

STATE OF ILLINOIS

BENEFITS HANDBOOK



Illinois Department of Central Management Services
Bureau of Benefits

July 1, 2004

Rod R. Blagojevich, Governor
Paul J. Campbell, 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 State of Illinois Employees, Retirees and Annuitants understand and become familiar with the benefits available under various State-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 life programs**.

Chapter 3 provides information regarding **optional tax-free programs and other programs** available.

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

IMPORTANT
Do not throw away.

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Chapter 1

Enrollment and Eligibility Information

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Notes

Your Group Insurance Benefits

Your benefits are a very important part of your compensation package as a State of Illinois Employee or Retiree. **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 State Employees Group Insurance Program (Program) 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.

Group Insurance Representative (GIR)

A Group Insurance Representative (GIR) is your employing agency's liaison to the Department. Every State agency and retirement system has a GIR. Some of the larger agencies also have Group Insurance Preparers (GIP) who may assist the GIR with your insurance needs. GIRs and GIPs are valuable resources for answering questions you may have about your eligibility for coverage and to assist you in enrolling or changing the benefits you have selected.

To identify your GIR, call your agency personnel office or visit the website at www.benefitschoice.il.gov. If you are retired or on extended disability leave, your GIR is located at your retirement system office. If you are on leave of absence, contact your employing agency GIR. If you have terminated state service and continued your coverage under COBRA, contact the Department's Group Insurance Division.

Where To Get Additional Information

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

- Each individual Plan Administrator can provide you with specific information on plan coverage inclusions/exclusions.
- The Department's website contains the most up-to-date information regarding benefits and links to Plan Administrators' websites. Visit www.benefitschoice.il.gov for information.
- Annual Benefit Choice Options booklet. This booklet contains the most current information regarding changes for the Plan Year. New benefits, changes in premium amounts and changes in Plan Administrators are included in the booklet. **Read this booklet carefully as it contains important eligibility and benefit information that may affect your coverage.**

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

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

ID Cards

The Plan Administrators produce ID Cards at the time of enrollment and cards are mailed to the 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 QCHP, refer to the annual Benefit Choice Options booklet for the Notice of Privacy Practices.

Member Responsibilities

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

Notify your Group Insurance Representative (GIR) at your employing agency or your retirement system immediately when any of the following occurs:

- **Change of address.** When you and/or your Dependents move, you must notify each of the following:
 - GIR at your employing agency or retirement system
 - Deferred Compensation Program (if enrolled)
 - Commuter Savings Program (CSP) Plan Administrator (if enrolled)

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

- **Life changing events.** Failure to notify the GIR **timely** 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 State Employees Group Insurance Program (Program) (including divorced Spouses) must be reported to your GIR **immediately**. Failure to report an ineligible Dependent is considered a fraudulent act and will result in the loss of a premium refund, termination of Dependent coverage under the Program and potentially the loss of COBRA continuation rights. (Effective January 1, 2006).

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

- **Other Coverage.** If you have group coverage provided by a plan other than the Program, or if you or your Dependents gain other coverage during the Plan Year, you must provide that information to your GIR **immediately**.
- **Leave of Absence.** You must notify your GIR when you go on and/or return from a leave of absence. See the Time Away from Work section in this chapter.
- **Change in Medicare Status.** You must provide a copy of your and/or your Dependent's Medicare card to your GIR when a change in Medicare status occurs.

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

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

- **Payroll Deductions.** It is your responsibility to ensure payroll deductions are accurate for the insurance coverages and benefit programs you have selected/enrolled.
- **Life Insurance Beneficiary Form.** Contact the Life Insurance Plan Administrator.
- **Deferred Compensation Beneficiary Form.** Contact the Department's Deferred Compensation Division.
- **Retirement System Beneficiary Form.** Contact the appropriate retirement system.

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 Quality Care Health Plan (QCHP). 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 Program is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the Member and/or Dependent, as well as expenses incurred by the Program.

Annuitants, Retirees and Survivors who are receiving pension benefits from any of the five State retirement systems may be eligible to participate in the State Employees Group Insurance Program (Program). See the Eligibility Requirements section in this Chapter or contact the appropriate retirement system for information.

Coverage Options

Annuitants, Retirees 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, Annuitants not wishing to participate in the Program may elect to:

- Opt out of coverage (proof of other coverage not administered by the Department is required), or
- Waive coverage and become a Dependent of a Spouse with coverage through the Program, or
- Waive coverage when responsible for a percentage of the cost.
- Effective January 1, 2006, SERS Annuitants who opt out of coverage and are not Medicare eligible may receive a \$150.00 monthly financial incentive.

If You Live or Spend Time Outside Illinois

Retirees, Annuitants and Survivors who move out of state or the country will most likely need to enroll in the Quality Care Health Plan (QCHP). 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.

Immediate Annuitants

Immediate Annuitants begin receiving an annuity within one year of terminating State employment. Immediate Annuitants may continue coverage in the same health, dental and vision plans in force prior to retirement, or make different coverage elections. Immediate Annuitants may change any coverage election and add or drop Dependents, if the change is requested within 60 days of the retirement effective date. For information on life insurance coverage for Immediate Annuitants, refer to the Life Insurance Plan section in Chapter 2.

Deferred Annuitants

Deferred Annuitants begin receiving an annuity one year or more after terminating State employment. Deferred Annuitants must complete the required group insurance enrollment forms in addition to the required retirement forms at the time of application for retirement benefits. Deferred Annuitants who do not complete and return the appropriate forms will automatically be defaulted to the QCHP and Quality Care Dental Plan (QCDP), with state-paid basic life insurance coverage and no Dependent coverage. Deferred Annuitants who are defaulted may not change health plans, enroll Dependents or opt out of defaulted coverage until the next annual Benefit Choice Period or until they experience a Qualifying Change in Status. See the Life Insurance Plan section in Chapter 2 for information on life insurance coverage for Deferred Annuitants.

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.

Life Insurance Coverage for Annuitants age 60 and Older

When an Annuitant/Retiree turns age 60, the following changes to life insurance coverage occur:

- Basic life insurance coverage reduces to \$5,000.
- Optional life insurance coverage reduces to increments of \$5,000, with a maximum of four times the basic life insurance amount.
- Spouse life insurance coverage reduces to \$5,000 (Child life remains \$10,000 regardless of the Annuitant's age).

Cost of Participation in the Program

The cost of health coverage varies based upon the following two factors: the date the Member retired and the number of full years of Creditable Service. Refer to the Eligibility Requirements section in this chapter for details.

Always review annuity checks to verify the accuracy of the insurance deductions.

Power of Attorney

Retirees, Annuitants and Survivors should consider having a Power of Attorney on file with the retirement system. A Power of Attorney is considered a representative to act on the members behalf.

Flexible Spending Accounts (FSA) Program

IRS regulations do not allow Annuitants, Retirees or Survivors to participate in the Flexible Spending Accounts (FSA) Program. Members enrolled in FSA at the time of retirement may elect to continue participation through the end of the Plan Year for which they are enrolled. Annuitants electing this option must contact the GIR at their employing agency to complete the appropriate

continuation of participation forms.

Medicare

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

Survivors

Contact the retirement system immediately upon becoming a Survivor to determine eligibility and begin the application process.

Reciprocal Service Credit

Annuitants and Retirees, as well as their Survivors, can, under certain circumstances, use Creditable Service established in the five retirement systems to qualify for or reduce their cost for health benefits. Contact the retirement system for specific questions regarding reciprocal service credit.

Retired Judges

Retired State Judges who become Federal Judges have spousal insurance options available. Contact the retirement system for details.

General Assembly

Vested Members of the General Assembly who leave the General Assembly before they are eligible to retire may continue group insurance coverage until they begin receiving their pension. Individuals electing this option are responsible for the entire cost of the coverage.

Eligibility Requirements

This section contains benefit eligibility information which applies to all **health, dental, vision and life** plans. Eligibility for optional programs can be found in Chapter 3.

Eligibility Requirements

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

Eligible As Members

Employees

In order to be eligible as an Employee the following criteria must be met:

Participate in and contribute to one of the following five State retirement systems:

- State Employees Retirement System (SERS)
- State Universities Retirement System (SURS)
- Teachers Retirement System (TRS)
- General Assembly Retirement System (GARS)
- Judges Retirement System (JRS)
- and -

Paid salary through the Comptroller's Office or a local university payroll or certain other agencies/ departments as specified in the Act.

- **Full-Time Employees - Permanent**
Employees who work 100% of a normal work period are eligible to participate in the health, dental, vision and life plans under the State Employees Group Insurance Program (Program).

Full-time Employees may elect not to participate in the dental plan. Employees may also elect to opt out of the health, dental and vision plans if proof of other major medical insurance (not administered by the Department) is provided. Basic life insurance coverage is provided at no cost to Employees in an amount equal to the Employee's annual basic salary. Employees may also purchase optional life insurance coverage. See the Life Insurance Plan section in Chapter 2 for details.

- **Employees of the State -**

Employees (including part-time Employees hired prior to January 1, 1980 that have been continuously employed).

- **University Full-time Faculty -** Employees working greater than or equal to 9 months of the year.

- **University Full-time Non-Faculty -**

Employees hired to work an average of 37.5 hours or more per week on a permanent basis.

- **Part-Time Employees -**

Employees who work 50-99% of a normal work period are eligible to participate in the health, dental, vision and life plans under the Program.

Part-time Employees may elect not to participate in the dental plan, or may also elect to **waive** health, dental and vision coverage. Part-time Employees must pay a portion of the health and dental cost in relation to the percentage of hours worked. Basic life insurance is provided at no cost to part-time Employees in an amount equal to the Employee's annual basic salary. Employees may also purchase optional life insurance coverage. See the Life Insurance Plan section in Chapter 2 for details.

NOTE: Although your employment status may be classified as full-time, your eligibility for Group Insurance could be part-time based upon hours worked.

- **Permanent Employees of the State/ University Non-Faculty** - Persons employed on or after January 1, 1980 (does not apply to those eligible for the Program before January 1, 1980) and regularly scheduled to work at least 50% of the average weekly hours required of a full-time Employee in a similar position, measured yearly.
- **University Part-time Faculty** - Employees working greater than or equal to 4.5 continuous months and not meeting requirements as a full-time faculty member.
- **Agency Seasonal Service** - Employees who work greater than or equal to 6 months but not less than 975 hours per 12-month work period.
- **University Seasonal Service** - Non-faculty Employees hired to work greater than 4 but less than 12 continuous months, but not less than 730 hours per 12-month work period.
- **Others considered as covered Employees are:**
 - Elected State 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 with the State of Illinois.
 - Former Members of the General Assembly who have vested and allowed their contributions to remain with the General Assembly Retirement System, but are not receiving an annuity, may participate at their own expense.

- Employees on approved leaves of absence.
- Emergency appointments may participate at their own expense.

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 Program in accordance with the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA participants may elect not to participate in the dental plan.

