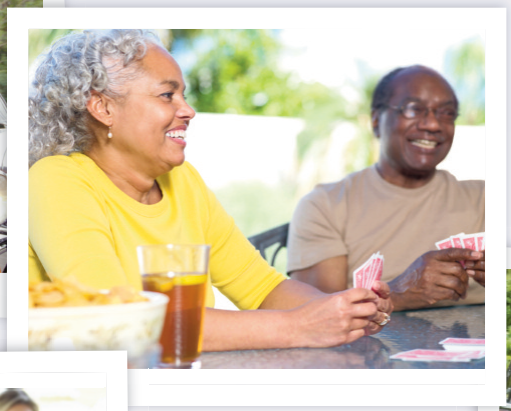
STATE OF ILLINOIS

Department of Central Management Services • Bureau of Benefits

# Benefit Choice Options

*Enrollment Period May 1 - June 1, 2015 • Effective July 1, 2015*



# Local Government Health Plan

# Benefit Choice is May 1 - June 1, 2015

Benefit Choice Forms must be submitted to your Health Plan Representative (HPR) no later than **Monday, June 1st**! If you do not want to change your coverage, you do not need to submit a form.

**It is each member's responsibility to know plan benefits and make an informed decision regarding coverage elections.**

Go to the 'Latest News' section of the Benefits website at
**www.benefitschoice.il.gov**
for LGHP updates throughout the plan year.

# FY2016 Benefit Choice Period

## (Enrollment Period May 1 – June 1, 2015)

The Benefit Choice Period will be **May 1 through June 1, 2015**, for all members. Members include employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), annuitants, elected officials, survivors and COBRA participants. **Elections will be effective July 1, 2015.**

All Benefit Choice changes should be made on the Benefit Choice Election Form available on the Benefits website at **www.benefitschoice.il.gov**. Members should complete the form **only if changes** are being made. Your unit Health Plan Representative (HPR) will forward the form to the LGHP for processing.

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

- Change health plans.
- Add or drop dependent coverage.
- Elect to waive coverage. **The election to waive coverage will terminate the health, dental, vision and prescription coverage for the member and any covered dependents.**
- Re-enroll in the Program if previously waived.

# Table of Contents


FY2016 Benefit Choice Period . . . . . 1
What You Should Know for Plan Year 2016 . . . . . 2
Member Responsibilities . . . . . 3
Health Plan . . . . . 4
Important Reminders . . . . . 4
Federally Required Notices . . . . . 5
Health Plan Descriptions . . . . . 6-8
Behavioral Health Services . . . . . 8
Map of Health Plans in Illinois Counties . . . . . 9
Benefits Comparison Charts . . . . . 10-14
Out-of-Pocket Maximums Description and Chart . . . . . 15
Prescription Benefit . . . . . 16
Vision Plan . . . . . 17
Dental Plan . . . . . 18-19
Plan Participants Eligible for Medicare . . . . . 20-21
Wellness Offerings . . . . . 22
Disease Management Programs . . . . . 23
Plan Administrators . . . . . 24-25

# What You Should Know for Plan Year 2016

**It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections.** Members should carefully review all the information in this booklet to be aware of the benefit changes for the upcoming plan year. **The Benefit Choice Period will be May 1 through June 1, 2015.** All elections will be effective July 1, 2015.

- **Federal Healthcare Reform:** As a result of the Affordable Care Act (ACA), prescription coinsurance and copayments paid by members will apply toward the out-of-pocket maximum, and once the maximum has been met, medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year. The out-of-pocket maximum amount for each type of health plan varies and is outlined on page 15.
- **Claim Appeal Process:** Effective July 1, 2015, for medical appeals under the self-insured plans (which include the Local Care Health Plan (LCHP), Local Consumer-Driven Health Plan (LCDHP), Coventry OAP and HealthLink OAP), decisions made by an independent external reviewer will be final and binding on all parties. The previous final level, the CMS Appeal Committee, will no longer be available.
- **Weight-Loss Benefit:** As a commitment to an employee's overall wellness, eligible plan participants are entitled to receive a rebate toward the cost of an approved weight-loss program. The maximum rebate is $200 once every three plan years. Employees who utilize a weight-loss program are eligible for the weight-loss benefit through CMS. For more information, refer to the Benefits website.
- **Ongoing Procurements:** Currently, contract negotiations are ongoing for the following:
  - Pharmacy benefits for Local Care Health Plan, Local Consumer-Driven Health Plan, Coventry OAP and HealthLink OAP

