is eligible for coverage when provided as the most appropriate and lowest cost alternative as required by the person's condition.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

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

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

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- **Physician's Office:**
 - 100% of U&C; no special emergency room Deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of Emergency Services presented above. Non-emergency medically necessary care is considered at 80% of U&C.
- **Urgent Care or Similar Facility:**
 - 100% of U&C; no special emergency room Deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of Emergency Services presented above. This benefit applies to professional fees only. If a facility fee is billed, the emergency room Deductible applies. Non-emergency medically necessary care is considered at 80% of U&C.

Eye Care

- 80% of U&C for treatment of injury or illness to eye.
 - First pair of eye glasses covered after cataract Surgery.
 - Routine eye exams/refraction are covered under the Vision Plan.

Foot Orthotics

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

Home Health Care Services

See Skilled Nursing Service - Home Setting

Hospice

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

Infertility Treatment

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

- Pre-determination of Benefits:
 - A written pre-determination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment to ensure optimum benefits. Documentation required from the Physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy and the proposed plan of treatment with Physicians' Current Procedural Terminology (CPT) codes.
- Infertility Benefits:
 - Coverage is provided only if the Plan Participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this Plan.

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- Coverage for Assisted Reproductive Procedures include, but is not limited to:
 - Artificial Insemination, In vitro Fertilization (IVF) and similar procedures which include but are not limited to: Gamete Intrafallopian Tube Transfer (GIFT), Low Tube Ovum Transfer (TET) and Uterine Embryo Lavage.
 - A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
 - A maximum of four (4) procedures per lifetime for any of the following: In vitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.
 - Eligible medical costs associated with sperm or egg donation by a person covered under the Plan may include, but are not limited to monitoring the cycle of a donor, and retrieval of an egg for the purpose of donating to a covered individual.
 - Benefit Level:
 - The appropriate benefit level will apply (i.e., Physician charges are covered at 80% of Eligible Charges; lab and x-ray are covered at 80% of Eligible Charges).
 - Infertility treatment exclusions include, but are not limited to:
 - Medical or non-medical costs of anyone NOT covered under the Plan.
 - Non-medical expenses of a sperm or egg donor covered under the Plan including, but not limited to transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryo-preservation and storage of sperm or embryo or fees payable to a donor.
 - Infertility treatment deemed experimental or unproven in nature.
 - Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization.
 - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a Plan Participant or not.
 - Pre-implantation genetic testing.
- Infusion Therapies**
- Coverage includes chemotherapy and other intravenous drugs/agents in a home or Physician office setting.
 - 80% of U&C.
 - Medical Necessity must be determined by the Medical Case Management (MCM) Administrator in order for therapy to be considered a covered expense.
 - Infusion therapy must be under the supervision of a Physician.
 - Covered expenses include, but are not limited to:
 - Medication and intravenous solution.
 - Equipment rental and supplies such as infusion sets, syringes and heparin.
- Inpatient Hospital/Facility Services**
- 90% at PPO Hospital/facility.
 - 80% of U&C if residence is not within 25 miles

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

of a PPO Hospital/facility, when approved by the Notification Administrator.

- 65% of U&C if residence is within 25 miles of a PPO Hospital but Plan Participant elects to use a non-PPO Hospital.
 - If residence is within 25 miles of a PPO Hospital, but emergency or specialized care is required which is not available at the PPO Hospital, an exception to the non-PPO rate of 65% may be requested. The Notification Administrator will evaluate the case and, when appropriate, may authorize an 80% of U&C benefit at a non-PPO Hospital.
 - 65% of U&C will apply if the Plan Participant voluntarily chooses to travel more than 25 miles and a PPO Hospital is available within the same travel distance.
- Inpatient hospitalization exclusions include, but are not limited to:
 - Holding charges (charges for days when the bed is not occupied by the patient).
 - Private room differential when private room is not medically necessary.
 - Nursing charges if billed separately.
 - Personal convenience items such as guest meals, television rental, admission kits and telephone charges.
 - Services not related to or necessary for the care and treatment of an illness or injury.

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

Lab and X-ray

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

Medical Supplies

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

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

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

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

Morbid Obesity Treatment

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

Newborn Care

- 80% of U&C for Professional Services in an office or Hospital setting.
- Benefits are available for newborn care only if the Dependent is enrolled no later than 60 days following the birth.
 - See Preventive Services in this section for well-baby/child care benefits and immunization schedule.

Nurse Practitioner

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

Occupational Therapy/Physical Therapy

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

Outpatient Hospital/Facility Services, including Surgery

- 90% at a PPO Hospital/facility.
- 80% of U&C at a non-PPO Hospital/facility, if an exception to non-PPO benefits is granted by the Notification Administrator.
- 65% of U&C at a non-PPO Hospital/facility.
- 90% of U&C if performed at an ambulatory surgical treatment center which is licensed by the Department of Public Health, or the equivalent agency in other states, to perform outpatient Surgery.
- Surgical facility exclusions include, but are not limited to:
 - Facility charges for a Surgery performed in or billed by a Physician’s office or clinic.
 - Facility charges for a Surgery or procedure which is NOT covered.

Physician Services

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

Physician Services – Surgical

- Inpatient Surgery:
 - 80% of U&C for Physician services. Follow-up care by the surgeon is considered part of the cost of the surgical procedure. It is NOT covered as a separate charge.
- Outpatient Surgery:
 - 80% of U&C for Physician services. If

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- Surgery is performed in a Physician's office, the following will be considered as part of the fee:
- Surgical tray and supplies.
 - Local anesthesia administered by the Physician.
 - Medically necessary follow-up visits.
- Plastic Surgery is limited to 80% of U&C for the following:
 - An accidental injury.
 - Congenital deformities that are evident in infancy.
 - Reconstructive mammoplasty following a mastectomy when medically indicated.
 - Assistant surgeon:
 - A payable assistant surgeon is a Physician who assists the surgeon, subject to Medical Necessity.
 - Up to 20% of U&C of Eligible Charges.
 - Multiple surgical procedures:
 - Standard guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
 - 80% of U&C for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the Plan Administrator for a pre-determination of benefits.
 - Surgical exclusions include, but are not limited to:
 - Abortion, induced miscarriage or induced premature birth, unless it is a Physician's opinion that such procedures are necessary to preserve the life of the woman, or an induced premature birth is intended to

produce a live, viable child and is necessary for the health of the woman or her unborn child.

- Keratotomy or other refractive Surgeries.
- Obesity Surgery unless medically necessary to treat morbid obesity (2 times normal body weight).
- Surgery not recommended, approved and performed by a Physician.

Podiatry Services

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

Prescription Drugs

- 80% of the drug charges if billed by a Physician's office and not obtained at a pharmacy.
- If purchased at a pharmacy, the Prescription Drug Plan benefits apply. See the section entitled Prescription Drug Coverage later in this chapter.
- Prescription Drugs obtained as part of a Hospital stay are payable at the appropriate facility benefit level.
- Prescription Drugs billed by a skilled nursing facility, extended care facility or a nursing home must be submitted to the Prescription Drug Plan Administrator.

Prosthetic Appliances

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

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- 80% of U&C for:
 - The original prosthetic appliance.
 - Replacement of a prosthetic appliance due to growth or a change in the person’s medical condition.
 - Repair of a prosthetic appliance due to normal wear and usage and no longer functional.
- No payment will be made if the appliance is damaged or lost due to negligence.
- Prosthetic appliances exclusions include, but are not limited to:
 - Appliances not recommended or approved by a Physician.
 - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
 - Items considered to be cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
 - Experimental or investigational appliances.
 - See Dental Plan section later in this chapter for coverage of dentures.

Administrator. No Plan Year Deductible applies.

- Contact the Notification Administrator who will determine if a second opinion for a procedure is required.
- Failure to obtain a second opinion when required and proceeding with the procedure will result in a financial penalty.

- 80% of U&C if not required by the Notification Administrator. Plan Year Deductible applies.

Skilled Nursing Service – Home Setting

- 80% of Eligible Charges.
- Contact the Notification/Medical Case Management Administrator for a determination of benefits.
- The benefit for Skilled Nursing Service will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home within the same geographic region.
- The continued coverage for Skilled Nursing Service will be determined by the review of medical records and nursing notes.