Retirees

An individual who began receiving pension benefits from one of the State's five retirement systems prior to January 1, 1966. Retirees are eligible to participate in the health, dental and vision plans under the Program. Retirees may elect not to participate in the dental plan. Retirees may also elect not to participate in the health, dental and vision plans if proof of other major medical insurance (not administered by the Department) is provided. No life insurance benefits are available to Retirees.

Annuitants

Immediate Annuitants

An individual who began receiving pension benefits on or after January 1, 1966 from one of the State's five retirement systems and within one year of terminating state employment. Immediate Annuitants are eligible on the effective date of the commencement of their retirement or annuity benefits, or the first of the month of their application for retirement, **whichever is later**. Immediate Annuitants must satisfy, based solely on prior state employment, the minimum vesting requirements of the appropriate retirement

system. Immediate Annuity holders should contact the retirement system prior to actual retirement to confirm they will be eligible for group insurance coverage.

Immediate Annuity holders are eligible to participate in the health, dental, vision and life plans under the Program. Immediate Annuity holders may elect not to participate in the dental plan. Immediate Annuity holders may also elect not to participate in the health, dental and vision plans if proof of other major medical insurance (not administered by the Department) is provided. Basic life insurance coverage is provided at no cost to Annuity holders for an amount equal to the annual basic salary as of the last day of employment, but reduces to \$5,000 at age 60. Immediate Annuity holders may also purchase optional life insurance coverage. See the Life Insurance Plan section in Chapter 2 for details.

- Immediate Annuity holders who **retired on or after January 1, 1998** under SERS or SURS with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service. Immediate Annuity holders who must pay a percentage of the cost may elect to waive health, dental and vision coverage.
- Immediate Annuity holders who **retired on or after July 1, 1999** under TRS with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service. Immediate Annuity holders who must pay a percentage of the cost for their health coverage may elect to waive health, dental and vision coverage.

Special Provisions:

ARCP - Employees vested under the State Employees Retirement System who elected the Alternative Retirement Cancellation Payment (ARCP) per Illinois Public Act 93-0839 (between August 16, 2004 and October 31, 2004), or Public Act 94-0109 (between July 1, 2005 and September 30, 2005) may be eligible for coverage under the Program. An ARCP recipient who would have otherwise qualified for an annuity within one year of leaving state service may be eligible for the same group insurance benefits as an Immediate Annuity holder.

SURS - Immediate Annuity holders who were employed under a SURS employer **on July 7, 1997** who retire under SURS **on or after July 30, 1999** are eligible to elect a lower pension benefit with fully State-paid insurance.

Both Spouses are Members - Upon receiving a retirement annuity, an Annuity holder may elect to become a Dependent of their Spouse for health, dental and vision coverage and continue life insurance coverage as an Annuity holder per Public Act 93-0553 (effective August 20, 2003).

Deferred Annuity holders

An individual who began to receive pension benefits on or after January 1, 1966 from one of the State’s five retirement systems one year or more after terminating state employment. Deferred Annuity holders are eligible on the effective date of the commencement of their annuity benefits, or the first of the month of their application for retirement, **whichever is later**. Deferred Annuity holders must satisfy, based solely on prior State employment, the minimum vesting requirements of the appropriate retirement system. Deferred Annuity holders should contact the retirement system prior to actual retirement to confirm they will be eligible for group insurance coverage.

Deferred Annuitants are eligible to participate in the health, dental, vision and life plans under the Program. Deferred Annuitants may elect not to participate in the dental plan. Deferred Annuitants may also elect not to participate in the health, dental and vision plans if proof of other major medical insurance (not administered by the Department) is provided. Basic life insurance coverage is provided at no cost to Deferred Annuitants for an amount equal to the Employee's annual basic salary as of the last day of employment but reduces to \$5,000 at age 60. Deferred Annuitants are not eligible to purchase optional life insurance coverage. See the Life Insurance Plan section in Chapter 2 for details.

- A Deferred Annuitant who **retired on or after January 1, 1998** under SERS or SURS with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service. Individuals who must pay a percentage of the cost may elect to waive health, dental and vision coverage.
- A Deferred Annuitant who **retired on or after July 1, 1999** under TRS with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service. Individuals who must pay a percentage of the cost may elect to waive health, dental and vision coverage.

Special Provisions:

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

under the Program. An ARCP recipient who would have otherwise qualified for an annuity more than one year from the date of leaving State service may be eligible for the same group insurance coverage as a Deferred Annuitant.

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

Survivors

A Spouse, child(ren) or Dependent parent(s) of a deceased Member who is certified as eligible to receive an annuity from one of the five State retirement systems as a result of the death of a Member in one of the above categories.

Survivors are eligible to participate in the health, dental, and vision plans under the Program. Survivors may elect not to participate in the dental plan. Survivors may also elect not to participate in the health, dental and vision plans if proof of other major medical insurance (not administered by the Department) is provided. Eligibility for life insurance coverage varies as indicated below.

A Survivor whose annuity is paid based upon the death of an Employee or Immediate/Deferred Annuitant whose **death occurred prior to September 22, 1979:**

- Survivors of an Employee, Immediate Annuitant or Deferred Annuitant are eligible for \$2,000 basic life insurance coverage.
- Survivors of an Employee or an Immediate Annuitant may purchase optional life insurance coverage in amounts of 1-4 times the basic amount as well as AD&D, Spouse life or child life coverage.

- Survivors of Deferred Annuitants are NOT eligible to purchase optional life insurance coverage, AD&D, spouse life or child life insurance coverage.

A Survivor whose annuity is paid based upon the death of an Employee or Immediate/Deferred Annuitant whose **death occurred on or after September 22, 1979:**

- Survivors of an Employee or an Immediate Annuitant may elect \$5,000 optional life insurance coverage and are NOT eligible for basic life, AD&D, spouse life or child life insurance coverage.
- No life insurance coverage benefits are available for Survivors of Deferred Annuitants on or after September 22, 1979.

A **SERS or SURS Survivor** whose annuity is paid based upon the death of an Employee whose death occurs **on or after January 1, 1998** with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service earned by the deceased Employee.

A **SERS or SURS Survivor** whose annuity is paid based upon the death of an Annuitant who became a SERS or SURS Immediate/Deferred Annuitant **on or after January 1, 1998** with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service earned by the deceased Employee.

A **TRS Survivor** whose annuity is paid based upon the death of an Employee whose death occurs **on or after July 1, 1999** with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service earned by the

deceased Employee.

A **TRS Survivor** whose annuity is paid based upon the death of an Annuitant who became a TRS Immediate/Deferred Annuitant **on or after July 1, 1999** with less than 20 years of service must pay a percentage of the cost for their health coverage in relation to the number of years of Creditable Service earned by the deceased Employee.

Special Provision:

ARCP - A Survivor of an ARCP recipient who would have otherwise qualified for an annuity within one year of leaving state service may be eligible for the same group insurance benefits as a Survivor of an Immediate Annuitant. A Survivor of an ARCP recipient, who would have otherwise qualified for an annuity more than one year from the date of leaving State service, may be eligible for the same group insurance coverage as a Survivor of a Deferred Annuitant.

SURS - Survivors of an Immediate or Deferred Annuitant who elected a lower pension benefit with State-paid insurance are also eligible for fully State-paid insurance coverage.

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 one of the five State retirement systems.

Eligible As Dependents

Eligible Dependents of a Member may participate in the same health, dental and vision plans as the Member. Eligibility for spouse life and child life insurance varies, see the Life Insurance Plan section in Chapter 2 for details. 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 or handicapped.

- **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 Member's mother, father, unmarried son, unmarried daughter, grandmother, grandfather, brother, sister, grandchild, niece or nephew who has been **continuously** enrolled as a Dependent prior to February 11, 1983, or 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

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 State 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. 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. Non-retroactive reinstatement will cause a break in coverage which would prevent a Dependent from qualifying for continued coverage in the Other category.

NOTE: Dependents with life insurance coverage only, as well as Dependents of COBRA participants, must also recertify eligibility for coverage.

Contact your GIR for questions regarding recertification of a Dependent.

Notes

Enrollment Periods

Members may enroll, opt out 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 State Employees Group Insurance Program (Program) or one who has had greater than a 10-day break in coverage (does not apply to coverage terminated due to non-payment of premium). 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 employment date or receipt of annuity to make health, dental, vision and life insurance coverage elections. All Members, including part-time Employees, who fail to make benefit elections within the 10-day initial enrollment period will automatically be enrolled in the Quality Care Health Plan (QCHP) and the Quality Care Dental Plan (QCDP) with no Dependent coverage, and will be provided with basic life coverage.

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

New Members have the following options:

- Elect a health plan.

- Enroll eligible Dependents.
- Enroll in the Flexible Spending Accounts (FSA) Program, the Commuter Savings Program (CSP) and/or the Deferred Compensation Program.
- Elect Member optional life insurance coverage up to 4 times basic life without Statement of Health approval.
- Elect optional 5 to 8 times basic life insurance coverage with a Statement of Health approval.
- Elect optional spouse life, child life or accidental death and dismemberment without Statement of Health approval.
- Full-time Members may elect to opt out of the health, dental and vision plans if proof of other major medical insurance can be provided by an entity other than the Department of Central Management Services (Department).
- Part-time Employees may elect to waive health, dental and vision coverage.
- Annuitants may elect to waive health, dental and vision coverage and become a Dependent of their State-covered Spouse.
- Elect not to participate in the dental plan.

Dependents must be enrolled within 10 calendar days of the Member’s employment effective date. Documentation is required for Dependent coverage and must be provided within 15 days of the employment 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 employment.
- Coverage for Annuitants becomes effective the first day of the month following 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 and dental changes become effective July 1st. Life insurance coverage changes requiring a Statement of Health become effective July 1st if the approval date from the Life Insurance Plan Administrator is prior to July 1st. If the approval date is after July 1st, the effective date of life insurance changes is the first day of the pay period following the Statement of Health approval date.

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

Members may make the following changes during the annual Benefit Choice Period:

- Change health plans.
- Add or drop Dependent coverages.
- Enroll or re-enroll in the Flexible Spending Accounts (FSA) Program or the Commuter Savings Program (CSP).
- Increase or decrease Member optional life insurance coverage, and add or drop Dependent life insurance coverage. An approved Statement of Health is required to increase or add coverage.
- Full-time Members may elect to opt out of or in to the health, dental and vision coverage. If opting out, proof of other major medical insurance provided by an entity other than the Department is required.
- Part-time Employees, or Annuitants and Survivors required to pay a portion of the premium, may elect to waive health, dental and vision coverage; or enroll in health, dental and vision coverage.
- Annuitants may elect to waive health, dental and vision coverage and become a Dependent of their State-covered Spouse.
- Elect to participate or not participate in the dental plan.

Qualifying Change in Status

Pursuant to Section 125 of the Internal Revenue Code, premiums paid by the Member for health, dental and life insurance coverage are tax exempt. The tax exemption applies only to premiums that are payroll deducted. The Internal Revenue Code requires plans 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.

If the State is not in compliance with the Irrevocability Rule, the Program could lose its qualification and/or Members could be subject to an IRS audit and be required to pay additional taxes and possible penalties.