  Once the contract has been finalized, the awarded vendor will be posted on the Benefits website.
- **Vision Changes**
  - Vision eye exams, lenses and standard frame copayment increases to $25
  - Frame allowance increases to $175
  - Eye exams, vision replacement lenses, including contact lenses, available once every 12 months (previously every 24 months)
  - Contact lens allowance increases to $120
  - Vision out-of-network allowances increased
- **Local Care Health Plan (LCHP) Changes**
  - In-network, out-of-pocket maximum (individual) increases to $1,750
  - In-network, out-of-pocket maximum (family) increases to $3,500
  - Out-of-network, out-of-pocket maximum (individual) increases to $4,750
  - Out-of-network, out-of-pocket maximum (family) increases to $9,500
- **Primary Care Physician (PCP) Leaves the Network:** Effective July 1, 2015, when an HMO member's primary care physician (PCP) leaves the plan's network, the member will only be allowed to change health plans if the network experienced a significant change in the number of medical providers offered, as determined by CMS.

# Member Responsibilities

You must notify the Health Plan Representative (HPR) at your employing unit if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union) must be reported to your HPR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment may not be refunded. Additionally, the ineligible dependent may lose any rights to continuation coverage.**
- **You go on a leave of absence or have time away from work.** You should immediately contact your HPR for your options, if any, to make changes to your current coverage. Requested changes will be effective the date of the written request if made within 60 days of beginning the leave.
- **You have or gain other coverage.** If you have group coverage provided by a plan other than the LGHP or if you or your dependents gain other coverage during the plan year.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to the LGHP when a change in your or your dependent's Medicare status occurs. **Failure to notify the LGHP at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.**
- **You get married or enter into a civil union partnership; or your marriage or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **The employment status of your dependent changes.**
- **You have a financial or medical power of attorney (POA) who you would like to be able to make decisions and get information on your behalf.**
  - **Financial POA – used by your agent to change your health plan elections.** The financial POA document would allow an agent to make health and dental plan elections on your behalf and should be sent to your health plan representative.
  - **Medical POA – used by your agent to speak with your health, dental and vision plans about your coverage and claims.** A medical POA generally gives an agent the authority to make medical decisions on your behalf; therefore, in order for your agent to speak with your health, dental and/or vision plan(s), you would need to submit the medical POA document to each plan for their files.

Contact your HPR if you are uncertain whether or not a life-changing event needs to be reported.

## Be a Good Consumer - Optimize Your Benefits!

In order to get the most savings from all of your benefit plans, be sure to:

- **Check with Your Doctor BEFORE having Tests Performed.** Research the provider networks of your health, prescription, behavioral health, dental and vision plans. All the plan administrators have contracted provider networks that can **optimize your benefits** and save you money. Out-of-network services can cost you considerably more money, especially with fees over the plans allowable charges.
- **Choose generics.** If you take any medications, make sure to choose generics whenever possible. Check to see if your prescription is on the formulary list, or ask your doctor before leaving the office.

# Health Plan

The Local Government Health Plan (LGHP) provides employees, annuitants, elected officials and survivors of an enrolled local government unit with health, prescription, behavioral health, dental and vision coverage.

As a member enrolled in the LGHP, you are offered various health insurance coverage options:

✦ **Local Consumer-Driven Health Plan (LCDHP)**

✦ **Local Care Health Plan (LCHP)**

✦ **Managed Care Plans** (two types)

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide and the doctors and hospitals you can access. See the Benefits Comparison charts on pages 10-14 for information to help you determine which plan is right for you.

You also have the option of waiving coverage if you have other comprehensive health coverage. Electing to waive includes the termination of health, dental, vision, behavioral health and prescription coverage.

If you change health plans during the Benefit Choice Period, or re-elect health coverage after waiving, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. If you need to have services but have not yet received your ID cards, contact your health insurance carrier.

Remember, whatever health plan you elect during the Benefit Choice Period will remain in effect the entire plan year unless you experience a qualifying change in status that allows you to change plans.