Radiation Therapy

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

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

- 80% of U&C. Benefits are subject to skilled care criteria and will be allowed for the most cost-effective setting or the level of care required as determined by Notification/ Medical Case Management Administrator.
- Must be a licensed healthcare facility primarily engaged in providing skilled care.

Second Surgical Opinion

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

- 100% of U&C if required by Notification

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- Notification is required at least 7 days prior to Admission or at time of transfer from an inpatient Hospital stay.
- Benefits are limited to the average cost of available facilities within the same geographic region.
- The service must be medically necessary and ordered by a Physician.
- The continued coverage for Skilled Nursing Service will be determined by the review of medical records and nursing notes.
- Holding charges (charges for days when the bed is not occupied by the patient) are not covered.
- Prescription Drug charges must be submitted to the Prescription Drug Plan Administrator.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

- 80% of U&C for medically necessary speech therapy ordered by a Physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature with the ability to improve communication.

- The person must have the potential for communication.

Sterilization

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

Transplant – Organ and Tissue (Notification Required)

LCHP includes a Transplant Preferred Provider Organization (TPPO) Hospital network. **In order for any organ or bone marrow transplant to be covered under the Plan, one of the designated organ-specific TPPO Hospitals must be utilized.** The transplant candidate must contact the Notification/Medical Case Management Administrator of the potential transplant. Once Notification occurs, the Medical Case Manager (MCM) will coordinate all treatments and further Notification is not required. Those refusing to participate in the MCM program will be notified that coverage may be terminated under the Plan for treatment of the illness.

The transplant benefit includes all diagnostic treatment and related services necessary to assess and evaluate the transplant candidate. All related transplant charges submitted by the TPPO

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

Hospital are covered at 80% of the contracted rate.

In some cases, transplants may be considered non-viable for some candidates, as determined by the MCM Administrator in coordination with the transplant Hospital.

- Transplant exclusions include, but are not limited to:
 - Investigational drugs, devices or experimental procedures.
 - Charges related to the search for an unrelated bone marrow donor.
 - A corneal transplant is not part of the TPPO benefit; however, standard benefits apply under the medical portion of the coverage.

Transplant Coordination of Donor/ Recipient Benefits

- When both the Donor and the Recipient are covered under the Plan, both are entitled to benefits under the Plan, under separate Claims.
- When only the Recipient is covered, the Donor's charges are covered as part of the Recipient's Claim if the donor does not have insurance coverage, or if the Donor's insurance denies coverage for medical expenses incurred.
- When only the Recipient is covered and the Donor's insurance provides coverage, the Plan will coordinate with the Donor's plan.
- When only the Donor is covered, only the Donor's charges will be covered under the Plan.

- When both Donor and Recipient are Members of the same family and are both covered by the Plan, no Deductible or Coinsurance shall apply.

The TPPO Hospital network is subject to change throughout the year. Call the Notification/Medical Case Management Administrator for current TPPO Hospitals.

Transplant – Transportation and Lodging Benefit

- The Plan will cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those Plan Participants who have been accepted as a candidate for transplant services.
- The maximum expense reimbursement is \$2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to \$70. There is no reimbursement for meals.
- Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

**Organ Transplant Reimbursement
Department of Central Management
Services (DCMS)
Group Insurance Division
201 E. Madison Street
P.O. Box 19208
Springfield, IL 62794-9208**

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

- The Plan Participant has twelve months from the date expenses were incurred to submit Eligible Charges for reimbursement. Requests submitted after the twelve month limit will not be considered for reimbursement.

Urgent Care Services

- 80% of U&C.

Urgent care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a Physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. If a facility fee is billed, the emergency room Deductible applies.

NOTE: See Emergency Services for medically necessary emergency care.

There is a 90% enhanced benefit for utilization of PPO network Providers, unless otherwise stated.

Overview

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

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

Only the Preventive Services listed below are covered under LCHP.

Covered Benefits – Adults

■ Colorectal Cancer Screening:

- 90% of U&C for sigmoidoscopy or colonoscopy once every 3 Plan Years for persons who are at least 50 years old.
- 90% of U&C for sigmoidoscopy or colonoscopy once every 3 Plan Years for persons who are at least 30 years old and have a family history of colorectal cancer.
- 90% of U&C for fecal occult blood testing once every 3 Plan Years for persons who are at least 50 years old or for persons at least 30 years old who have a family history of colorectal cancer.
- 80% of U&C for professional charges associated with the interpretation of the screening.

■ Comprehensive Physicals for Adults (age 19 and over):

- For adults age 19-49, one exam is covered every 3 Plan Years.
- For adults age 50 and over, one exam is covered every Plan Year.

- 80% of U&C for immunizations, limited to the immunization schedule in this section.
- 80% of U&C for office visits.
- 80% of U&C for Physician ordered lab and x-ray work.
- 80% of U&C for professional charges associated with the interpretation of the test.
- Maximum benefit of \$175 per physical.

■ Mammography:

- 100% of U&C.
- One baseline mammogram for women age 30-39.
- One mammogram per Plan Year for women age 40 and over.
- 80% of U&C for professional charges associated with the interpretation of the test.

■ Pap/Cervical Smears:

- 100% of U&C for pap/cervical smear once per Plan Year.
- 80% of U&C for office visit.
- 80% of U&C for professional charges associated with the interpretation of the test.

■ Prostate Screening:

- 100% of U&C for prostate-specific antigen test for men age 40 and over once per Plan Year.
- 80% of U&C for office visit for prostate exam.
- 80% of U&C for professional charges associated with the interpretation of the screening.

Covered Benefits – Children

- **Well-Baby Care and Immunizations (through age 6):**
 - 80% of U&C for office visits.
 - 80% of U&C for lab.
 - 80% for immunizations, limited to the immunization schedule later in this section.
- **Well-Child Exams and Immunizations (for children entering grades 5 and 9):**
 - 80% of U&C for office visits.
 - 80% of U&C for lab.
 - 80% for immunizations, limited to the immunization schedule later in this section.

*Well-Baby Care/Well-Child Exams and Immunization Schedules Ages 0-6 Years. Children Entering Grades 5 and 9 and Adults							
SERVICE	RECOMMENDED FREQUENCY					PLAN BENEFIT	
DTP (Diphtheria-tetanus-pertussis) or Td booster	2 months	4 months	6 months	12-18 months	4-6 years	Entrance to 5th or 9th grade 80% of U&C for immunizations	
OPV (Oral poliovirus)	2 months	4 months	6-18 months	4-6 years		Entrance to 5th or 9th grade 80% of U&C for immunizations	
MMR (Measles-mumps-rubella)	12-15 months	4-6 years				Entrance to 5th or 9th grade 80% of U&C for immunizations	
HIB (Conjugate H. Influenza type b)	2 months	4 months	6 months	12-15 months		Entrance to 5th or 9th grade 80% of U&C for immunizations	
Hepatitis B Series of three injections ¹	0-2 months					Entrance to 5th or 9th grade. Second injection 2 months after first, third injection 6 months after second. 80% of U&C for Immunizations	
Pneumococcal (Prevnar)	2 months	4 months	6 months	12-15 months		80% of U&C for Immunizations	
Varicella (Chicken Pox) ²	12-18 months					Entrance to 5th or 9th grade ³ 80% of U&C for immunizations	
Quantitative Lead Screening						1 per lifetime 80% of U&C for lab	
TB Tine Test and Intradermal Tuberculosis Test if needed						Entering 5th grade	Entering 9th grade 80% of U&C for lab
School-Health Examination ⁴						Entering 5th grade	Entering 9th Grade 80% of U&C for professional charges
Well Baby/Child Care Examination	0-6 years					Entering 5th grade	Entering 9th grade 80% of U&C for professional charges
Adult Immunizations (Included in comprehensive physical for adults age 19 and over)							
Service	Frequency and Age Limitations					Plan Benefit	
Hepatitis B	Through age 24 if not previously immunized					80% of U&C up to the maximum benefit	
Tetanus-diphtheria (Td)	No primary series received, booster every 10 years					80% of U&C up to the maximum benefit	
Influenza Vaccine	Age 65 and over, 1 per plan year					80% of U&C up to the maximum benefit	
Pneumococcal Vaccine	Age 65 and over, 1 per plan year					80% of U&C up to the maximum benefit	
Rubella and/or MMR	Through age 64					80% of U&C up to the maximum benefit	

***Note:** Immunizations administered in acceptable combinations are covered. For children entering Grades 5 and 9, exceptions to recommended frequency or age limitation will be allowed if needed to bring child up to date with state requirement for school health examination.