Coverage elected during the annual Benefit Choice Period remains in effect throughout the entire Plan Year, unless the Member experiences a Qualifying Change in Status or a Special Enrollment Event which would allow them to change their coverage elections.

Any request to change an election mid-year must be consistent with the qualifying event the Member has experienced.

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 Program.
- 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 Group Insurance Representative (GIR) 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.

There are some coverage options that are taxable and therefore exempt from the Irrevocability Rule and can be changed anytime during the year. Coverage options include:

- Changes in Member’s life insurance coverage above \$50,000. Includes basic life and any optional life insurance coverage. An approved Statement of Health is required to increase coverage.
- Changes to spouse life or child life coverage. An approved Statement of Health is required to add coverage.
- Changes to Member’s Accidental Death and Dismemberment (AD&D) coverage. A Statement of Health is not required.

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.

Life insurance increases become effective the first day of the pay period following the Statement of Health approval date.

Flexible Spending Account (FSA) elections/changes become effective the first day of the pay period following the date the request for change was signed or the date of the Qualifying Event, whichever is later.

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.

Waiving Coverage

Eligible part-time Employees, Annuitants and Survivors may elect to waive coverage for which they are required to pay a portion of the State-paid premium. These Members may waive health, dental and vision coverage during the Initial Enrollment Period, the annual Benefit Choice Period or upon experiencing a Qualifying Change in Status.

The election to waive coverage remains in effect until the eligible Member becomes full time, elects to re-enroll during the next annual Benefit Choice Period or due to a Qualifying Change in Status.

Part-time Employees may not waive coverage and become a Dependent of their State-employed Spouse. Only those Members who waived all coverage prior to July 1, 2003 and have been continuously enrolled on their Spouse's coverage may continue to waive coverage and be carried as a Dependent. This group of part-time Employees is not eligible for life insurance coverage as a Member.

Opting Out of Health, Dental and Vision Coverage

Full-time active Employees, Annuitants/ Retirees and Survivors are allowed to opt out of the health, dental and vision coverage if they can provide proof of comprehensive major medical health coverage (indemnity or managed care) by an entity other than the Department. Members electing to opt out **cannot** be enrolled as a Dependent in any plan administered by the Department. All Members may elect to opt out of health, dental and vision during the Initial

Enrollment Period, the annual Benefit Choice Period or upon experiencing a Qualifying Change in Status.

NOTE: A Member's application for other health coverage is not acceptable proof of other coverage.

New full-time Employees may elect to opt out of health, dental and vision coverage during the 10-day Initial Enrollment Period if they can provide proof of comprehensive major medical health coverage (indemnity or managed care) provided by an entity other than the Department. All full-time Employees electing to opt out will be provided with basic life insurance coverage and may elect optional life insurance coverage.

Annuitants wishing to waive coverage to become a Dependent of a Spouse enrolled under a health plan administered by the Department should see 'Both Spouses are Members' in the Eligibility Requirements section.

Opting In to Health, Dental and Vision Coverage

Members may enroll/re-enroll in health, dental and vision coverage during the annual Benefit Choice Period or upon experiencing a Qualifying Change in Status (see the Member Qualifying Changes in Status chart later in this chapter). Members electing to enroll/re-enroll are subject to Pre-existing Conditions requirements.

Members electing to enroll/re-enroll in the Program mid-year due to a Qualifying Change in Status must provide a Certificate of Creditable Coverage from the previous carrier to prove the loss of other coverage.

Members electing to enroll/re-enroll in the Program during the annual Benefit Choice Period do not need to prove loss of other coverage; however, they do need to provide a Certificate of Creditable Coverage

from the previous carrier to satisfy Pre-Existing Condition requirements.

Members enrolling/re-enrolling may elect not to participate in the dental plan.

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 Program. 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 State'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 agency 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

With few exceptions, Employees and Annuitants eligible for insurance coverage must be enrolled as a Member in their own right. The following may waive coverage and become a Dependent of their State-employed Spouse:

- Employees in certain non-pay status who are ineligible for the State paid insurance, such as personal/general leave of absence or suspension over 30 days, as well as those Members who have exhausted the maximum leave of absence coverage period.
- Annuitants whose Spouse is an active Member.

Full-time Employees may not opt out of health, dental and vision and enroll as a Dependent in any plan administered by the Department (i.e., State, LGHP, CIP, TRIP).

Either Member may elect coverage for Dependents; however, the same Dependent cannot be enrolled under both Members for the same type of coverage. For example, eligible Dependents may be enrolled under one Member for health, dental and vision coverage and enrolled under the other Member for life coverage. Not all Dependents are required to be enrolled under the same Member.

NOTE: Part-time Employees who waived all coverage prior to July 1, 2003 and have been continuously enrolled as a Dependent on their Spouse's coverage may continue to waive coverage as a Member and be carried as a Dependent.

Dependent Enrollment

Members must request Dependent coverage in writing. Members must contact their GIR 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.

Dependents must be enrolled in the same health, dental and vision plans as the Member. Members electing to opt out of health, dental and vision insurance coverage may enroll their Dependents with life insurance coverage only.

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, vision and life 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 Student must provide verification of military time served, verification of full-time student status in an accredited school, or, if enrolling the following semester, a letter from the Member advising of the students "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 either received an organ transplant after June 30, 2000, **or** has been **continuously** enrolled in the Program (or CNA Insurance for universities) since February 11, 1983. The period of time a Dependent was enrolled with Golden Rule Insurance Company (prior to April 1, 1988) does not count toward the requirement of continuously enrolled. Dependents enrolled in the Other Category are not eligible to participate in life insurance coverage.

Penalty for Fraud

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

The Internal Revenue Code requires Plans 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								
	Opt Out of Health & Dental Coverage	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	Waive Health & Dental Coverage
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 becomes eligible for non-State group insurance coverage	O								
Eligibility: Member loses eligibility (for other than non-payment of premium) of non-State group insurance coverage		X							
Employment Status: Full-time to part-time (part-time = 50% or greater)						X	X		P
Employment Status: Part-time participating to full-time	O								
Employment Status: Part-time waiving coverage or working <50% to full-time	O			X	X				
Initial enrollment - within 10 days	O	X		X	X				P
Leave of Absence: Member entering non-pay status						X	X		X
Leave of Absence: Member entering non-pay status responsible for 100%						X	X		X
Leave of Absence: Member returns to work from non-pay status	O	X		X	X				P
Marriage	O	X	X		X				P
Medicaid or Medicare eligibility gained	O					X	X		
Medicaid or Medicare eligibility lost		X		X	X				
Military Call-up: Member called-up by executive order						X	X	X	X
Military Call-up: Member returns to work	O	X		X	X			X	P
PCP leaves network								X	
Premium increase 30% or greater: Employee's non-State health insurance		X		X	X				
Premium increase 30% or greater: Member's State health insurance						X	X		P
Residence/Work location: Member's county changes								X	
Retirement	X	X		X	X	X	X	X	

X= Eligible changes for all Members.

P= Eligible changes for part-time Employees and/or Survivors and Annuitants required to pay a Member premium.

O= Eligible changes for full-time Employees, Retirees and/or Survivors and Annuitants not required to pay a Member premium.

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 Opt Out of Program	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	Waive Health/ Dental Coverage
Coordination of Spouse's open enrollment period	O	X		X	X	X	X		P
Death of Spouse		X					X		
Eligibility: Spouse loses eligibility for group insurance coverage		X		X	X				
Eligibility: Spouse now provided with group insurance coverage	O					X	X		P
Employment Status: Spouse gains employment	O					X	X		P
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 & DENTAL Options								
	Member May Opt Out of Program	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	Waive Health/ Dental Coverage
Death of Dependent						X			
Eligibility: Dependent becomes eligible for State group coverage				X					
Eligibility: Dependent loses eligibility for non-State group coverage				X					
Eligibility: Dependent now eligible for non-State 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).
Student Military 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 been continuously enrolled prior to February 11, 1983	Member's tax return, or other documentation proving financial dependency, ~ AND ~ Dependent Recertification form (CMS-138).
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 State Employees Group Insurance Program is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the Member, as well as expenses incurred by the Program.</p>	

Documentation Time Limits			
<p>Dependent coverage may be added with the corresponding effective date when documentation is provided to your GIR 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 hire	Day 1–10 after hire date	1–15 days after hire 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

It is each Member's responsibility to verify the accuracy of premiums paid, whether payroll deducted or direct billed.

As a participant in the State Employees Group Insurance Program (Program), the amount the Member must pay for coverage elected is contingent on employment status and coverage elected. The State covers the majority of the cost of health, dental and vision insurance coverage for most Members. Premiums can be found in the current Benefit Choice Options booklet, through your Group Insurance Representative (GIR) or by visiting the website at www.benefitschoice.il.gov.

Employees

The contribution for health coverage each Plan Year (July 1 through June 30) is based on the Employee's annual salary as of the preceding April 1st. The contribution remains in effect throughout the Plan Year unless the Employee retires, accepts a voluntary salary reduction or returns to state employment at a different salary (does not apply to an Employee returning to work from a leave of absence). Premiums for dental, optional life and Dependent insurance coverage are **in addition** to the monthly salary-based contribution.

Full-Time Employees

Premiums for full-time active Employees are payroll deducted. It is the Member's responsibility to verify the accuracy of payroll deductions and to notify their GIR of any errors.

Part-Time Employees

Part-time employees who elect to participate in the Program must pay a percentage of the State's cost for health and dental coverage. This percentage is in addition to the salary-based contribution and is applied to the Employee as well as Dependent premiums. The percentage of

the cost the State contributes is based on the percentage of time worked. The Employee is responsible for the remaining balance.

Part-time Employees should check with their GIR to determine the premium contribution for the Plan Year.

Employees Off Payroll

A bill will be generated by the Department of Central Management Services (Department) for premium amount due. Bills are generated and mailed each month. Federal IRS regulations do not allow these premiums to be payroll deducted.

Bills from the Department are mailed the first week of each month and must be paid by the due date to ensure continuation of coverage. Employees who do not receive a bill within 30-days of going off payroll should contact their GIR.

Failure to submit payment will result in termination of coverage retroactive to the last day of the pay period for which full payment was received.

Employees whose coverage is terminated for non-payment of premium will be responsible for any medical, dental and/or vision claims incurred on or after the termination date. Employees and their Dependents who have been terminated for non-payment of premium are not eligible for continuation of coverage through COBRA.

Retirees, Annuitants and Survivors

Members who participate in the Program as a Retiree, Annuitant or Survivor are not subject to salary-based premium contributions. Premiums for optional coverages are generally deducted from the Member's annuity check. In situations where the annuity check is less than the insurance premium owed, the Member will be direct billed for the coverage by the Department.

Annuitants and Survivors responsible for paying a percentage of the State contribution due to having less than 20 years of Creditable Service should contact their GIR at their retirement system to determine the premium contribution for the Plan Year.

Annuitants and Survivors whose coverage is terminated for non-payment of premium are not eligible to re-enroll in the Program at any time in the future.