# Important Reminders

**Transition of Care after Health Plan Change:** Members and their dependents who elect to change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Members or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

**Continuation of Coverage:** During the Benefit Choice Period, Continuation of Coverage participants have the same benefit options available to them as all other members.

**Documentation Requirements:** Documentation, including the SSN, is required when adding dependent coverage.

# Federally Required Notices

## Notice of Creditable Coverage

Prescription Drug Information for LGHP Medicare Eligible Plan Participants

This Notice confirms that the Local Government Health Plan has determined that the prescription drug coverage it provides is creditable. This means that your existing prescription coverage is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your group coverage through the LGHP and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your LGHP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after the loss of creditable coverage.

If you keep your existing group coverage, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll into a Medicare prescription drug plan; however, may need a personalized Notice of Creditable Coverage in order to enroll into a prescription plan without a financial penalty. Participants who need a personalized Notice may contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007.

## Summary of Benefits and Coverage (SBC) and Uniform Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The regulation is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in, coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All LGHP health plan SBC's are available on the Benefits website.

## Notice of Privacy Practices

The Notice of Privacy Practices has been updated on the Benefits website effective April 1, 2013. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at **www.benefitschoice.il.gov**.

# Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Health maintenance organizations (HMOs) have limitations including geographic availability and defined provider networks, whereas the two open access plans (OAPs), the Local Consumer-Driven Health Plan (LCDHP) and the Local Care Health Plan (LCHP) have nationwide networks of providers available to their members.

All health plans require a determination of medical appropriateness prior to specialized services being rendered. HMO plans require the member to obtain a copy of the authorized referral prior to services being rendered. For the LCDHP, LCHP and OAPs, it is the member's responsibility to make sure authorization of medical services has been obtained by the health plan provider to avoid penalties or nonpayment of services. Important note: OAPs are self-referral plans. It is the member's responsibility to ensure that the provider and/or facility from which they are receiving services are in either the Tier I or Tier II network to avoid significant out-of-pocket costs. For more detailed information, refer to each health plan's summary plan document (SPD).

## Local Consumer-Driven Health Plan (LCDHP)

The Local Consumer-Driven Health Plan (LCDHP) is a benefit option often referred to as a high-deductible health plan which requires members to be more responsible for managing their healthcare including how they spend their healthcare dollars. LCDHP is administered by Cigna and offers a comprehensive range of benefits including a nationwide network of physicians, hospitals and ancillary providers. The plan design offers both in- and out-of-network benefits; however, utilizing in-network providers will result in cost savings to the member. Notification to Cigna, the LCDHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Cigna at (800) 962-0051 for direction.

Members interested in more information regarding the LCDHP benefit levels should refer to page 13. Plan highlights are listed below:

- An annual collective plan year deductible (includes medical and pharmacy) applies to all nonpreventive medical services, nonpreventive prescriptions and behavioral health services.
- There are two plan year deductibles, one for in-network and one for out-of-network. Each plan year deductible (i.e., in-network vs. out-of-network) is exclusive and separate from the other.
- Members with one or more dependents on their coverage must satisfy the family annual plan year deductible before services will be covered at the plan's benefit levels of 90% in-network and 70% out-of-network.
- Preventive medical services obtained through an in-network provider are covered at 100% and are not subject to the annual plan year deductible. Preventive medical services obtained out-of-network are not covered.
- Preventive medications are covered at the applicable coinsurance level and are not subject to the annual plan year deductible.
- The plan has two out-of-pocket maximums, one for all eligible in-network services and one for all eligible out-of-network services. Each out-of-pocket maximum (i.e., in-network vs. out-of-network) is exclusive and separate from the other. Plan coinsurance and deductibles are applied to the out-of-pocket maximums. Benefits will be paid at 100% up to the allowed charges after the applicable out-of-pocket maximum has been met.

The LCDHP currently utilizes Magellan for behavioral health benefits and Express Scripts for prescription benefits.

# Health Plan Descriptions

## Local Care Health Plan (LCHP)

LCHP is a medical plan that offers a comprehensive range of benefits. Under the LCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a LCHP network provider. Plan participants can access plan benefit and participating LCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

The LCHP has a nationwide network that consists of physicians, hospitals and ancillary providers. Notification to Cigna is required for certain medical services in order to avoid penalties. Contact Cigna at (800) 962-0051 for direction.