¹ Only the first office visit in conjunction with first Hepatitis B injection is covered at 80%, no deductible applies.

² Only if no reliable history of varicella infection or previous immunization.

³ For older children only if no reliable history of varicella infection or previous immunization.

⁴ Billing must indicate "School Health Examination" to be covered. Sports physicals and other similar exams are not eligible under the preventive services benefit.

The above information is based upon the most recent Guide to Clinical Preventive Services Report of the U.S. Preventive Services Task Force.

Notes

Overview

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.

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

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

The Prior Authorization Program is designed to manage the use of a select list of medications. If a prescription is presented for one of these medications, the pharmacist will indicate that a prior authorization is needed before the prescription can be filled. To receive a prior authorization the prescribing Physician must provide a diagnosis to the Prescription Drug Plan Administrator for review. Once a prior authorization is in place, the prescriptions may be filled until the authorization expires, usually one year.

Plan Coverage Information

Diabetic supplies and insulin are covered through the Prescription Drug Plan. In order for insulin and diabetic supplies to be a covered benefit under this

Plan, they must be purchased with a prescription. Diabetic supplies are subject to the appropriate Copayment.

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

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

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

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

If a network pharmacy does not stock a particular drug or supply and is unable to obtain it, call the Prescription Drug Plan Administrator for further direction.

Pre-packaged Prescriptions – A Copayment is based on a 1 to 30-day supply as prescribed by the Physician. Since manufacturers sometimes pre-package products in amounts that may be more or less than a 30-day supply as prescribed, more than one Copayment may be required.

- **Example A** (more than a 30-day supply): Manufacturers commonly pre-package lancets in units of 100. If the 30-day prescription is for 90 units, two Copayments are required, since the pre-packaged amount exceeds the 30-day supply as required by the prescription.
- **Example B** (less than a 30-day supply) Manufacturers commonly pre-package inhalers or tubes of ointment. Since the packaged medication may be less than a 30-day supply, more than one package unit may be required; therefore, more than one Copayment will be required.

Prescribed medical supplies are supplies necessary for the administration of Prescription Drugs such as covered hypodermic needles and syringes. Copayments apply.

In-Network Benefits

The Pharmacy Network consists of retail pharmacies which accept the Copayment and electronically transmit the Prescription Drug Claim for processing. Copayment amounts are subject to change each Plan Year. Refer to the current Benefit Choice Options booklet for Copayment amounts.

There are thousands of pharmacies in the network nationwide, including independent community pharmacies.

The most up-to-date information on network pharmacies is available in the current Benefit Choice Options booklet, section entitled Plan Administrators or visit the website at www.benefitschoice.il.gov for a link to the Prescription Drug Plan Administrator

website.

Retail Pharmacy

■ In-Network Benefit Summary:

- No Plan Year deductibles; no Claim forms to file.
- Medications
 - 1 to 30-day supply, 1 copayment
 - 31 to 60-day supply, 2 copayments
- Copayments for Prescription Drugs are separated into three different categories: generic, preferred brand or non-preferred brand. Copayment amounts are subject to change each Plan Year. Refer to the current Benefit Choice Options booklet for Copayment amounts.
- When the pharmacy dispenses a brand drug for any reason and a generic is available, the Plan Participant must pay the cost difference between the brand product and the generic product, plus the generic Copayment.
- If no generic is available, the appropriate preferred brand or non-preferred brand Copayment will be charged.
- If the price of a prescription is lower than the Copayment, the pharmacist will collect the lower amount.

Mail Order Pharmacy

The mail order pharmacy provides up to a 90-day supply of medication for two Copayments. See the current Benefit Choice Options booklet for Copayment amounts. To receive a discounted 61 to 90-day supply of medication, obtain an original prescription from the attending Physician written for a 61 to 90-day supply plus up to three 90-day refills, totaling one year of medication. If ordering through the Prescription Drug Plan Administrator mail order pharmacy, complete the mail order form. The original prescription must be attached to the order form and mailed to the mail order pharmacy.

Medication should be delivered within 11 days from the time the mail order pharmacy receives the order.

Out-of-Network Benefit

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand or generic in-network contracted rate minus the appropriate in-network Copayment. In most cases, the cost of the Prescription Drugs will be higher when not using in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from the Prescription Drug Plan Administrator) and the original prescription receipt.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans; the appropriate Copayment will be applied for each prescription filled.

Exclusions

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

Notes

Overview

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

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

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

Authorization for Services

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

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

- **Inpatient Services** must be Authorized prior to Admission or within 48 hours of an

emergency Admission. Authorization is required with each new Admission. Failure to notify the Behavioral Health Plan Administrator of an Admission to an Inpatient facility within 48 hours will result in a financial penalty.

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

Medicare COB for Behavioral Health Services

Medicare Part A

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

Medicare Part B

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

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

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

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

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

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

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

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

NOTE: Plan Participants eligible for premium-free Medicare Part A must enroll in Medicare Part B to avoid reduction in benefits by the amount that Medicare Part B would have paid.

Out-of-Area Benefits

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

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

Behavioral Health Services

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

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

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

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

Notes

Local Care Health Plan Exclusions and Limitations

No benefits are available:

1. Services incurred during the first six months of an individual's coverage to the extent that the services are in connection with any Pre-existing Condition, unless the Pre-existing Condition waiting period has been reduced by a Certificate of Creditable Coverage. A Pre-existing Condition is any disease, condition (excluding maternity) or injury for which the individual was diagnosed, received treatment/ services or took prescribed drugs during the three months immediately preceding the effective date of coverage under LCHP.
2. Services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a Nurse Midwife who has completed an organized program of study recognized by the American College of Nurse Midwives or by a Christian Science Practitioner.
3. Services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this Handbook to be a Covered Service in effect at the time the service was rendered. Excluded services and supplies include, but are not limited to: sports-related health check-ups, employer-required check-ups, wigs and hairpieces.
4. Care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable by the Plan.
5. Charges exceeding U&C for the services, Room and Board or supplies.
6. Personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, non-Hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps or any other services or items determined by the Plan to be for personal convenience.
7. Rest, convalescence, custodial care or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.
8. Extended care and/or Hospital Room and Board charges for days when the bed has not been occupied by the covered person (holding charges).
9. Private room charges which are not medically necessary as determined by the Plan Administrator.
10. Routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.
11. Chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.

12. Keratotomy or other refractive surgeries.
13. The diagnosis or treatment of obesity, except services for morbid obesity (two times normal body weight), as approved by the Plan Administrator.
14. Sexual dysfunction, except when related to an injury or illness.
15. Services relating to the diagnosis, treatment, or appliance for temporomandibular joint disorders or syndromes (TMJ), myofunctional disorders or other orthodontic therapy.
16. The expense of obtaining an abortion, induced miscarriage or induced premature birth, unless it is a Physician's opinion that such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the woman or her unborn child.
17. Cosmetic Surgery or therapies, except for the repair of accidental injury, for congenital deformities evident in infancy or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.
18. Services rendered by a health care Provider specializing in behavioral health services who is a candidate in training.
19. Services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.
20. Treatment or services which are investigational, experimental or unproven in nature including, but not limited to, procedures and/or services: which are performed in special settings for research purposes or in a controlled environment; which are being studied for safety, efficacy and effectiveness; which are awaiting endorsement by the appropriate national medical specialty organization; which medical literature does not accept as a reasonable alternative to existing treatments; or, that do not yet meet medical standards of care.
21. The purchase of the first three pints of blood or blood plasma.
22. Services due to bodily injury or illness arising out of or in the course of a Plan Participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.
23. Court mandated services, if not a Covered Service under this Plan or not considered to be medically necessary by the appropriate Plan Administrator.
24. Services or supplies for which a charge would not have been made in the absence of coverage or for services or supplies for which a Plan Participant is not required to pay.
25. Services arising out of war or an act of war, declared or undeclared, or from participation in a riot, or incurred during or as a result of a Plan Participant's commission or attempted commission of a felony.
26. Services related to the reversal of sterilization.
27. Lenses (eye glasses or contacts) except initial pair following cataract Surgery.
28. Expenses associated with obtaining, copying or completing any medical or dental reports/ records.