COBRA Participants

While a Member is on COBRA, a monthly bill is generated by the Department for the premium amount due. Bills are mailed the first week of each month and must be paid by the due date to ensure continuation of coverage. Members who do not receive a bill should contact the Department for assistance.

Failure to submit payment will result in termination of coverage retroactive to midnight the last day of the month for which full payment was received.

Payroll Premium Refunds

Under the Retroactive Policy, premium refunds based on corrections to a Member's insurance elections may be processed retroactively up to six months. Members who fail to notify their GIR within 60 days of Dependent ineligibility will not receive a premium refund. (Effective January 1, 2006).

Premium Underpayments

Underpaid premiums are the responsibility of the Member and must be paid in full, regardless of the time period for which the underpayment occurred.

Penalty for Fraud

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

Time Away From Work (including Leaves of Absence)

Employees who are away from work for reasons such as approved medical or personal leave of absence are eligible to continue insurance coverage in the State of Illinois Group Insurance Program (Program) for a specified period of time, subject to premium payment.

While an Employee is on a leave of absence, and/or off payroll on the first work day of a pay period, premiums are directly billed by the Department of Central Management Services (Department) and not deducted through payroll. Refer to the Premium Payment section in this chapter for information regarding premium payments.

Employees on an approved leave covered under FMLA, educational/sabbatical, seasonal or military service continue to pay the member contribution while the state maintains the employer premium contribution for a specified period. Refer to the Time Away From Work charts later in this section to determine the maximum length of State contribution.

Additionally, Employees who are in non-pay status greater than 30 calendar days per Plan Year (including authorized, unauthorized or excused absences), are responsible for 100% of the insurance premium for each applicable pay period in which a day in non-pay status occurs. Premiums are billed by the Department and not deducted through payroll.

Insurance Coverage While on a Leave of Absence

Employees may choose, within the first 60 days of the leave, to continue all current coverages or waive certain coverages. Employees should contact their Group Insurance Representative (GIR) for options.

Changes to coverage are effective the date of the request.

Family Medical Leave Act (FMLA)

Employees granted an FMLA leave of absence are afforded up to 12 work weeks of job protection under federal guidelines. The State contributes toward the insurance premiums for these Employees for a limited period of time. See the Time Away From Work charts later in this section. Time away from work, whether paid or unpaid, runs concurrent with any other FMLA protected time.

Family Leave

State agencies, boards, commissions and/or universities may provide Family Leave for Employees who request time away from work for family medical situations that are consistent with the FMLA guidelines. Employees who are extended this benefit continue to have the State's portion of the premiums paid by the State for a specified period. The length of this State-paid benefit varies by agency.

Employees who remain on Family Leave after the State-paid benefit has been exhausted, as well as Employees on a non-medical family leave, may continue coverage at 100% of the cost. The length of time the Employee may continue coverage on a Family Leave varies by agency. See the applicable chart on the following pages.

Maximum Length of Employer Contribution

Some leaves of absence have a maximum length of participation for continued coverage. For purposes of calculating the maximum length of employer contribution for employees on leave of absence, refer to the Time Away From Work charts in this section. A physical return to work of one pay period or less, or a return to payroll in order to pay out benefit time (i.e., sick, vacation, etc.), does not extend the maximum length of employer contribution.

Termination of Coverage

Group Insurance coverage for Employees on leave of absence who have exhausted the maximum length of participation will be terminated.

Employees whose coverage is terminated for this reason are eligible under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). See the COBRA section in this chapter for information.

In most cases, Employees whose coverage is terminated for non-payment of premium are not eligible for continuation of coverage through COBRA. However, an Employee whose coverage is terminated for non-payment of premiums while under FMLA protection may be eligible for COBRA. Contact the Department for details.

Reinstatement of Coverage

Employees whose coverage has been terminated due to non-payment of premium will be reinstated the first day of the first full pay period upon the Employee's physical return to work.

Employees whose coverage has been terminated due to non-payment of premium and have not returned to work may elect to re-enroll in the Program during the annual Benefit Choice Period.

Time Away From Work Protected by Family Medical Leave Act (FMLA)

While on an FMLA qualifying leave of absence, such as to care for a family member with a serious health condition or to care for a newborn, an Employee is afforded up to 12 work weeks of job protection under federal guidelines. While on a job-protected FMLA leave of absence, the State continues to make contributions toward the insurance premiums.

In order to qualify for FMLA, an Employee must meet all of the following requirements:

- employed by the State for at least 12 months;
- worked at least 1,250 hours in previous 12 month period; and
- have not used the allotted FMLA coverage for any other time away from work in the preceding 12 months.

In order to determine whether a specific reason for time away from work qualifies for FMLA, Employees should contact their agency Personnel Office.

For purposes of calculating the length of time the State will continue contributions toward insurance premium, the state-paid coverage period begins the day the Employee leaves work. This period includes all time away from work, including paid and unpaid time off, i.e. vacation, sick, personal and maternity/paternity.

*Employees using intermittent FMLA are limited to 450 hours (12 work weeks) of leave in which the State maintains the Employer premium contribution.

	Type of Leave	State Maintains Employer Contribution	Maximum Length of Employer Contribution	Additional Information
F M L A R u n s C o n c u r r e n t l y	Family Leave (Medical)	Yes	12 weeks for Employees whose agency is not under the Governor.* ----- 6 months for Employees whose agency is under the Governor.*	Leave to care for a seriously ill immediate family member or to care for a newborn.
	Occupational Disability (Workers' Compensation)	Yes	Varies - State will continue to make premium contribution while the Employee is receiving a Workers' Compensation/TTD benefit.	Employee is required to continue to pay for health, dental and optional life insurance coverage normally payroll deducted. Workers' Compensation pays only for work-related claims. Employee must provide the employing agency with monthly physicians' statements upon request.
	Non-Occupational Disability with retirement system disability benefits	Yes	Varies	Receiving a disability payment from one of the five State Retirement Systems. Employee must provide the employing agency with monthly physicians' statements upon request.
	Non-Occupational Disability without retirement system disability benefits	Yes	24 months	Not receiving a disability payment from one of the five State Retirement Systems. Employee must provide the employing agency with monthly physicians' statements upon request.

Time Away From Work <u>Not</u> Protected by the Family Medical Leave Act (FMLA)			
<p>Time away from work not protected by FMLA is divided into two categories:</p> <ul style="list-style-type: none"> ■ Time for which the State contributes toward the insurance premiums. ■ Time for which the State does not contribute toward the insurance premiums, i.e., the Employee is responsible for paying 100% of the premium. 			
Type of Leave	State Maintains Employer Contribution	Maximum Length of Employer Contribution	Additional Information
Educational/Sabbatical	Yes	24 months - lifetime benefit	Must be work related.
Seasonal Leave (State Agency and University Non-Faculty)	Yes	6 months	Applies to seasonal workers who work greater than or equal to six months but less than 12 months. Employee required to pay same prorated share (percentage of hours worked as compared to 1,950 hours) while away from work as when actively working.
Seasonal Leave (University Full-Time Faculty)	Yes	3 months	Seasonal break for faculty. Automatic termination September 1 if Employee has not returned to work.
Seasonal Leave (University Part-Time Faculty)	Yes	6 months	Leave for part-time faculty. Automatic termination September 1 if Employee has not returned to work. Employee required to pay same prorated share while away from work as when actively working.
Dock/Suspension (Includes authorized, unauthorized and excused absences)	Yes	30 calendar days per Plan Year	After 30 calendar days of State-paid coverage, the Employee may continue coverage at 100% of the cost.
Military Call Up	Yes	Duration of call up	Applies to Employees ordered to active duty by a Presidential call up.
Military Leave	Yes	24 months/48 months	Health, dental, vision and life coverage for the first 24 months. After 24 months Employee eligible for life insurance coverage only for an additional 24 months.
Personal/General Leave	No	Not Applicable	Non-medical time away from work for reasons not covered by any other type of leave. The maximum period allowed for coverage is 24 months.
Permanent Layoff	Varies	24 months	Employees may be eligible for 6 - 24 months of premium-free coverage. Contact your Group Insurance Representative for further details.
Family Leave (Non-Medical)	No	Not Applicable	Family leave that does not qualify for State-paid coverage or family leave that exceeds the maximum period of State-paid coverage. The maximum period allowed for coverage varies by agency, but may not exceed 12 months.

Termination of Coverage

This section describes the events and timing of the termination of benefits. In most cases, health, dental and vision insurance coverage can be continued under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Members may be eligible to continue life insurance coverage under portability and conversion options. See the Life Insurance Plan section in Chapter 2.

Termination of Member Coverage

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

- Termination of State employment (e.g., not increased by any type of lump sum payment).
- Change from full-time employment to less than 50% part-time employment.
- Recalculation of actual hours worked (i.e. any employee – regardless of classification as full-time or part-time – who actually works less than 50% of a normal work period) measured yearly.
- 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).
- Permanent Layoff. Certain Employees may be eligible for 6 – 24 months of premium-free coverage. Employees who do not qualify for the premium-free coverage have the option to continue health, dental and vision coverage under COBRA. Life insurance coverage may be continued for one year entirely at the Employee's expense. If interested in continuing life insurance coverage, the Employee should contact their Group Insurance Representative (GIR).

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 Dependent in the two or more 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 Program as a Member.
 - Marriage of the Dependent.
 - Divorce from the Member.

NOTE: Members who fail to notify their GIR within 60 days of Dependent ineligibility will not receive a premium refund. (Effective January 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.

An initial notice is provided to all new Members upon enrollment in the Group Insurance Program. This notice is to acquaint individuals with COBRA law, notification obligations and possible rights to COBRA coverage if loss of group health coverage should occur. If an initial notice is not received, contact your Group Insurance Representative (GIR).

Eligibility

Covered Members and Dependents who lose coverage due to certain qualifying events (see chart at end of this section) are considered Qualified Beneficiaries and may be able to continue coverage under the provisions of COBRA. Continuation of coverage under COBRA for Qualified Beneficiaries is identical to the health, dental and vision insurance coverage provided to Members. The life insurance coverage in force on the date of termination is not available through COBRA; however, the Member and/or Dependent may be eligible to convert or port their life insurance coverage. See the Life Insurance Plan section in Chapter 2 for details.

Covered Dependents retain COBRA eligibility rights even if the Member chooses not to enroll. Qualified Beneficiaries electing continuation of coverage under COBRA are enrolled as a Member.

If the Spouse or Dependent children live at another address, notify the Department immediately so that notification can be sent to the proper address.

Employees who have opted out of health, dental and vision insurance coverage, and their Dependents, are not eligible to participate in COBRA.

Pre-existing Condition limitations do not apply to individuals electing COBRA, unless they have not previously met the pre-existing period. See the Enrollment section in this chapter for more information regarding Pre-existing Conditions limitations.

Notification of COBRA Eligibility

The Member or Qualified Beneficiary must notify their GIR within 60 days of the date of the event or the date on which coverage would end, whichever is earlier. Failure to notify your GIR within 60 days will result in disqualification of COBRA continuation coverage. (Effective January 1, 2006).