LCHP currently utilizes Magellan for behavioral health benefits and Express Scripts for prescription benefits.

## Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Members who elect an HMO plan will need to select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment will apply. There are no annual plan deductibles for medical services obtained through an HMO.

  The minimum level of HMO coverage provided by all plans is described on page 10. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

  If a member is enrolled in an HMO and their PCP leaves the HMO plan's network, the member must choose another PCP within that plan. Alternatively, if CMS determines the plan's network experienced a significant change in the number of medical providers offered, the member may change health plans (the request to change health plans must be elected within 60 days of the qualifying event).

- **Open Access Plans (OAPs)**

  Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted. Members enrolled in an OAP can mix and match providers and tiers.

  - Tier I offers a managed care network which provides enhanced benefits. Tier I benefits require copayments which mirror an HMO plan's copayments, but do not require a plan year deductible.
  - Tier II offers another managed care network, in addition to the managed care network offered in Tier I, and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
  - Tier III covers all providers which are not in the managed care networks of Tiers I or II (i.e., out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of-pocket costs. Tier III has a higher plan year deductible and has a higher

# Health Plan Descriptions

coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, plan participants who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services, which could result in substantial out-of-pocket costs (i.e., allowable charges). When using out-of-network providers, it is recommended that the participant obtain preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and will be eligible for benefit coverage.

Members who use providers in Tiers II and III will be responsible for the plan year deductible. **In accordance with the Affordable Care Act, these deductibles will accumulate separately from each other and will not 'cross accumulate.'** This means that amounts paid toward the deductible in one tier will not apply toward the deductible in the other tier.

Mimimum level benefits are described on page 11 and may also be found in the summary plan document (SPD) on the OAP administrator's website.

# Behavioral Health Services

### Local Care Health Plan/Local Consumer-Driven Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under the Local Consumer-Driven Health Plan (LCDHP) and the Local Care Health Plan (LCHP). Behavioral health services are included in an enrollee's annual plan year deductible and annual out-of-pocket maximum. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the benefit schedule on pages 12-13 for in-network and out-of-network providers. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611. Please contact Magellan for specific benefit information.

### Managed Care Plans (HMO and OAP Plans)

Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 10-11. Please contact the managed care plan for specific benefit information.

To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

# Map of Health Plans by Illinois County

## July 1, 2015 through June 30, 2016

**Refer to the code key below for the health plan code for each plan by county.**

BlueAdvantage HMO. . . . CI
Coventry HMO. . . . . AS
Coventry OAP . . . . . CH
Health Alliance HMO . . . AH
HealthLink OAP . . . . . CF
HMO Illinois. . . . . BY
Local Care Health Plan (LCHP). . . . . D3
Local Consumer-Driven Health Plan (LCDHP) . . . . . D9