-
29. Services rendered while confined within any federal Hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.
 30. Charges imposed by immediate relatives of the patient or members of the Plan Participant's household as defined by the Centers for Medicare and Medicaid Services (formerly HCFA).
 31. Services rendered prior to the effective date of coverage under the Plan or subsequent to the date coverage is terminated.
 32. Private duty nursing, skilled or unskilled, in a Hospital or facility where nursing services are normally provided by staff.
 33. Services or care provided by an employer-sponsored health clinic or program.
 34. Travel time and related expenses required by a Provider.
 35. Facility charges when services are performed in a Physician's office or urgent care centers.
 36. Residential treatment for behavioral health services.
 37. Treatment for educational disorders relating to learning, motor skills, communication and pervasive development conditions, such as autism.
 38. Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neuro feedback, hypnosis, sleep therapy, employment counseling, back-to-school, return to work services, work hardening programs, driving safety and services, training, educational therapy or non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

Notes

LCHP - Claim Filing Deadlines and Procedures

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

Claim Filing Deadlines

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

Claims with Service Dates of:	Final Filing Date
Prior to July 1, 2004	No longer eligible
July 1, 2004 thru June 30, 2005	June 30, 2006
July 1, 2005 thru June 30, 2006	June 30, 2007
July 1, 2006 thru June 30, 2007	June 30, 2008
July 1, 2007 thru June 30, 2008	June 30, 2009
July 1, 2008 thru June 30, 2009	June 30, 2010
July 1, 2009 thru June 30, 2010	June 30, 2011

Claim Filing Procedures

All communication to the Plan Administrators must include the Member's Social Security Number (SSN) or Alternate Member Identifier (AMI) and appropriate Group Number as listed on the Identification Card. This information must be included on every page of correspondence.

- Complete the Claim form obtained from the appropriate Plan Administrator.
- Attach the itemized bill from the Provider of services to the Claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the Provider's name, address and telephone number.

- If the person for whom the Claim is being submitted has primary coverage under another group plan or Medicare, the Explanation of Benefits (EOB) from the other plan must also be attached to the Claim.
- The Plan Administrators may communicate directly with the Plan Participant or the Provider of services regarding any additional information that may be needed to process a Claim.
- The benefit check will be sent and made payable to the Member (not to any Dependents), unless benefits have been assigned directly to the Provider of service.
- If benefits are assigned, the benefit check is made payable to the Provider of service and mailed directly to the Provider. An EOB is sent to the Plan Participant to verify the benefit determination.
- Claims are adjudicated using industry standard Claim processing software and criteria. Claims are reviewed for possible bundling and unbundling of services and charges. Providers may occasionally bill for services that are not allowed by the Claim review process.

Notes

Local Care Dental Plan (LCDP)

Overview

The Local Care Dental Plan (LCDP) is designed to offer Plan Participants coverage for basic dental services regardless of the health plan chosen.

- The maximum benefit paid for eligible services is listed in the Schedule of Benefits at the Local Government link at www.benefitschoice.il.gov and can be obtained from your Health Plan Representative (HPR). **Services not listed in the Schedule of Benefits are not covered by the Plan.**
- Plan Participants are responsible for any amount over the maximum benefit.
- Plan Participants may go to any dentist of choice.
- Claims must be filed with the Dental Plan Administrator listed in the current Benefit Choice Options booklet.
- Plan Participants may obtain Claim forms and Identification Cards from the Dental Plan Administrator.
- The benefit Plan Year is July 1 through June 30.

Annual Deductible

For the Plan Year July 1, 2004 - June 30, 2005, each Plan Participant is required to satisfy a \$50 Plan Year Deductible for Covered Services except preventive and diagnostic services, as listed under the Schedule of Benefits. If services span more than one Plan Year, a Deductible applies each Plan Year.

Effective July 1, 2005, Plan Participants will be required to satisfy a \$100 Plan Year Deductible.

Maximum Benefit Levels

For the Plan Year 7/1/04 - 6/30/05, the maximum benefit is \$1,200 per Plan Participant per Plan Year including orthodontic, periodontic and all other services.

Effective 7/1/05 the maximum benefit is \$2,000. The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations.

NOTE: Total benefit reimbursement for any and all dental services combined may not exceed the maximum benefit level each Plan Year.

Pre-treatment Estimate

A Pre-treatment Estimate assists Plan Participants in determining the benefits available. To obtain a Pre-treatment Estimate, contact the Dental Plan Administrator.

Plan Limitations

Preventive and Diagnostic Services include, but are not limited to:

- Two periodic oral examinations per Plan Participant per Plan Year.
- Two adult or child prophylaxis (scaling and polishing of teeth) per Plan Participant per Plan Year.
- Two bitewing radiographs per Plan Participant per Plan Year.
- Full mouth radiographs are covered once in a period of three Plan Years.

Prosthodontics are subject to the following limitations:

- Immediate dentures are covered only if five or more teeth are extracted on the same day.
- Permanent dentures to replace missing teeth are covered **only for teeth that are lost while the person is covered under this Plan.**
- Permanent dentures to replace immediate dentures are covered only if placed in the person’s mouth within two years from the placement of the immediate denture.
- Replacement dentures are covered only under one of the following circumstances:
 - Existing denture is at least five years old, or
 - Structural changes in the person’s mouth require a new denture.

Orthodontic Services

The lifetime maximum benefit for child orthodontics is \$1,500. The benefit is based on the length of treatment. This lifetime maximum applies to each Plan Participant regardless of the number of courses of treatment.

Length of Treatment	Maximum Benefit
0-36 Months	\$1,500
0-18 Months	\$1,364
0-12 Months	\$ 780

Orthodontic Limitations

- The course of treatment (initial banding) must begin before age 19.
- For a detailed description of your Dental Plan benefits see the Schedule of Benefits at www.benefitschoice.il.gov. For covered orthodontic services contact the Dental Plan Administrator.
- The Plan Year Deductible will apply to the orthodontic benefit if it is the initial claim processed in a Plan Year except for Preventive or diagnostic procedures.

Reimbursement of Benefit: 25% of the applicable maximum benefit, based on the length of treatment, is reimbursed after the initial banding. The remaining benefit is prorated over the remaining length of treatment.

LCDP - Exclusions and Limitations

No benefits shall be payable for:

1. Dental services covered under the health plan. (See the Medical Benefits Summary section - Dental Services.)
2. Services rendered prior to the Plan Participant's effective date of coverage or subsequent to the date of termination of coverage.
3. Services not listed in this plan description or for services rendered prior to the date a service or procedure became a covered benefit as indicated in this plan description.
4. Services performed to correct development malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia.
5. Dental services relating to the diagnosis or treatment, including appliances, for Temporomandibular Joint Disorders (TMJ) and myofunctional disorders, craniofacial pain disorders and orthognathic surgery. However, occlusal guards are covered.
6. Services not necessary or not consistent with the diagnosis or treatment of a dental condition, as determined by the Dental Plan Administrator.
7. Orthodontia of deciduous (baby) teeth or adult orthodontia.
8. Services not listed in the Schedule of Benefits, such as, but not limited to, implants, gold foil restorations and bleaching.
9. Services compensable under the Workers' Compensation or Employer's Liability Law.
10. Procedures or surgeries undertaken for primarily cosmetic reasons.
11. Construction of duplicate dentures.
12. Replacement of a prosthesis for which benefits were paid under this Plan, if the replacement occurs within five years from the date the expense was incurred, unless:
 - The replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth;
 - The prosthesis is a stayplate or a similar temporary prosthesis and is being replaced by a permanent prosthesis; or
 - The prosthesis, while in the oral cavity, has been damaged beyond repair, as a result of injury while eligible under the Plan.
13. Customization of dental prosthesis, including personalized, elaborate dentures or specialized techniques.
14. Expenses associated with obtaining, copying or completing any dental or medical reports.
15. Charges for procedures considered experimental in nature.
16. Service or care performed by a family member or other person normally residing with the participant.
17. Services provided or paid for by a governmental agency or under any governmental program or

law, except for charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its amendments.