The Department will send a letter to the Qualified Beneficiary regarding COBRA rights within 14 days of receiving notification of the termination from your GIR. Included with the letter will be an enrollment form, premium payment information and important deadlines. If a letter is not received within 30 days, and you notified your GIR within the 60 day period, you should contact the Department immediately for information.

COBRA Enrollment

Individuals have 60 days from the date of the COBRA eligibility letter to elect enrollment in COBRA and 45 days from the date of election to pay all premiums. Failure to complete and return the enrollment form or to submit payment by the due dates will terminate COBRA rights. If the enrollment form and all required payments are

received by the due dates, coverage will be reinstated retroactive to the date of the qualifying event.

Individuals who elected not to participate in the dental plan while an active Employee, may not enroll in the dental plan until the annual Benefit Choice Period.

Medicare or other group coverage impact on COBRA

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

If a Member and/or Dependent's Medicare entitlement or eligibility (see the COBRA Qualifying Events chart at the end of this section) occurs **after** a COBRA qualifying event, affected Qualified Beneficiaries are not eligible to continue COBRA coverage.

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

NOTE: Premiums will not be refunded for coverage terminated retroactively due to ineligibility. (Effective January 1, 2006).

COBRA Extensions

Disability Extension

Individuals covered under COBRA who have been determined to be disabled by the Social Security Administration (SSA) may be eligible to extend

coverage from 18 months to 29 months. Enrolled Dependents are also entitled to COBRA and are eligible for the extension.

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

The affected individual must also notify the Department of any SSA final determination loss of disability status. This notification must be provided **within 30 days** of the SSA determination letter.

Second Qualifying Event Extension

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

Waiver of COBRA Rights and Revocation of that Waiver

A Qualified Beneficiary may waive rights to COBRA coverage during the 60-day election period and can revoke the waiver at any time before the end of the 60-day period. Coverage will be retroactive to the qualifying event.

Premium Payment under COBRA

The Qualified Beneficiary has 45 days from the date coverage is elected to pay all premiums.

Individuals electing COBRA are considered Members and charged the Member rate. A divorced or widowed Spouse who has Dependent coverage would be considered the Member and charged the Member rate, with the child covered as a Dependent and charged the applicable Dependent rate. If only a Dependent child elects COBRA, then each child would be considered a Member and charged the Member rate.

Once the COBRA enrollment form is received and the premium is paid, coverage will be reinstated retroactive to the date coverage was terminated. The Department will mail monthly billing statements to the Member's address on file on or about the 5th of each month. Bills for the current month are due by the 25th of the same month. Final notice bills (those with a balance from a previous month) are due by the 20th of the same month. Failure to pay the premium by the final due date will result in termination of coverage retroactive to the last date of the month in which premiums were paid.

It is the Member's responsibility to promptly notify the Department in writing of any address change or billing problem.

The State does not contribute to the premium for COBRA coverage. Most COBRA Members must pay the applicable premium plus a 2% administrative fee for participation. COBRA Members who extend coverage for 29 months due to SSA's determination of disability must pay the applicable premium plus a 50% administrative fee for all months covered beyond the initial 18 months.

Adding Newly-Acquired Dependents While Enrolled in COBRA

Newborns, a newly-adopted child or a newly-acquired Spouse may be added to existing COBRA coverage. Documentation requirements must be met. See the Documentation

Requirements chart in this chapter for details.

Termination of Coverage under COBRA

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

- Maximum continuation period ends.
- Covered Member or Dependent fails to make timely payment of premium.
- Covered Member or Dependent becomes a participant in another group health plan which does not impose a Pre-existing Condition exclusion or limitation (for example, through employment or marriage).
- Covered Member or Dependent becomes entitled to Medicare. Special rules apply for End Stage Renal Disease. Contact the Department for more information.
- Covered Member or Dependent reaches the qualifying age for Medicare.

Refer to the COBRA Qualifying Events chart in this chapter for more information.

Conversion Privilege for Health Coverage

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

- Failure to pay the required premium, or
- Coverage is replaced by another group health plan, or

COBRA - Continuation of Benefits

- Member enrolls in Medicare, or
- Voluntary termination during COBRA coverage.

Approximately two months before COBRA coverage ends, the Department will send a letter providing instructions on how to apply for conversion. 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 Department is not involved in the administration or premium rate structure of insurance benefits obtained through conversion.

COBRA QUALIFYING EVENTS	
A qualifying event is defined as any of the events shown below that result in a loss of coverage.	
Duration of COBRA Coverage	
Qualifying Events	Maximum Continuation Period
Member	
Termination of employment for any reason, including termination of disability benefits and layoff, except for gross misconduct	18 months
Loss of eligibility due to reduction in work hours	18 months
Loss of annuity or survivor benefits within one of the five State retirement systems	18 months
Dependent	
Member's termination of employment for any reason	18 months
Member's loss of eligibility due to reduction in work hours	18 months
Member's death, divorce or legal separation: <div style="margin-left: 40px;">Spouse or ex-spouse, under age 55</div> <div style="margin-left: 40px;">Spouse or ex-spouse, age 55 or older</div>	<div style="margin-left: 20px;">36 months</div> <div style="margin-left: 20px;">36 months (if Medicare Entitled), or Obtains Medicare, or Reaches the qualifying age for Medicare</div>
COBRA Member's Medicare entitlement	Up to 36 months
Loss of dependent status	36 months
<p>COBRA Members or Dependents who, after enrollment, obtain Medicare or coverage under another group health plan which does not impose Pre-existing Condition limitations or exclusions are ineligible to continue COBRA coverage.</p> <p>Additionally, COBRA Members or Dependents who become Medicare <u>eligible</u> after a COBRA qualifying event are ineligible to continue COBRA coverage.</p> <p>The Department reserves the right to retroactively terminate COBRA coverage if an individual is deemed ineligible. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.</p>	

Notes

Chapter 2

Health, Dental, Vision and Life: Options and Plan Information

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Notes

Overview

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

Each plan provides medical and behavioral health benefits as well as prescription drugs. However, the Covered Services, benefit levels and exclusions and limitations differ. In making choices, consider the following: health status, coverage needs and service preferences. Dependents must 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 — Quality Care Health Plan (QCHP).

Managed Care Health Plans

Managed care is a method of delivering health care through a system of network Providers. There are differences in the premiums and 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 QCHP 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 State of Illinois 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 - Quality Care Health Plan (QCHP)

The Quality Care Health Plan (QCHP) is the self-insured indemnity health plan that offers a comprehensive range of benefits. Under the QCHP, 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

Quality Care Health Plan (QCHP)

Overview

The Quality Care Health Plan (QCHP) is a traditional indemnity plan which offers a comprehensive range of benefits. Under QCHP, 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

- QCHP 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

Member Responsibilities

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

- Any charges NOT covered by the Plan or determined by the Plan Administrator to be not **medically necessary** services.

Plan Year Deductible

The Plan Year Deductible must first be satisfied before benefits begin, unless the Family Cap has been met. 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 Employee's Plan Year Deductible is based on the annual salary as of the first of each April preceding the beginning of the next Plan Year. To verify the Plan Year Deductible or Family Cap, contact the agency Group Insurance Representative (GIR) or review the current Benefit Choice Options booklet. Each Plan Year begins on July 1.

Salary-based Deductibles stay in force for the entire Plan Year, regardless of any change in salary. The annual Deductible in force at the time of termination of eligibility under the Program remains in force for those who elect continuation of coverage under COBRA.

If a Member retires, accepts a voluntary reduction in pay or returns to State employment at a different salary, the Deductible is reassessed. Should the Deductible requirement be reduced, only the lower Deductible must be met. However, no reimbursements will be made if the lower Deductible has been exceeded.

The family members' Plan Year Deductibles will be accumulated toward a Family Cap. Once the family as a unit has satisfied the Family Cap, no further Plan Deductibles will be taken for eligible charges incurred for the remainder of that Plan Year.

Special Deductibles

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

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

Coinsurance

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

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

Annual Out-of-Pocket Maximum Expenses

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

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

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

Eligible Charges

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

Medical Necessity

- **QCHP covers charges for services and supplies that are medically necessary. Medically necessary services or supplies are those which are:**
 - Provided by a Hospital, medical facility or prescribed by a Physician or other Provider and are required to identify and/or treat an illness or injury.
 - Consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
 - Generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.
 - The most appropriate supply or level of service which can be safely provided to the patient.
 - Not solely for the convenience of the patient, Physician, Hospital or other Provider.
 - Repeated only as indicated as medically appropriate.
 - Unable to be safely provided in an outpatient setting due to the patient's medical symptoms, condition, diagnosis or treatment.
 - Not redundant when combined with other treatment being rendered.

Pre-Determination of Benefits

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

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

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

Usual and Customary (U&C) Charges

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

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

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

Preferred Provider Organization (PPO) Network

The QCHP 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

QCHP 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 Plan. Participation in MCM has proven to enhance benefits based on an evaluation of the individual's needs. MCM is part of the benefits under QCHP. 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 QCHP Plan Administrator or by request from a Plan Participant. The case manager serves as a liaison and facilitator between the patient, family, Physician and other healthcare Providers. This case manager is a Registered Nurse or other health care professional with extensive clinical background. The case manager can effectively minimize the fragmentation of care so often encountered within the health care delivery system in response to complex cases.

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

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

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of upcoming behavioral health services, Surgery, outpatient procedure or Admission to a facility such as a Hospital 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 GIR 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 QCHP 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 GIR 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 PPO and 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
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.

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

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

QCHP 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 ■ Behavioral Health Coinsurance or Copayments. ■ Notification penalties. ■ Ineligible charges (amounts over U&C and charges for non-covered services). ■ The portion (\$50) of the Medicare Part A Deductible the Plan Participant is responsible to pay. 	

Notes

QCHP - Medical Benefits Summary

This section contains a brief overview of some of the benefits available under the Quality Care Health Plan (QCHP). 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

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

symmetrical appearance.

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

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.
- 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.

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.

- 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).**

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.

- **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.
- **Physician's Office:**
 - 100% of U&C; no special emergency room Deductible applies. Treatment must be

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

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.

Hearing Services

- Hearing aids and associated costs, including the exam and evaluation for the purpose of screening and obtaining a hearing aid, are not covered prior to July 1, 2005.

- Effective July 1, 2005 diagnostic hearing exams performed by an audiologist are covered up to \$100 and hearing aids are covered up to \$500 every three Plan years.
- 80% of U&C for Professional Services for the hearing exam associated with the care and treatment of an injury or an illness.

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.

Inpatient Hospital/Facility Services

- 90% at PPO Hospital/facility.
- 80% of U&C if residence is not within 25 miles 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

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

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.

Infertility Treatment

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

- Pre-determination of Benefits:
 - A written pre-determination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment to ensure optimum benefits.

Documentation required from the Physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy and the proposed plan of treatment with Physicians' Current Procedural Terminology (CPT) codes.