AH, AS, BY, CF, CH, CI, D3, D9

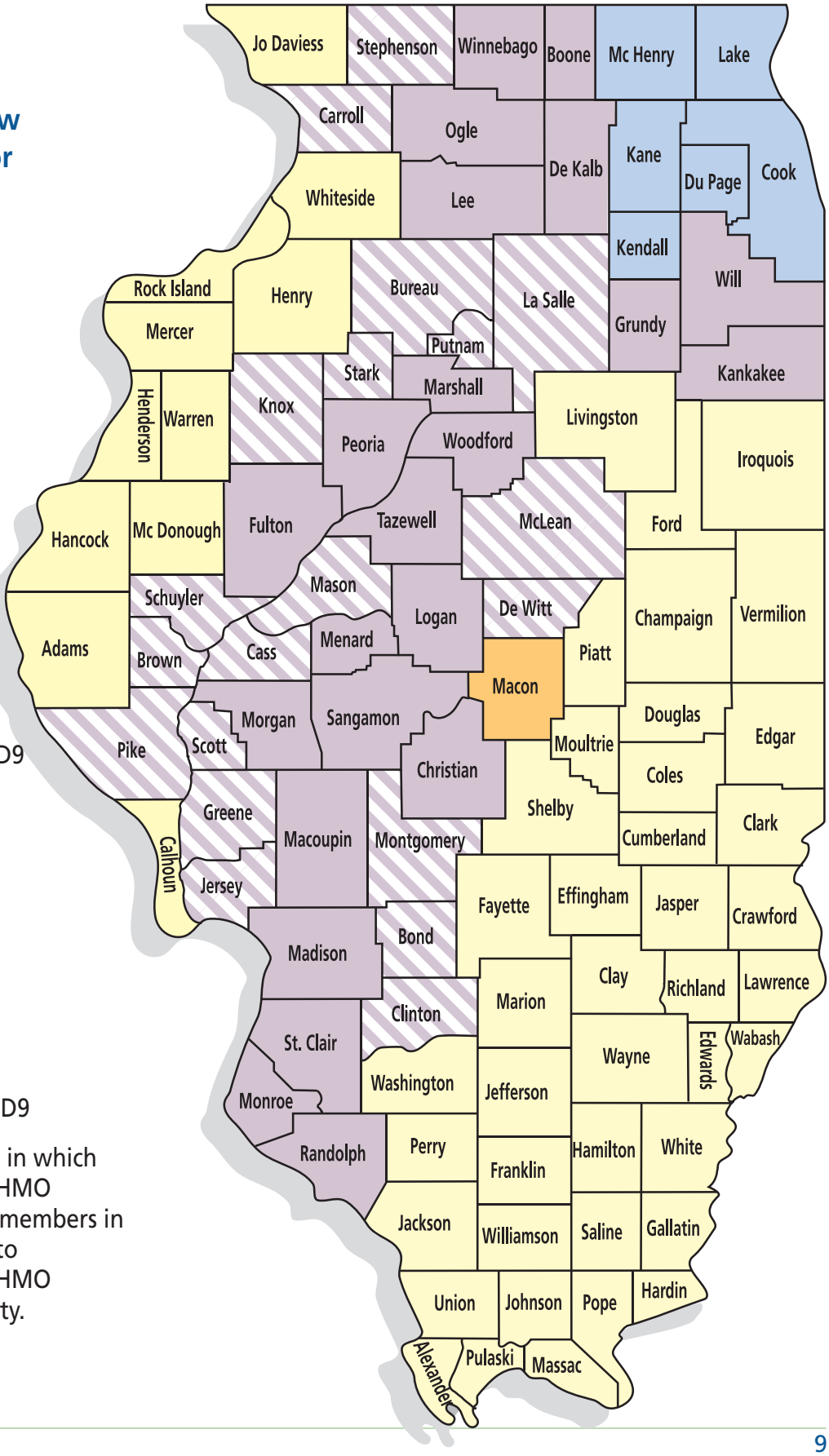
BY, CF, CH, CI, D3, D9

AH, AS, CF, CH, D3, D9

AH, AS, CF, CH, CI, D3, D9

AH, AS, BY, CI, CH, CF, D3, D9

Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.



# HMO Benefits

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

| HMO Plan Design | |
|---|---|
| Plan year maximum benefit | Unlimited |
| Lifetime maximum benefit | Unlimited |
| **Hospital Services** | |
| Inpatient hospitalization | 100% after $250 copayment per admission |
| Alcohol and substance abuse | 100% after $250 copayment per admission |
| Psychiatric admission | 100% after $250 copayment per admission |
| Outpatient surgery | 100% after $200 copayment |
| Diagnostic lab and x-ray | 100% |
| Emergency room hospital services | 100% after $200 copayment per visit |
| **Professional and Other Services (Copayment not required for preventive services)** | |
| Physician Office visit | 100% after $30 copayment per visit |
| Preventive Services, including immunizations | 100% |
| Specialist Office visit | 100% after $30 copayment per visit |
| Well Baby Care (first year of life) | 100% |
| Outpatient Psychiatric and Substance Abuse | 100% after $30 copayment per visit |
| Prescription drugs<br>(30-day supply)<br>(formulary is subject to change during plan year) | $12 copayment for generic<br>$24 copayment for preferred brand<br>$48 copayment for nonpreferred brand<br>$96 copayment for specialty |
| Durable Medical Equipment | 80% |
| Home Health Care | $30 copayment per visit |

Some HMOs may have benefit limitations based on a calendar year.

# Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD.

| Benefit | Tier I<br>100% Benefit | Tier II<br>90% Benefit | Tier III (Out-of-Network)<br>80% Benefit |
|---|---|---|---|
| Plan Year Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Annual Out-of-Pocket Max<br>Per Individual Enrollee<br>Per Family | $6,250 (includes eligible charges from Tier I and Tier II combined)<br>$12,750 (includes eligible charges from Tier I and Tier II combined) | | Not Applicable |
| Annual Plan Deductible (must be satisfied for all services) | $0 | $300 per enrollee* | $500 per enrollee* |
| **Hospital Services** | | | |
| Inpatient | 100% after $250 copayment per admission | 90% of network charges after $300 copayment per admission | 80% of allowable charges after $400 copayment per admission |
| Inpatient Psychiatric | 100% after $250 copayment per admission | 90% of network charges after $300 copayment per admission | 80% of allowable charges after $400 copayment per admission |
| Inpatient Alcohol and Substance Abuse | 100% after $250 copayment per admission | 90% of network charges after $300 copayment per admission | 80% of allowable charges after $400 copayment per admission |
| Emergency Room | 100% after $200 copayment per visit | 100% after $200 copayment per visit | 100% after $200 copayment per visit |
| Outpatient Surgery | 100% after $200 copayment per visit | 90% of network charges after $200 copayment | 80% of allowable charges after $200 copayment |
| Diagnostic Lab and X-ray | 100% | 90% of network charges | 80% of allowable charges |
| **Physician and Other Professional Services**<br>**(Copayment not required for preventive services)** | | | |
| Physician Office Visits | 100% after $30 copayment | 90% of network charges | 80% of allowable charges |
| Specialist Office Visits | 100% after $30 copayment | 90% of network charges | 80% of allowable charges |
| Preventive Services, including immunizations | 100% | 100% | Covered under Tier I and Tier II only |
| Well Baby Care (first year of life) | 100% | 100% | Covered under Tier I and Tier II only |
| Outpatient Psychiatric and Substance Abuse | 100% after $30 copayment | 90% of network charges | 80% of allowable charges |
| **Other Services** | | | |
| Prescription Drugs (30-day supply)<br>Generic $12 | Preferred Brand $24 | Nonpreferred Brand $48 | Specialty $96 |
| Durable Medical Equipment | 80% of network charges | 80% of network charges | 80% of allowable charges |
| Skilled Nursing Facility | 80% | 80% of network charges | Covered under Tier I and Tier II only |
| Transplant Coverage | 100% | 80% of network charges | Covered under Tier I and Tier II only |
| Home Health Care | 100% after $30 copayment | 80% of network charges | Covered under Tier I and Tier II only |

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

# The Local Care Health Plan (LCHP)

| Plan Year Maximums and Deductibles* | |
|---|---|
| Plan Year Maximum<br>Lifetime Maximum | Unlimited<br>Unlimited |
| Plan Year Deductible* | $750 per participant |
| Additional Deductibles**<br>** These are in addition to the plan year deductible. | Each emergency room visit $400<br>LCHP hospital admission $250<br>Non-LCHP hospital admission $500<br>Transplant deductible $250 |

* For members who have at least one dependent, the family deductible must be met before any family member can receive coverage at the plan's benefit levels of 90% (in-network) and 60% (out-of-network).

| Out-of-Pocket Maximum Limits | | | |
|---|---|---|---|
| In-Network Individual<br>$1,750 | In-Network Family<br>$3,500 | Out-of-Network Individual<br>$4,750 | Out-of-Network Family<br>$9,500 |

| Hospital Services | |
|---|---|
| LCHP Hospital Network | $250 deductible per hospital admission.<br>90% after annual plan deductible. |
| Non-LCHP Hospitals | $500 deductible per hospital admission.<br>60% of allowable charges after annual plan deductible. |

| Outpatient Services | |
|---|---|
| Preventive Services, including immunizations | 100% in-network, 60% of allowable charges out-of-network, after annual plan deductible. |
| Diagnostic Lab/X-ray | 90% in-network, 60% of allowable charges out-of-network, after annual plan deductible. |
| Approved Durable Medical Equipment (DME) and Prosthetics | |
| Licensed Ambulatory Surgical Treatment Centers | |

| Professional and Other Services | |
|---|---|
| Services included in the LCHP Network | 90% after the annual plan deductible. |
| Services not included in the LCHP Network | 60% of allowable charges after the annual plan deductible. |
| Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year) | 90% in-network, 60% of allowable charges out-of-network, after the annual plan deductible. |

| Transplant Services | |
|---|---|
| Organ and Tissue Transplants | 90% after $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services. |

| Prescription Drugs | |
|---|---|
| Prescription Drugs<br>(30-day supply) | Generic $12.50<br>Preferred Brand $25.00<br>Nonpreferred Brand $50.00<br>Specialty $100.00 |