18. General anesthesia and intravenous sedation services (with the exception of children under age 6) unless a documented medical condition exists, such as, but not limited to, heart disease, hemophilia and epilepsy. Supporting documentation from a medical provider will be reviewed by the Dental Plan Administrator.

LCDP - Claim Filing Deadlines and Procedures

The following procedures and deadlines pertain to the LCDP. Contact the Dental Plan Administrator with any questions about Covered Services, benefit levels or Claim Payments.

Claim Filing Deadlines

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

Claims with Service Dates of:	Final Filing Date
Prior to July 1, 2004	No longer eligible
July 1, 2004 thru June 30, 2005	June 30, 2006
July 1, 2005 thru June 30, 2006	June 30, 2007
July 1, 2006 thru June 30, 2007	June 30, 2008
July 1, 2007 thru June 30, 2008	June 30, 2009
July 1, 2008 thru June 30, 2009	June 30, 2010
July 1, 2009 thru June 30, 2010	June 30, 2011

Claim Filing Procedures

All communication to the Dental Plan Administrator must include the Member's Social Security Number (SSN) or Alternate Member Identifier (AMI) and appropriate Group Number as listed on the Identification Card. This information must be included on every page of correspondence.

- Complete the Claim form obtained from the Dental Plan Administrator.
- Attach the itemized bill from the provider of services to the Claim form. The Itemized Bill must include name of patient, date of service, diagnosis, procedure code and the Provider's name, address and telephone number.
- If the person for whom the Claim is being submitted has primary coverage under another group plan or Medicare, the

Explanation of Benefits (EOB) from the other plan must also be attached to the Claim.

- The Dental Plan Administrator may communicate directly with the Plan Participant or the provider of services regarding any additional information that may be needed to process a Claim.
- The benefit check will be sent and made payable to the Member (not to Dependents), unless benefits have been assigned directly to the Provider of service.
- If benefits are assigned, the benefit check is made payable to the Provider of service and mailed directly to the Provider. An EOB is sent to the Plan Participant to verify the benefit determination.

Benefits for Services Received While Outside The United States

The Plan covers Eligible Charges incurred for services received outside of the United States. All Plan benefits are subject to Plan provisions and Deductibles.

Payment for the services may be required at the time service is provided and a paper Claim must be filed with the Dental Plan Administrator. When filing the Claim, enclose the Itemized Bill with a description of the service translated to English and converted to U.S. currency along with the name of the patient, date of service, diagnosis, procedure code and the Provider's name, address and telephone number.

Notes

Overview

The Vision Care Benefit Plan is designed to assist with the costs of well-vision care and to encourage the maintenance of vision through regular eye exams. Periodic eye exams can detect and prevent ailments not only in the eyes, but throughout the body. The Plan provides coverage when glasses or contacts are required.

Eligibility

All Plan Participants covered by any of the health plans offered by the Local Government Health Plan (Program) are eligible for the Vision Care Benefit Plan.

Frequency of Benefits

Each service component is available once every 24 months from the last time the benefit component was used. Each service component is independent and may be obtained at separate times from separate Providers. For example, a Plan Participant may receive an eye examination from one Provider and purchase frames/lenses from a different Provider. Coordination of Benefits apply to Medicare and any other vision coverage.

Network Provider Services

- To receive services from a Network Provider, here are the steps to follow:
 - **Select a Network Provider.**
To obtain vision care services, call a participating network Provider or contact the Vision Plan Administrator to obtain information on participating Providers.
 - **Schedule an appointment.**
Call the Provider to schedule an appointment. Identify yourself as a Plan Participant in the State of Illinois Vision Plan. The network Provider will contact the Vision Plan Administrator to verify

eligibility, plan coverage and obtain authorization for services and materials.

- **Obtain services.**
Materials and services obtained from a Network Provider are paid at the Network Provider Coverage benefit level. Applicable Copayments and additional charges must be paid at the time of service.

Out-of-Network Provider Services

Eligible services or materials may be obtained from any licensed optometrist, ophthalmologist or optician. However, if an out-of-network Provider is used, the Plan Participant must pay the Provider in full and request reimbursement from the Vision Plan Administrator. To request reimbursement, send an itemized receipt and the Member's Identification Number along with a letter requesting reimbursement to the Vision Plan Administrator. Reimbursement will be paid up to the maximum allowance amount as detailed in the Schedule of Benefits, Out-of-Network Provider Coverage chart in this section.

All receipts for services and materials should be filed promptly. **Receipts filed later than one year from the end of the Plan Year for which the charge was incurred will not be paid.** Out-of-network Provider benefits are paid directly to the covered Plan Participant and are not assignable to the Provider. Exams and eyewear obtained from out-of-network Providers are subject to the same Plan limitations.

For More Information

For more information, contact the Vision Plan Administrator in the current Benefit Choice Options booklet.

Schedule of Benefits		
Network Provider Coverage		
Service Component	Frequency	Copayment and/or Allowance
Eye Exam	Once every 24 months	\$10.00 Copayment
Spectacle Lenses* (single, bifocal and trifocal)	Once every 24 months	\$10.00 Copayment
Standard Frame Selection	Once every 24 months	\$10.00 Copayment (for frames within the Standard Frame selection)
Contact Lenses** <u>All contact lenses are in lieu of standard frames with spectacle lenses.</u>	Once every 24 months	\$50.00 Copayment \$70.00 Allowance
Lasik and PRK Vision Correction Procedures***	Unlimited	15% off retail price or 5% off promotional price, whichever is the greater benefit
Low Vision Supplementary Testing***	Once every 24 months	\$10.00 Copayment
Low Vision Aids***	Once every 24 months	100% coverage <u>after</u> a 25% Copayment with a \$1,000 maximum allowance
Out-of-Network Provider Coverage		
Service Component	Frequency	Allowance
Eye Exam	Once every 24 months	\$20.00 Allowance
Spectacle Lenses*	Once every 24 months	\$20.00 Allowance for single vision lenses \$30.00 Allowance for bifocal and trifocal lenses
Standard Frames	Once every 24 months	\$20.00 Allowance
Contact Lenses** <u>All contact lenses are in lieu of standard frames with spectacle lenses.</u>	Once every 24 months	\$70.00 Allowance
Lasik and PRK Vision Correction Procedures	Available In-Network only	
Low Vision Supplementary Testing***	Once every 24 months	\$125.00 Allowance
Low Vision Aids***	Once every 24 months	100% coverage <u>after</u> a 25% Copayment with a \$1,000 maximum allowance

* Spectacle Lenses: Plan Participant pays any and all optional lens enhancement charges. Network Providers may offer additional discounts on lens enhancements and multiple pair purchases.

** Contact Lenses: The contact lens allowance applies towards the cost of the contact lenses as well as the professional fees for fitting and evaluation services.

***Subject to prior approval by the Vision Plan Administrator.

If a Plan Participant enrolled under one of the Plans administered by the Department's medical, dental or vision plans is entitled to primary benefits under another group plan, the amount of benefits payable under the Local Government Health Plan (LGHP) may be reduced. The reduction may be to the extent that the total payment provided by all plans does not exceed the total Allowable Expense incurred for the service. Allowable Expense is defined as a medically necessary service for which part of the cost is eligible for payment by the LGHP or one of the plans identified below.

Under Coordination of Benefits (COB) rules, the LGHP first calculates what the benefit would have been for the Claim if there was no other plan involved. The LGHP then considers the amount paid by the primary plan and pays the Claim up to 100% of the Allowable Expense.

NOTE: When a managed care health plan is the secondary plan and the Plan Participant does not utilize the managed care health plan's network of Providers or does not obtain the required referrals, the managed care health plan is not required to pay. Refer to the Managed Care Plan's Summary Plan Description (SPD) for additional information.

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

- Any group insurance plan.
- Any governmental plan (including Medicare), except the Illinois Medical Assistance Program (Medicaid).
- Any "no-fault" motor vehicle plan. This term means a motor vehicle plan which is required by law and provides medical or dental care

payments which are made, in whole or in part, without regard to fault. A person who has not complied with the law will be deemed to have received the benefits required by the law.