- Infertility Benefits:
 - Coverage is provided only if the Plan Participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this Plan.
- Coverage for Assisted Reproductive Procedures include, but is not limited to:
 - Artificial Insemination, In Vitro Fertilization (IVF) and similar procedures which include but are not limited to: Gamete Intrafallopian Tube Transfer (GIFT), Low Tube Ovum Transfer (TET) and Uterine Embryo Lavage.
 - A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
 - A maximum of four (4) procedures per lifetime for any of the following: In Vitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.
 - Eligible medical costs associated with sperm or egg donation by a person covered under the Plan may include, but are not limited to monitoring the cycle of a donor, and retrieval of an egg for the purpose of donating to a covered individual.

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

- 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 90% 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.
- Medical Necessity must be determined by the MCM Administrator in order for therapy to be considered a covered expense.
 - Infusion therapy must be under the supervision of a Physician.
- Covered expenses include, but are not limited to:
 - Medication and intravenous solution.
 - Equipment rental and supplies such as infusion sets, syringes and heparin.

Lab and X-ray

- Outpatient:
 - 90% 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.

Infusion Therapies

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

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

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

Morbid Obesity Treatment

- 80% 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.

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

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 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.

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

- 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.

- 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.
 - Hearing aids through June 30, 2005. Effective July 1, 2005 hearing aids will be covered. See Hearing Services in this section.
 - See Dental Plan section later in this chapter for coverage of dentures.

Radiation Therapy

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

Second Surgical Opinion

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

- 100% of U&C if required by Notification Administrator. No Plan Year Deductible applies.
 - Contact the Notification Administrator who will determine if a second opinion for a procedure is required.
 - Failure to obtain a second opinion when required and proceeding with the procedure will result in a financial penalty.
- 80% 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.

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

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.
- 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)

QCHP 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

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

Management Administrator of the potential transplant. Once Notification occurs, the Medical Case Manager (MCM) will coordinate all treatments and further Notification is not required. Those refusing to participate in the MCM program will be notified that coverage may be terminated under the Plan for treatment of the illness.

The transplant benefit includes all diagnostic treatment and related services necessary to assess and evaluate the transplant candidate. All related transplant charges submitted by the TPPO Hospital are covered at 80% of the contracted rate.

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

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

Transplant Coordination of Donor/ Recipient Benefits

- When both the Donor and the Recipient are covered under the Plan, both are entitled to benefits under the Plan, under separate Claims.
- When only the Recipient is covered, the Donor's charges are covered as part of the Recipient's Claim if the donor does not have insurance coverage, or if the Donor's

insurance denies coverage for medical expenses incurred.

- When only the Recipient is covered and the Donor's insurance provides coverage, the Plan will coordinate with the Donor's plan.
- When only the Donor is covered, only the Donor's charges will be covered under the Plan.
- When both Donor and Recipient are 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 maximum expense reimbursement is \$2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to \$70. There is no reimbursement for meals.
- The Plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those Plan Participants who have been accepted as a candidate for transplant services.

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

- Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

**Organ Transplant Reimbursement
DCMS Group Insurance Division
201 E. Madison Street
P.O. Box 19208
Springfield, IL 62794-9208**

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

Urgent Care Services

- 80% 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 QCHP.

Covered Benefits – Adults

■ Colorectal Cancer Screening:

- 80% of U&C for sigmoidoscopy or colonoscopy once every 3 Plan Years for persons who are at least 50 years old.
- 80% 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.
- 90% 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 \$250 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.
 - 90% of U&C for lab.
 - 90% 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.
 - 90% of U&C for lab.
 - 90% 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		90% of U&C for immunizations
OPV (Oral poliovirus)	2 months	4 months	6-18 months	4-6 years		Entrance to 5th or 9th grade		90% of U&C for immunizations
MMR (Measles-mumps-rubella)	12-15 months	4-6 years				Entrance to 5th or 9th grade		90% 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		90% 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.		90% of U&C for Immunizations
Pneumococcal (Pevnar)	2 months	4 months	6 months	12-15 months				90% of U&C for Immunizations
Varicella (Chicken Pox) ²	12-18 months					Entrance to 5th or 9th grade ³		90% of U&C for immunizations
Quantitative Lead Screening						1 per lifetime		90% of U&C for lab
TB Tine Test and Intradermal Tuberculosis Test if needed						Entering 5th grade	Entering 9th grade	90% 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 Coinsurance payment at the time of purchase. The claim must first be submitted to Medicare for reimbursement. Upon receipt of the Explanation of Medicare Benefits (EOMB), a Claim may be filed with the Prescription Drug Plan Administrator for any secondary benefit due, 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 Non-Maintenance Medication

■ In-Network Benefit Summary:

- No Plan Year deductibles; no Claim forms to file.
- Non-maintenance medications (1 to 30-day supply) and the first two fills of maintenance medication.
- 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 Benefits Choice Options booklet for maintenance medication Copayment amounts. To receive a discounted 61 to 90-day supply of maintenance 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.

Maintenance Medication Program (MMP)

The MMP consists of contracted retail pharmacies who have chosen to participate in the Retail Maintenance Network. The MMP allows the Plan Participant to obtain a 61 to 90-day supply of maintenance medication for two (30-day) retail Copayments. Maintenance medication purchased at a retail pharmacy not participating in the Retail Maintenance Network will, after the initial two fills, be available for two Copayments for each 30-day supply. A list of the pharmacies participating in the Retail Maintenance Network is also available at www.benefitschoice.il.gov or from the Prescription Drug Plan Administrator.

It is NOT necessary to obtain two 30-day fills of maintenance medication before obtaining a 61 to 90-day supply of maintenance medication. The 61 to 90-day supply may be filled at the Prescription Drug Plan Administrator's mail order pharmacy or a participating Retail Maintenance Network pharmacy without first obtaining two 30-day supplies at retail.

MMP Summary

- No Plan Year Deductibles; no Claim forms to file. These pharmacies can fill all prescriptions up to a 90-day supply.
- Maintenance medication (61 to 90-day supply) and maintenance medications after the second 30-day fill.
- 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.

NOTE: Non-maintenance medications are available at all network pharmacies.

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

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

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

Notes

Quality Care Health Plan Exclusions and Limitations

No benefits are available:

1. For 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 QCHP.
2. For services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a Nurse Midwife who has completed an organized program of study recognized by the American College of Nurse Midwives or by a Christian Science Practitioner.
3. For services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this Handbook to be a Covered Service in effect at the time the service was rendered. Excluded services and supplies include, but are not limited to: sports-related health check-ups, employer-required check-ups, wigs and hairpieces.
4. For care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable by the Plan.
5. When the charges for the services, Room and Board or supplies exceed U&C.
6. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, non-Hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps or any other services or items determined by the Plan to be for personal convenience.
7. For rest, convalescence, custodial care or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.
8. For extended care and/or Hospital Room and Board charges for days when the bed has not been occupied by the covered person (holding charges).
9. For private room charges which are not medically necessary as determined by the Plan Administrator.
10. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.
11. For chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.
12. For keratotomy or other refractive surgeries.

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

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29. For services rendered while confined within any federal Hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.
 30. For charges imposed by immediate relatives of the patient or members of the Plan Participant's household as defined by the Centers for Medicare and Medicaid Services (formerly HCFA).
 31. For services rendered prior to the effective date of coverage under the Plan or subsequent to the date coverage is terminated.
 32. For hearing aids and associated costs including the exam and evaluation for the purpose of screening and obtaining a hearing aid, regardless of diagnosis through 6/30/05. Effective 7/1/05, this exclusion will not apply. See Hearing Services section earlier in this chapter.
 33. For private duty nursing, skilled or unskilled, in a Hospital or facility where nursing services are normally provided by staff.
 34. For services or care provided by an employer-sponsored health clinic or program.
 35. Travel time and related expenses required by a Provider.
 36. Facility charges when services are performed in a Physician's office or urgent care centers.
 37. For residential treatment for behavioral health services.
 38. Treatment for educational disorders relating to learning, motor skills, communication and pervasive development conditions, such as autism.
 39. 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

QCHP - Claim Filing Deadlines and Procedures

The following procedures and deadlines pertain to the QCHP, 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, 2003	No longer eligible
July 1, 2003 thru June 30, 2004	June 30, 2005
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

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

Quality Care Dental Plan (QCDP)

Overview

The Quality Care Dental Plan (QCDP) 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 website at www.benefitschoice.il.gov.
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.
- Dental procedure codes not listed in the Schedule of Benefits are considered non-Covered Services and are **not** eligible for payment.
- 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

The maximum benefit is \$2,000 per Plan Participant per Plan Year including orthodontic, periodontic and all other services.

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 person per Plan Year.
- Two adult or child prophylaxis (scaling and polishing of teeth) per person per Plan Year.
- Two bitewing radiographs per person 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.

QCDP - 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. Implants will be a Covered Service effective July 1, 2007.
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.

QCDP - Claim Filing Deadlines and Procedures

The following procedures and deadlines pertain to the QCDP. 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, 2003	No longer eligible
July 1, 2003 thru June 30, 2004	June 30, 2005
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

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 State Employees Group Insurance Program (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, except for the eye examination benefit which is available once every 12 months from the last time 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 12 months	\$10.00 Copayment
Spectacle Lenses* (single, bifocal and trifocal)	Once every 24 months	\$10.00 Copayment
Standard Frame Selection (up to \$130 Retail Value, Plan Participant responsible for remaining balance)	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	\$100.00 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 12 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 12 months	\$30.00 Allowance
Spectacle Lenses*	Once every 24 months	\$40.00 Allowance for single vision lenses \$60.00 Allowance for bifocal and trifocal lenses
Standard Frames	Once every 24 months	\$50.00 Allowance
Contact Lenses** <u>All contact lenses are in lieu of standard frames with spectacle lenses.</u>	Once every 24 months	\$100.00 Allowance
Lasik and PRK Vision Correction Procedures	Available In-Network only	
Low Vision Supplementary Testing***	Once every 12 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.

Overview

There are two types of coverage available: basic life insurance coverage and optional life insurance coverage. See Certificate Specifications in Chapter 1 of the State of Illinois Group Life Insurance Program booklet or contact the agency GIR for further information regarding coverage options.

Basic Life Insurance Coverage for Members (State paid)

Term life insurance coverage is provided automatically at no cost to eligible Members through the State Employees Group Insurance Program (Program). This coverage is provided to the following:

Full-time and Part-time Employees

- Each eligible active, non-retired Employee is insured for an amount equal to their annual basic salary.

Immediate and Deferred Annuitants

- Benefit is equal to their annual basic salary as of the last day of active employment. At age 60, the basic life insurance coverage amount reduces to \$5,000.

Individuals who became Survivors of Employees, Immediate Annuitants and Deferred Annuitants prior to September 22, 1979:

- The basic life amount is \$2,000.

Individuals eligible as Survivors on or after September 22, 1979 are not eligible for basic life insurance coverage.

Optional Life Insurance Coverage (Member paid)

Employees, Immediate Annuitants and certain Survivors may purchase optional life insurance coverage. All premiums for optional life insurance coverage are at the Member's expense.

Optional life insurance coverage includes:

- Life insurance coverage for active Employees and eligible Annuitants under age 60, up to eight times the basic State-provided amount. Optional life coverage in excess of four times the basic coverage amount will terminate when an Annuitant turns age 60.
- Accidental Death and Dismemberment (AD&D) coverage for the Member in the amount equal to the basic life insurance amount, or the combined amount of the basic and optional life insurance, subject to a total maximum of five times the basic life insurance amount or \$3,000,000.00, whichever is less.
- Spouse term life insurance coverage of \$10,000; reduces to \$5,000 when Member is retired and reaches age 60.
- Child term life insurance coverage of \$10,000.

Benefits may be paid prior to death under certain circumstances. Accelerated benefits offer access to a portion of optional life insurance benefits if the Member is diagnosed with a terminal illness. Contact your Group Insurance Representative (GIR) or the Life Insurance Plan Administrator for more information.

Changes to Coverage

Certain changes to life insurance coverage may be made at any time during the Plan Year. These changes include increasing Member's life

changes include increasing Member's life insurance coverage above \$50,000 (this amount includes basic and optional life insurance coverages), adding AD&D coverage and adding spouse life or child life insurance coverage.

When a Member requests to increase optional life insurance coverage or adds spouse life or child life insurance coverage, evidence of insurability (an approved Statement of Health) is required. Contact the GIR or the Life Insurance Plan Administrator to obtain the Statement of Health form. Coverage will be effective the first pay period following approval by the Life Insurance Plan Administrator.

A Statement of Health is not required for newborns added within 60 days of birth, or newly-acquired Dependents (Spouse, adopted child, stepchild or child for whom the Member has obtained legal guardianship) added within 60 days of the qualifying event. See the Enrollment section in Chapter 1 for effective dates.

Beneficiary Form

A life insurance beneficiary form must be completed by the Member at the time of employment. It is the Member's responsibility to contact the Life Insurance Plan Administrator for any changes to the beneficiary designation and/or beneficiary address.

Terminating Employment

When State employment terminates, life insurance coverage may be continued at the Member's expense. Basic and optional life insurance coverage may be converted to a form of individual life insurance (not term insurance) offered by the Life Insurance Plan Administrator. Optional life insurance coverage may be ported in lieu of converting. In order to continue coverage, the Member must contact their GIR or the Life

Insurance Plan Administrator within 31 days of the date the Member terminates employment.

Contact the Life Insurance Plan Administrator for additional information regarding conversion and portability options.

Should the Member choose to continue coverage through one of the available insurance products, the full premium must be paid directly to the Life Insurance Plan Administrator. Once the Member makes the selection, the Program is no longer involved in the administration or premium rate structure of these insurance products.

For More Information

For more information regarding life insurance coverage and benefits, consult the State of Illinois Group Term Life Certificate of Insurance, or contact the Life Insurance Plan Administrator or your GIR.

If a Plan Participant enrolled under one of the Programs 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 Program 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 this Plan or one of the plans identified below.

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

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

For purposes of COB, the term "plan" is defined as any plan that provides medical, 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 Department's Plan is primary.

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

Order of Benefit Determination

The Department'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 a laid-off Employee or Retiree) is primary over the plan that covers the Plan Participant as a laid-off Employee or Retiree.

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

Dependent Children of Parents Not Separated or Divorced

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

- 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 Group Insurance Representative (GIR) 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 State of Illinois and without other group health coverage, must enroll in Medicare Parts A and B when first eligible.** If the Plan Participant does not enroll in Medicare Part B when first eligible, **the Quality Care Health Plan (QCHP) 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 Quality Care Health Plan (QCHP)

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

Part A - Hospital Insurance

After Medicare Part A pays, QCHP pays:

- All but \$50.00 of the Medicare Part A Deductible.
- Hospital and Skilled Extended Care Facility stays beyond the maximum days allowed under Medicare, provided that the care satisfies the QCHP criteria of Medical Necessity and skilled care.

Part B - Medical Insurance

After Medicare Part B pays, QCHP pays:

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

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:

- QCHP 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 QCHP deductible applies. A denial of Medicare benefits must accompany the claim.

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

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.

COBRA & Medicare

Refer to the COBRA section in Chapter 1.

Notes

Subrogation and Reimbursement

Overview

Department Plans 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 State's 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 State Employees Group Insurance Program (Program) 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 Quality Care Health Plan (QCHP) and Self-funded Managed Care Plans

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

The Plan Administrator's internal review

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

1. Initial Appeal to the Plan Administrator

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

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

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

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

Submit Appeal Documentation to:

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

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

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

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

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

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

that a designated union representative be a member of the committee. AFSCME shall provide the Department with prior notification, if applicable, of the representative who will serve as a member of the committee.

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

Submit Appeal Documentation to:

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

Chapter 3

Optional Programs

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Notes

Deferred Compensation Program

Overview

The State of Illinois Deferred Compensation Plan is a long-term supplemental retirement savings program authorized under Section 457 of the Internal Revenue Code. The Deferred Compensation Plan provides an investment opportunity for Employees to save for the future by offering tax savings, a wide variety of investment options, flexibility to make investment changes and convenient services.

Benefits of Deferred Compensation

Combined pension and Social Security benefits may not be sufficient for retirement needs. Deferred Compensation is one way to save for the future while enjoying tax benefits today. Participating in the Deferred Compensation Plan will not affect Social Security benefits, pension benefits or the ability to save independently.

- **Reduce taxable income**

The amount contributed to a deferred compensation account reduces taxable income which allows more savings, less taxes and more spendable income.

- **Investment earnings grow tax-free**

The money contributed and any interest or earnings on contributions grow free of taxes until withdrawal. At that point, only federal taxes are payable. Deferred Compensation distributions are not subject to Illinois State taxes.

Eligibility

All State of Illinois Employees are eligible to participate.

Enrollment

There is no specific enrollment period; Employees may enroll at anytime. An enrollment packet is

available from the Deferred Compensation Division or from the Agency Liaison. The enrollment form must be submitted in the month prior to the month in which deferrals begin. All contributions are through payroll deductions only.

Contribution Limitations

Contributions may be as little as \$20 per month up to \$14,000 for tax year 2005 and \$15,000 for tax year 2006. Participants age 50 and older are allowed an additional "catch-up" amount for a total contribution of \$18,000 for 2005 and \$20,000 for 2006. Contribution maximums and "catch-up" amounts beyond 2006, will be adjusted in accordance with the Consumer Price Index (CPI).

Investment Choices

There are a variety of funds in which to invest. This makes it easy to customize an investment strategy. Individuals decide how much and where to invest the money deferred. Money may be exchanged between funds once per calendar quarter at no charge. Additional exchanges cost \$10 per transaction.

Cost of Participation

A fee of .15 of 1% or less, up to a maximum of \$45 per year, is automatically deducted from the account. This may be subject to periodic adjustments.

Distribution

There are specific distribution events:

- Money may be withdrawn at retirement or severance of employment with the State of Illinois regardless of age. At that time, only federal taxes are payable. There are several distribution options from which to choose including lump-sum and installment payouts.

- Money may be withdrawn from the account prior to retirement or severance of employment only in the event of a severe financial hardship. Contact the Deferred Compensation Division for information on limitations and possible penalties.
- Upon death of the Plan Participant, the account is paid to the named Beneficiary(ies).

For More Information

Contact the Deferred Compensation Division or the Agency Liaison for additional information. For Plan Administrator information see the current Benefit Choice Options booklet. More information can be found by visiting www.state.il.us/cms/employee/defcom.

Flexible Spending Accounts (FSA) Program

Overview

- **The Flexible Spending Account (FSA) Program offers two plans:**
 - **The Medical Care Assistance Plan (MCAP)** uses tax-free dollars to pay eligible, Medically Necessary health, dental and vision expenses incurred by the Plan Participant, Spouse and eligible Dependents during the Plan Year.
 - **The Dependent Care Assistance Plan (DCAP)** uses tax-free dollars to pay eligible child and/or adult day care expenses during the Plan Year.

FSA is an optional benefit that allows eligible Employees to set aside up to \$5,000 tax-free to one or both of these Plans for a combined maximum of \$10,000.

NOTE: For detailed information on MCAP/DCAP, obtain a copy of the current FSA Booklet by contacting your Group Insurance Representative (GIR) or by visiting www.benefitschoice.il.gov.

MCAP

- **Eligibility for MCAP:**
 - State of Illinois Employees working full-time or not less than half-time; and
 - receiving a paycheck from which deductions can be taken; and
 - eligible to participate in the State Employees Group Insurance Program (Program).

DCAP

- **Eligibility for DCAP:**
 - State of Illinois Employees actively at work; and

- receiving a paycheck from which deductions can be taken; and
- if the Employee is married, the Spouse must also be gainfully employed, a full-time student, disabled and incapable of self-care or seeking employment and have income for the year.

NOTE: Temporary, intermittent or contractual Employees and Retirees, Annuitants and Survivors are not eligible for participation in MCAP or DCAP.

How the Program Works

The amount designated is payroll deducted and deposited into the account prior to state, federal and Social Security tax withholdings, thereby lowering taxable income and increasing spendable income.

- **Here are the steps to follow:**
 - Determine anticipated eligible Out-of-Pocket expenses for the Plan Year. Reimbursement is only for expenses incurred during the Plan Year or any portion of the Plan Year in which enrolled as a Plan Participant. Deduction amounts cannot be changed unless a Qualifying Change in Status is experienced.
 - Divide the anticipated eligible Out-of-Pocket expense during the Plan Year by the number of pay periods in the Plan Year. This is the amount deducted from each paycheck.
 - Complete the FSA Enrollment form. Return the completed form to your GIR for approval. The form will then be forwarded to the Department of Central Management Services (Department) for processing.

- Once the enrollment form is processed an FSA welcome packet will be mailed which contains enrollment verification, a Claim form and important participation information. Additional claim forms can be obtained from the FSA Plan Administrator or by visiting www.benefitschoice.il.gov.
- Pre-tax payroll deductions will be initiated by the employing agency and deposited into the FSA participant's account.
- When eligible expenses are incurred, complete an MCAP or DCAP Claim form, attach the required documentation (as detailed in the FSA Booklet) and send to the address on the Claim form.
- Once the claim has been approved by the FSA Plan Administrator, reimbursement will be made to the Plan Participant.

Reimbursement

Reimbursement checks are mailed directly from the FSA Plan Administrator. To obtain information on direct deposit as a reimbursement option, contact the FSA Plan Administrator or visit www.benefitschoice.il.gov.

MCAP participants also have the option to enroll in the EZ Reimburse® Mastercard Program. This program allows Plan Participants to directly access their MCAP account and could by pass the need to submit paper Claims and remit payment at the time of service. Certain restrictions apply. Contact the FSA Plan Administrator for more information or visit www.benefitschoice.il.gov.

FSA Enrollment

- **There are certain periods during which Employees can enroll in the FSA Program:**
 - **New employment** – New Employees may enroll within 60 days of the date of hire. The earliest effective date of participation

would be the first day of the pay period after the signature date on the FSA enrollment form. Payroll deductions must correlate with the effective date of enrollment.