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

It is the Member's responsibility to provide other insurance information (including Medicare) to their Health Plan Representative (HPR). Any changes to other insurance coverage must be reported to the HPR promptly.

Order of Benefit Determination

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

The order is as follows:

Employee or Member

- The plan that covers the Plan Participant as an active Employee or Member is primary over the plan that covers the Plan Participant as a Dependent.
- The plan that covers the Plan Participant as an active Employee (not as an Annuitant) is primary over the plan that covers the Plan Participant as an Annuitant.

- If the Plan Participant is covered as an active Employee or Member under more than one plan, but is covered under COBRA (state or federal) under one of the plans, then the plan covering the Plan Participant as an active Employee or Member is primary over the plan covering the Plan Participant under COBRA.
- If the Plan Participant is covered as an active Employee or Member under more than one plan, and none of the above rules apply, then the plan that has been in effect the longest is primary, back to the original effective date under the employer group, whether or not the insurance company has changed over the course of coverage.

Dependent Children of Parents Not Separated or Divorced

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

- Birthday Rule - The plan covering the parent whose birthday* falls earlier in the calendar year is the primary plan.
- If both parents have the same birthday, the plan that has provided coverage longer is the primary plan.

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

NOTE: Some plans not covered by state law may follow the Gender Rule for dependent children. This rule states that the father's coverage is the primary carrier. In the event of a disagreement between two plans, the Gender Rule applies.

Dependent Children of Separated or Divorced Parents

If a child is covered by more than one group plan and the parents are separated or divorced, the plans must pay in the following order:

- The plan of the parent with custody of the child;
- The plan of the Spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child.

NOTE: If the terms of a court order state that one parent is responsible for the health care expenses of the child, and the health plan has been advised of the responsibility, that plan is primary payer over the plan of the other parent.

Dependent Children of Parents With Joint Custody

The Birthday Rule applies to dependent children of parents with joint custody.

Overview

Medicare is a federal health insurance program for individuals:

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

The Medicare program is administered by the federal Centers for Medicare and Medicaid Services (federal CMS), formerly known as the Health Care Financing Administration (HCFA). Medicare Part A provides coverage for Hospital care, skilled nursing facility care, home health and hospice care. Medicare Part B provides coverage for Physician/professional care, outpatient Hospital care and other medical services. Effective January 2006, Medicare Part D will provide Prescription Drug benefits.

Qualifying for Medicare

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

Age 65 & Over

Medicare Ineligible

If the Plan Participant is ineligible for premium-free Medicare Part A, they must provide written certification from the SSA that they are ineligible based on their work history or the work history of any current or former Spouse. The certification must be submitted to their Health Plan Representative (HPR) upon turning age 65. The Plan Participant is not required to purchase Medicare Part B if ineligible for free Medicare Part A.

Medicare Eligible

Eligibility for Medicare benefits begins when the Plan Participant turns age 65. **All retired Plan Participants, as well as Plan Participants actively employed with an employer other than the Local Government Health Plan and without other group health coverage, must enroll in Medicare Parts A and B when first eligible.** If the Plan Participant (is retired or not actively working) does not enroll in Medicare Part B when first eligible, **the Local Care Health Plan (LCHP) and the managed care health plans will pay as if the Plan Participant has Medicare Part B benefits.** If Medicare Part B is not purchased at age 65, Medicare will impose a 10% penalty for each year it was not purchased.

Plan Participants actively working elsewhere with other group health coverage through that employer must enroll in Medicare Part A, but may delay enrollment in Medicare Part B until the loss of other insurance coverage and/or the loss of other employment.

Under Age 65 - Medicare Due to Disability

Plan Participants under the age of 65 and receiving SSA benefits or Railroad Retirement Board disability

benefits will automatically be enrolled in Medicare Parts A and B after 24 months. If the Plan Participant does not remain enrolled in Medicare Part B, the Plan will pay as if the Plan Participant has Medicare Part B benefits.

End Stage Renal Disease (ESRD)

Plan Participants of any age may qualify for premium-free Medicare Part A due to ESRD. To make application for Medicare benefits due to ESRD, the Plan Participant must contact their local SSA office. If determined that the Plan Participant qualifies for free Medicare Part A, the purchase of Medicare Part B is required. If the Plan Participant does not enroll in Medicare Part B when eligible, the Plan will pay as if the Plan Participant has Medicare Part B benefits.

Medicare Coordination with the Local Care Health Plan (LCHP)

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

Part A - Hospital Insurance

After Medicare Part A pays, LCHP pays:

- 80 % of the balance after the LCHP annual Plan deductible.
- Hospital and Skilled Extended Care Facility stays beyond the maximum days allowed under Medicare, provided that the care satisfies the LCHP criteria of Medical Necessity and skilled care.

Part B - Medical Insurance

After Medicare Part B pays, LCHP pays:

- 80% of the balance after the LCHP and Medicare Part B annual Plan deductibles.

Private Contracts with Providers who Opt Out of Medicare

When a Medicare primary Plan Participant signs a private contract with a Provider of service who does not accept Medicare's assignment of benefits or the Provider has opted out of the Medicare program, Medicare will not pay for service(s) or provide an Explanation of Benefits. If the service(s) would have normally been covered by Medicare, the Medical Plan Administrator will pay at 20% of the billed charges. The Plan Participant is responsible for the remaining balance. When a private contract is signed, neither the Plan Participant nor the Provider may bill Medicare.

Medicare Crossover

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

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

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

If services and supplies are not covered by Medicare:

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

NOTE: If the Provider accepts Medicare assignment, LCHP pays the 80% of the balance after Medicare pays. If the Provider does not accept Medicare LCHP pays 80% of the amounts Medicare does not cover, up to the Maximum limiting charges set by Medicare. The LCHP becomes primary for eligible services or supplies not covered by Medicare, or after Medicare benefits have been exhausted.

Medicare Part D

Medicare Part D is part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, commonly referred to as the MMA. The Act includes a new Prescription Drug benefit referred to as Medicare Part D and is effective January, 2006.

Qualifications for Medicare Part D

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

Notice of Creditable Coverage

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

Notes

Smoking Cessation Program

Overview

Members and their enrolled Dependents are eligible to receive a rebate towards the cost of a Smoking Cessation Program. The maximum rebate is \$50, limited to one per Plan Year and available only upon completion of a Smoking Cessation Program.

Ineligible For Reimbursement

The following therapies are not eligible for reimbursement unless they are an integral part of a Smoking Cessation Program.

- Hypnosis (even if an integral part, will not be reimbursed unless performed by a medical Doctor);
- Acupuncture;
- Prescription Drug therapy;
- Non-Prescription Drug therapy.

Reimbursement Documentation Requirements

- Receipt indicating payment for the Smoking Cessation Program.
- Program certificate verifying the number of sessions and date of completion of the Smoking Cessation Program.
- Member's name, address, unit name and unit telephone number.

Submit Documentation to:

**Smoking Cessation Program
Department of Central Management
Services (DCMS)
Group Insurance Division
201 E. Madison Street
P.O. Box 19208
Springfield, IL 62794-9208**

For More Information

The Department of Central Management Services (Department) is the Plan Administrator of the Smoking Cessation Program. Questions regarding the Smoking Cessation Program should be directed to the Department.

Notes

Subrogation and Reimbursement

Overview

The plans included under the Local Government Health Plan (LGHP) will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. These Plans also do not provide benefits to the extent that there is other coverage under non-group medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

However, the Plans will provide benefits otherwise payable under one of these plans, to or on behalf of its covered persons, but only on the following terms and conditions:

- In the event of any payment under one of these Plans, the Plan shall be subrogated to all of the covered person's rights of recovery against any person or entity. The covered person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The covered person shall do nothing after loss to prejudice such rights. The covered person shall cooperate with the Plan and/or any representatives of the Plan in completing such documents and in providing such information relating to any accident as the Plan by its representatives may deem necessary to fully investigate the incident. The Plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the covered person.
- The Plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the covered person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the Plan.
- The Plan, by payment of any proceeds to a covered person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the covered person or a representative. The covered person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the Plan secure said lien.
- The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the covered person as a result of the injuries sustained, including but not limited to the following:
 - Payments made directly by a third party tort-feasor or any insurance company on behalf of a third party tort-feasor or any other payments on behalf of a third party tort-feasor.
 - Any payments or settlements or judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a covered person or other person.
 - Any other payments from any source designed or intended to compensate a covered person for injuries sustained as the result of negligence or alleged negligence of a third party.
 - Any Workers' Compensation award or settlement.
- The parents of any minor covered person understand and agree that the Plan does not pay for expenses incurred for injuries received

as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor covered person are conditional upon the Plan's express right of reimbursement. No adult covered person hereunder may assign any rights that such person may have to recover medical expenses from any tort-feasor or other person or entity to any minor child or children of the adult covered person without the express prior written consent of the Plan. In the event any minor covered child is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the Plan of the existence of any claim on behalf of the minor child against the third party tort-feasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any Claim against the third party tort-feasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tort-feasor or other person or entity to the Plan, or at their election, to prosecute a Claim for medical expenses on behalf of the Plan.

In default of any obligation hereunder by the adult covered persons/parents, the Plan is entitled to recover the conditional benefits advanced plus costs, (including reasonable attorneys' fees), from the adult covered persons/parents.

- No covered person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by a covered person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat

the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No covered person under the Plan shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- The Plan shall recover the full amount of benefits paid hereunder without regard to any Claim of fault on the part of any covered person, whether under comparative negligence or otherwise.
- The benefits under this Plan are secondary to any coverage under no-fault, medical payments or similar insurance.
- This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.
- In the event that a covered person shall fail or refuse to honor its obligations hereunder, the Plan shall have a right to suspend the covered person's eligibility and be entitled to offset the reimbursement obligation against any entitlement for future medical benefits, regardless of how those medical benefits are incurred. The suspension and offset shall continue until such time as the covered person has fully complied with his obligations hereunder.

Overview

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

Appeal Process for Managed Care Health Plans

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

Managed care health plans must comply with the Managed Care Reform and Patient Rights Act. In order to file a formal appeal, refer to the process outlined in the managed care health plan's Summary Plan Document (SPD) or Certificate of Coverage. Specific timetables and procedures apply. Plan Participants may call the customer service number listed on their Identification Card to request a copy of such documents.

Appeal Process for Local Care Health Plan (LCHP) and Self-funded Managed Care Plans

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

The Plan Administrator's internal review process must be used to the fullest extent prior to filing an appeal with the Department. The

Plan Participant will receive written notification regarding their appeal rights from the Plan Administrator.

1. Initial Appeal to the Plan Administrator

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

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

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

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

Submit Appeal Documentation to:

**Department of Central Management
Services (DCMS)
Group Insurance Division
201 E. Madison Street, Suite 1C
P.O. Box 19208
Springfield, IL 62794-9208**

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

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

3. **Appealing the Final Claim Determination**

A Medical Necessity appeal of the Final Claim Determination may be made to the LGHP Advisory Board within 60 days of the Final Review determination. This committee will review the documentation and facts presented in the Final Determination.

The Advisory Board will consider the merits of each individual case and make a recommendation to the Director of the Department of Central Management Services, whose decision shall be final and binding on all parties. Notification of the decision will be made in writing to the Plan Participant.

Submit Documentation to:

**Department of Central Management
Services (DCMS)
Local Government Advisory Board
P.O. Box 10105
Springfield, IL 62791**

Chapter 3

Reference

SECTION	PAGE
Glossary	97
Index	103

Notes

Admission: Entry as an inpatient to an accredited facility, such as a Hospital or skilled care facility, or entry to a structured Outpatient, Intensive Outpatient or Partial Hospitalization program.

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

Annuitant: Any former Member who has retired from the unit and is receiving an annuity from an Illinois Public Pension System or from a qualified pension plan provided as a result of services to the unit.

Authorization (as applies to Behavioral Health Services): The result of a review that approves treatment as meeting medical necessity criteria and appropriateness of care.

Behavioral Health Services: Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders.

Benefit: The amount payable for services obtained by Plan Participants and Dependents.

Benefit Choice Period: A designated period when Members may change benefit coverage elections.

Certificate of Coverage: A document containing a description of benefits provided by licensed insurance Plans. Also known as a Summary Plan Description (SPD).

Certificate of Creditable Coverage: A certificate that provides evidence of prior health coverage.

Christian Science Nurse: A nurse who is listed in a Christian Science Journal at the time services are given and who: (a) has completed nurses' training at a Christian Science Benevolent Association Sanitarium; or (b) is a graduate of another School of Nursing; or (c) had three consecutive years of Christian Science Nursing, including two years of training.

Christian Science Practitioner: An individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.

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

Claim: A paper or electronic billing. This billing must include full details of the service received, including name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis and any other information which a Plan may request in connection with services rendered.

Claim Payment: The benefit payment calculated by a Plan, after submission of a Claim, in accordance with the benefits described in this handbook. All Claim Payments will be calculated on the basis of the Provider's Charge for Covered Services rendered.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272.

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

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

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

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

Covered Services: Services eligible for benefits under a Plan.

Creditable Coverage: The amount of time a Plan Participant had continuous coverage under a previous health plan.

Custodial Care: Room and board or other institutional or nursing services which are provided for a Plan Participant due to age or mental or physical condition mainly to aid in daily living; or, medical services which are given merely as care to maintain present state of health and which cannot be expected to improve a medical condition.

Deductible: The amount of eligible charges which Plan Participants must pay before benefits begin.

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

Dependent: A Member's Spouse, or unmarried child or other person as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Diagnostic Service: Tests performed to diagnose a condition due to symptoms or to determine the progress of an illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms (ECG), electroencephalograms (EEG), radioisotope tests and electromyograms.

Eligible Charges: Charges for Covered Services and supplies which are medically necessary and based on Usual and Customary charges as determined by a Plan Administrator.

Emergency Services: Services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries such that in the opinion of a prudent layperson might result in permanent disability or death if not treated immediately.

Employee: A person employed by a participating unit or facility who received compensation for work currently performed. See the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Evidence of Insurability: Documentation that an individual's health condition is satisfactory for coverage. May require proof of age or a statement

of health status from the Physician.

Exclusions and Limitations: Services not covered under the Local Government Health Plan or services that are provided only with certain qualifications, conditions or limits.

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

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

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

Formulary (Prescription Drugs): A list of prescription medications that have been chosen because of their ability to be both clinically and cost effective.

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

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

Health Certificate: See Evidence of Insurability.

Health Plan Representative: An individual who provides information and/or materials and processes enrollment changes related to benefits. A Health Plan Representative is often located in the personnel office.

Home Health Care: See Skilled Nursing Service.

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

Hospice: A program of palliative and supportive services for terminally ill patients that must be

approved by a Plan Administrator as meeting standards including any legal licensing requirements.

Hospital: A legally constituted and licensed institution having on the premises organized facilities (including organized diagnostic and surgical facilities) for the care and treatment of sick and injured persons by or under the supervision of a staff of Physicians and registered nurses on duty or on call at all times.

Identification Card: Document identifying eligibility for benefits under a Plan.

Initial Enrollment Period: The ten-day period beginning with the date of eligibility.

Injury: Damage inflicted to the body by external force.

Inpatient Services: A Hospital stay of 24 or more hours.

Intensive Outpatient Program (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy and adjunctive services such as medical monitoring.

Itemized Bill: A form submitted for claim purposes; must have the name of the patient, description, diagnosis, date and cost of services provided.

Investigational: Procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness; and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or Federal Government agency for general use by the medical community at the time they are rendered to a covered person; and (c) with respect to drugs, combination of drugs and/or devices, which have not received final approval by the Food and Drug Administration at the time used or administered to the covered person.

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

Medical Documentation: Additional medical information required to substantiate the necessity of procedures performed. This could include daily nursing and doctor notes, additional x-rays, treatment plans, operative reports, etc.

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

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

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

Member: Employee, Annuitant, Retired Employee, Survivor or COBRA participant.