- **Annual Benefit Choice Period** – Eligible Employees may enroll each Plan Year during the annual Benefit Choice Period (May 1-31). The designated salary deduction will begin the first paycheck **issued** on or after July 1. The effective date of enrollment would be July 1.
- **Qualifying Change in Status** – Employees who experience a Qualifying Change in Status may enroll within 60 days of experiencing the qualifying event. The earliest effective date of participation would be the first day of the pay period after the signature date on the FSA Change in Status form or the date of the event, whichever is later. Payroll deductions will correlate with the effective date of enrollment. **Any election changes must be consistent with the Qualifying Change in Status.**

NOTE: Re-enrollment in FSA is not automatic. FSA enrollment forms must be submitted each Plan Year in order to participate in the Program.

For More Information

Contact the FSA Plan Administrator for questions regarding Claim submissions, Claim eligibility, reimbursements and account balance statements. Contact the Department for information regarding enrollment, mid-year Qualifying Changes in Status and deposits.

Commuter Savings Program (CSP)

Commuter Savings Program (CSP) (formerly known as the Qualified Transportation Benefit (QTB) Program)

The Commuter Savings Program (CSP) is an optional benefit that gives eligible Employees the opportunity to use tax-free dollars to pay out-of-pocket, work-related commuting and/or parking expenses. This benefit allows employees to lower their taxable income and increase spendable income.

CSP allows eligible employees to use pre-tax dollars to pay for bus or train transit passes or for vanpooling expenses incurred for work-related commuting costs. The transit media selected is conveniently mailed directly to the participant's home before the beginning of the month. The parking benefit allows the participant to payroll deduct pre-tax dollars for work-related parking expenses. The parking provider may be paid directly or the participant may be reimbursed directly by submitting a Claim form and proof of services to the CSP Plan Administrator.

Full-time and part-time Employees working 50% or more who have payroll checks processed through the Office of the Comptroller may enroll in CSP at any time. There is no Qualifying Change in Status required to enroll mid-year and you may cancel or change your deductions at any time. Deductions are made before federal, state and Social Security taxes are withheld. See the current Benefit Choice Options booklet for up-to-date information on maximum amounts that may be deducted for transportation or parking. To enroll, change or cancel your election, or for other information, contact the CSP Plan Administrator.

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 \$200, 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, agency name and agency telephone number.

Submit Documentation to:

**Smoking Cessation Program
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

Adoption Benefit Program

Overview

Recognizing adoption as a meaningful and viable way to build a family, the Department provides an Adoption Benefit Program to assist State of Illinois Employees who adopt a child. To encourage adoption, especially of children who traditionally wait longer for families, the Adoption Benefit Program will reimburse eligible Employees for some adoption expenses.

Eligibility

The Adoption Benefit Program is available to all Employees who are eligible for benefits under the State Employees Group Insurance Program (Program). Active Employees who opt out or waive health, dental and vision coverage remain eligible for the Adoption Benefit Program.

The adoption must be final before expenses are eligible for reimbursement. The request for reimbursement must be received within one year from the end of the Plan Year the adoption became final. If both husband and wife are State Employees, only one adoption benefit is available per child.

Waiting Children

Hundreds of children in Illinois are waiting to be adopted. Most live in foster homes, group homes or residential centers operated by child welfare agencies. Because many of these children wait too long for families, the State of Illinois is determined to shorten their wait by finding permanent homes for more of them. The Adoption Benefit Program will help in this effort.

Waiting Children are defined as:

- Minority children age 3 and over and Caucasian children age 11 and over, or

- Children with a diagnosis of a specific mental, physical or emotional disability, or
- Children who need to be adopted with brothers and sisters, or
- Foreign children age three and over.

Benefit Amount

The Program pays eligible expenses up to a maximum of \$1,500 for a waiting child and up to a maximum of \$1,000 for any other child. All adoption benefits are subject to Medicare and Social Security taxes. If more than one child is adopted, benefits are available for each child.

Eligible Expenses

The following adoption charges are eligible for reimbursement:

- Legal fees.
- Court fees.
- Adoption agency fees, including foreign adoption fees (adoption agency must be licensed by the State of Illinois).
- Required medical exams for the child.
- Initial immunizations for the child.
- Transportation costs to bring the child to the adopting parents (or for the adult accompanying the child to the United States).

Ineligible Expenses

The following charges are not eligible for payment:

- Expenses for adopting stepchildren.
- Expenses for adopting children related to either parent, such as nephews, nieces, cousins, brothers or sisters.
- Transportation for the adopting parents.
- Medical examination fees for the adopting parents.
- Cost of personal items for either parents or child during or after the adoption, such as clothing or food.
- Expenses provided by other adoption assistance programs.
- Pledges, gifts or support fees to an adoption agency.

The following documentation must be submitted:

- Receipts of eligible expenses.
- An informal memo or letter to the Department stating that an adoption has been completed of a child who is not related to the Employee or Spouse.
- The memo or letter must include the State Employee's name, address, Employee work and/or home telephone number and agency name.

- A copy of the adoption decree from a court in the United States or the Department of Children and Family Services (DCFS) home study approval letter for adoption of a child outside the United States.

Submit Documentation to:

**Adoption Benefit Program
DCMS Group Insurance Division
201 E. Madison Street
P.O. Box 19208
Springfield, IL 62794-9208**

Health Coverage for Adopted Child

Once a petition for adoption has been filed or custody of the child has been granted, the child may be enrolled in the Program. If custody is obtained and the child is added to the Employee's coverage within 60 days of the event, the effective date of coverage can be retroactive to the child's date of birth or placement for adoption. Adopted Dependents are not subject to Pre-existing Condition limitations.

Leave of Absence for Adoption

For details concerning an eligible leave of absence for adoption, contact your agency's personnel office.

For More Information

The Department of Central Management Services (Department) is the Plan Administrator of the Adoption Benefit Program. Questions regarding the Adoption Benefit Program should be directed to the Department. For questions about adoptions in general, please contact the Adoption Information Center of Illinois at 1-800-572-2390.

Employee Assistance Program

Support for the Employee and Family

The Employee Assistance Program (EAP) provides a valuable resource for support and information during difficult times. The EAP is a confidential assessment and referral service that will link the individual to EAP counselors who will help develop the life management skills needed to enjoy life more fully.

Getting help is easy, convenient and confidential. Trained customer service associates and EAP care managers are available via a toll-free telephone number. Individuals will be directed to counseling services to assist with a variety of concerns.

The EAP is a free, voluntary and confidential program that provides problem identification, counseling and referral services for Employees and their families. EAP counselors are experienced in providing support, understanding and guidance for a broad range of needs. The EAP provides confidential assistance on a variety of concerns including, but not limited to:

- Anger management
- Anxious feelings
- Conflict at work or home
- Domestic violence
- Elder care issues
- Family/parenting issues
- Feelings of worry or the blues
- Financial concerns
- Grief/loss

- Pre and postnatal concerns
- Problems with alcohol or drugs
- Stress

Authorization

EAP is a free benefit, however authorization is required before services are rendered. If help is needed beyond the scope of the EAP services, the EAP counselor may refer the individual for additional help. Call the Plan Administrator for further information.

Getting Assistance

Face-to-face evaluations will easily provide the help needed. The EAP counselor will help clarify the reason the individual is seeking assistance, identify available options and help develop a plan. Short-term counseling may be all that is required with the EAP counselor.

Privacy and Confidentiality

All calls and counseling sessions are confidential. Information will not be disclosed unless written consent is given or as required by law.

Eligibility

Active State Employees and their Dependents participating in the State Employees Group Insurance Program (Program) may access this benefit. Active Employees who opt out or waive health, dental and vision coverage remain eligible for this benefit. Eligible Employees may participate regardless of their choice of health plan.

Accessing Services

There are two separate Employee Assistance

Programs for active Employees: the Personal Support Program (PSP) through AFSCME Council 31 and the EAP through the EAP/Behavioral Health Administrator.

- Bargaining unit Employees represented by AFSCME Council 31 and covered under the collective bargaining agreement between the State of Illinois and AFSCME must access EAP services through the Personal Support Program. See the Benefit Choice Options booklet for Plan Administrator information.
- All other active and eligible Employees NOT represented or covered by the collective bargaining agreement between the State of Illinois and AFSCME must contact the EAP/Behavioral Health Administrator. See the Benefit Choice Options booklet for Plan Administrator information.

Services beyond EAP

If the individual is referred for additional help beyond the scope of services provided by the EAP and elects to use those services, the resulting costs and Copayments, as applicable, are the individual's responsibility.

Management Support

Management consultation is available when an Employee's personal problems are causing a decline in work performance. Critical Incident Stress Management is also available through the EAP.

Chapter 4

Reference

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Notes

Admission: Entry as an inpatient to an accredited facility, such as a Hospital or skilled care facility, or entry to a structured outpatient, intensive outpatient or partial hospitalization program.

Agency Liaison: An individual who provides information and/or materials and processes enrollment changes related to the Deferred Compensation Program. An Agency Liaison is often located in your personnel office.

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

Annuitant: A Member who began receiving an annuity on or after January 1, 1966.

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

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

Benefit Choice Period: A designated period when 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 QCHP 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.

Creditable Service: The amount of time a Member has established in one or more of the five

State retirement systems, as determined by those systems, when retiring under the Retirement Systems Reciprocal Act.

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.

Deferred Annuitant: Persons who began receiving an annuity one year or more after terminating state employment.

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 presently employed by the State of Illinois as defined by 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. Evidence of insurability is generally required to add Dependent Life Insurance and to increase Member Optional Life Insurance.

Exclusions and Limitations: Services not covered under the State Employees Group Insurance Program, 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.

Family Cap: A Plan provision that limits the total amount of the deductibles applied for all family Members enrolled under the member.

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 Insurance Representative (GIR): An individual who provides information and/or materials and processes enrollment changes related to benefits. A Group Insurance Representative is often located in the personnel office.

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.

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.

Immediate Annuitant: Persons who began receiving an annuity within one year of terminating State employment.

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

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 Quality 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.

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

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

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

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

Partial Hospitalization Program (behavioral health services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy. Services are medically-

supervised and essentially the same intensity as would be provided in a hospital setting except that the patient is in the program less than 24 hours per day.

Physician/Doctor: A person licensed to practice under the Illinois Medical Practice Act or under similar laws of Illinois or other states or countries; a Christian Science Practitioner listed in the *Christian Science Journal* at the time the medical services are provided.

Plan: A specifically designed program of benefits.

Plan Administrator: An organization, company or other entity contracted 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 Quality 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 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 State Employees Group Insurance Program as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

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

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

Retiree: A Member who retired before January 1, 1966, and began to receive an annuity.

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

Schedule of Benefits: A listing of specific services covered by the QCDP 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 to State Employees, Retirees, Annuitants (5 ILCS 375/1 et seq.).

Statement of Health: A form which a Plan Participant completes and submits to the Life Insurance Plan Administrator to have a determination made of health status for life insurance coverage.

Survivor: Spouse, Dependent child(ren) or Dependent parent(s) of a deceased Member as determined by the appropriate State retirement system.

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.

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