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

Notice of Creditable Coverage: A document that is intended to advise Medicare beneficiaries whether Prescription Drug coverage through the Program is creditable, meaning that coverage is the same or better than the Medicare Part D benefit. This Notice of Creditable Coverage prevents a Member from being penalized if enrolling in Medicare Part D at a later date. The Notice of Creditable Coverage will be provided prior to the enrollment period of Medicare Part D.

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

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

Outpatient Services (Behavioral Health Services): Care rendered for the treatment of mental health or substance abuse. This type of care is limited to individual, group and/or family psychotherapy when not confined to an inpatient hospital setting.

Outpatient Services (medical/surgical): Services provided in a hospital emergency room or outpatient clinic, at an ambulatory surgical center, or in a doctor's office.

Partial Hospitalization Program (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy. Services are medically-supervised and essentially the same intensity as would be provided in a hospital setting except that the patient is in the program less than 24 hours per day.

Physician/Doctor: A person licensed to practice under the Illinois Medical Practice Act or under similar laws of Illinois or other states or countries;

a Christian Science Practitioner listed in the *Christian Science Journal* at the time the medical services are provided.

Plan: A specifically designed program of benefits.

Plan Administrator: An organization, company or other entity contracted by the Department to:

- review and approve benefit payments,
- pay claims, and
- perform other duties related to the administration of a specific Plan

Plan Participant: An eligible person properly enrolled and participating in the Program.

Plan Year: July 1 through the following June 30.

PPO: See Preferred Provider Organization Hospital.

Pre-certification: See Notification.

Pre-existing Condition: Any disease, condition, (excluding maternity) or injury for which the individual was diagnosed, received treatment/ services, or took prescribed drugs during the three months immediately preceding the effective date of coverage under the Local Care Health Plan. Pre-existing would not apply provided there was not a break in coverage of more than 63 days. Refer to Creditable Coverage.

Preferred Brand Drug: A list of drugs, biologicals and devices approved by the pharmacy benefit manager for inclusion in the prescription drug plan. These drugs are proven to be both clinically and cost effective. The preferred brand drug list is subject to change.

Preferred Drug List: See Formulary.

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

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

Pre-treatment Estimate (Dental): A review by the dental Plan Administrator of a Provider's statement, including diagnostic X-rays and laboratory reports describing planned treatment and expected charges for verification of eligible benefits.

Preventive Service: Routine services which do not require a diagnosis or treatment of an illness or injury.

Primary Care Physician/Primary Care Provider (PCP): The Physician or other medical Provider a Plan Participant selects under a managed care plan to manage all health care needs.

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

Program: The Local Government Health Plan as authorized by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Provider: Any organization or individual which provides services or supplies to Plan Participants. This may include such entities as Hospitals, pharmacies, Physicians, laboratories or home health companies.

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

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

Schedule of Benefits: A listing of specific services covered by the LCDP and the Vision Plan.

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

Skilled Nursing Service: Non-custodial professional services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) which require the technical skills and professional training of such a licensed professional acting within the scope of their licensure.

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

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

State Employees Group Insurance Act: The statutory authority for benefits offered under the Local Government Health Plan (5 ILCS 375/1 et seq.).

Summary Plan Description (SPD): A document containing a description of benefits provided by licensed insurance Plans. Also known as a Certificate of Coverage.

Survivor: Spouse or dependent child(ren) of deceased Member who is receiving monthly benefits from the unit's sponsored retirement plan.

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

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

Transplant Preferred Provider Organization (TPPO) Hospital: A Hospital with which the Plan has negotiated favorable rates to perform certain transplants.

Usual and Customary (U&C): U&C is an amount determined by the Plan Administrator not to exceed the general level of charges by Providers in the locality where the charge is incurred when furnishing like or similar services,

treatment or supplies for a similar medical condition. This comparison takes into account all factors specific to a given claim including:

- Complexity of the services.
- Range of services provided.
- Any unusual circumstances or complications that require additional skill, time or experience.
- Prevailing charge level in the geographic area where the Provider is located and other geographic areas having similar medical-cost experience.

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

-A-		Coordination of Benefits	83
Acupuncture	45	-D-	
Allergy Injections	45	Dental Plan, <i>See Local Care Dental Plan</i>	
Ambulance	45	Dental Services (Medical)	
Annual Benefit Choice Period	17	Accidental	46
-B-		Diabetic Coverage	47
Behavioral Health Services	65	Dialysis	47
Benefits Summary	67	Durable Medical Equipment	47
Notification and Authorization Requirements	65	-E-	
Blood/Blood Plasma	45	Eligibility	
Breast Implantation Removal	45	Eligible as Dependents	14
Breast Reconstruction	45	Eligible as Members	13
-C-		Emergency Services	47
Cardiac Rehabilitation	46	Enrollment	17
Certificate of Creditable Coverage	19	Exclusions	
Chiropractic Services	46	LCDP	77
Christian Science Practitioner	46	LCHP	69
Circumcision	46	-F-	
Claim Appeal Process	93	Foot Orthotics	48
Claim Filing Procedures and Deadlines		Formulary	61
LCDP	79	-G-H-	
LCHP	73	Health Maintenance Organizations (HMOs)	34
COBRA	29	Health Plans, <i>See Local Care Health Plan, Health Maintenance Organizations and/or Open Access Plan</i>	
Colonoscopy and Sigmoidoscopy	46	Home Health Care Services, <i>See Skilled Nursing</i>	
Colorectal Cancer Screening	57		
Conversion Privilege Health Coverage	29		

Hospice	48	Medical Supplies	50
Hospital Bill Audit Program	42	Medicare	
Hospital Services	49, 51	COB with LCHP	86
		COB with Managed Care Plans	85
-I-		Morbid Obesity Treatment	51
Immunizations	59	-N-	
Infertility Treatment	48	Newborn Care	51
Infusion Therapies	49	Non-PPO Hospital Benefits	50
Irrevocability Rule	18	Notification Requirements	40
-J-K-L-		Nurse Practitioner	51
Lab and X-ray	50	-O-	
Local Care Dental Plan		Occupational Therapy	51
Exclusions	77	Open Access Plan	34
General Information	75	Orthodontic Services	76
Local Care Health Plan		-P-Q-	
Behavioral Health Services	65	Pap/Cervical Smears	57
Claim Filing Procedures and		Physical Therapy	51
Deadlines	73	Physicals for Adults	57
Exclusions	69	Physician Services	51
Medical Benefits Summary	45	Physician Services - Surgical	51
Plan Components	37	Plan Year Deductible	
Plan Features	37	LCDP	75
Prescription Drug Coverage	61	LCHP	43
Preventive Services	57	Podiatry Services	52
-M-		Pre-certification, <i>See Notification</i>	
Mammography	57	Requirements	
Managed Care Health Plans, <i>See Health</i>		Pre-determination of Benefits	
<i>Maintenance Organizations and</i>		(Health)	38
<i>Open Access Plan</i>			
Medical Case Management (MCM)	39		
Medical Necessity	38		

Pre-existing Conditions	19	-T-	
Pre-treatment Estimate (Dental)	75	Termination of Coverage	27
Preferred Provider Organization (PPO) Hospital Network	39	Transplants	54
Prescription Drugs (LCHP)	61	Transplant Transportation and Lodging Benefit	55
Preventive Services (LCHP)	57	-U-	
Prior Authorization Prescription Drugs (LCHP)	61	Urgent Care Services	56
Prostate Screening	57	Usual and Customary Charges (LCHP)	38
Prosthetic Appliances	52	-V-	
Prosthodontics	76	Vision Care Benefit Plan	81
-R-		-W-	
Radiation Therapy	52	Well Baby Care/Immunizations	58, 59
Recertification of Dependent Coverage	15	Well Child Exams/Immunizations	58, 59
-S-		-X-Y-Z-	
Second Surgical Opinion	53		
Skilled Nursing			
In a facility	53		
In a home setting	53		
Smoking Cessation Program	89		
Special Deductibles (LCHP)	37		
Speech Therapy	54		
Sterilization	54		
Subrogation and Reimbursement	91		
Surgery, <i>See Hospital Services</i>			

Notes

Notes

Notes

**Illinois Department of Central Management Services
Bureau of Benefits
PO Box 10105
Springfield, IL 62791**

**Printed by the authority of the State of Illinois
(CMS-BEN2002-02-25M-02/06)
Printed on recycled paper.**