# Local Consumer-Driven Health Plan (LCDHP)

| Plan Year Maximums and Deductibles | | |
|---|---|---|
| Plan Year Maximum | Unlimited | |
| Lifetime Maximum | Unlimited | |
| Plan Year Deductible* | In-Network | Out-of-Network |
| Individual | $1,500 | $3,000 |
| Family | $3,000 | $6,000 |

* For members who have at least one dependent, the family deductible must be met before any family member can receive coverage at the plan's benefit levels of 90% (in-network) and 70% (out-of-network).

| Out-of-Pocket Maximum Limits | | | |
|---|---|---|---|
| **In-Network Individual** | **In-Network Family** | **Out-of-Network Individual** | **Out-of-Network Family** |
| $3,000 | $6,000 | $6,000 | $12,000 |

The plan has two out-of-pocket maximums, one for all eligible in-network services and one for all eligible out-of-network services. Each out-of-pocket maximum (i.e., in-network vs. out-of-network) is exclusive and separate from the other. Plan medical and prescription drug coinsurance and medical deductibles apply toward the out-of-pocket maximums. Out-of-network benefits will be paid at 100% up to the allowed charges after the applicable out-of-pocket maximum has been met. In-network benefits will be paid at 100% of the charges after the applicable out-of-pocket maximum has been met.

| Hospital Services | |
|---|---|
| LCDHP Hospital Network | 90% after annual plan deductible. |
| Non-LCDHP Hospitals | 70% after annual plan deductible. |
| **Outpatient Services** | |
| Preventive Services, including immunizations | 100%; covered in-network only |
| Diagnostic Lab/X-ray | 90% in-network, 70% of allowable charges out-of-network, after annual plan deductible. |
| Approved Durable Medical Equipment (DME) and Prosthetics | |
| Licensed Ambulatory Surgical Treatment Centers | |
| **Professional and Other Services** | |
| Services included in the LCDHP Network | 90% after the annual plan deductible. |
| Services not included in the LCDHP Network | 70% of allowable charges after the annual plan deductible. |
| Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year) | 90% in-network, 70% of allowable charges out-of-network, after the annual plan deductible. |
| **Transplant Services** | |
| Organ and Tissue Transplants | 90% limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services. |
| **Prescription Drugs** | |
| Preventive Prescription Drugs | Applicable coinsurance; not subject to plan year deductible |
| Prescription Drugs (30-day supply) | 70% coinsurance for generic<br>60% coinsurance for preferred brand<br>50% coinsurance for nonpreferred brand |

# Health Plan Comparison

| Benefit | LCHP | | LCDHP | | HMO | OAP Tier I (in-network) | OAP Tier II (in-network) | OAP Tier III (out-of--network) |
|---|---|---|---|---|---|---|---|---|
| **Patient Responsibilities** | | | | | | | | |
| Annual Out-of-Pocket Maximum | In-Network | Out-of-Network | In-Network | Out-of-Network | | | | |
| Per Enrollee | $1,750 | $4,750 | $3,000 | $6,000 | $3,000 per enrollee | $6,250 ( Tier I and Tier II combined) | | Not applicable |
| Per Family | $3,500 | $9,500 | $6,000 | $12,000 | $6,000 per family/plan year | $12,750 ( Tier I and Tier II combined) | | Not applicable |
| Annual Plan Deductible* | | | | | | | | |
| Per Enrollee | $750 per enrollee | | $1,500 | $3,000 | Not applicable | Not applicable | $300 per enrollee | $500 per enrollee |
| Per Family | $750 per enrollee | | $3,000 | $6,000 | | | $300 per enrollee | $500 per enrollee |
| **Plan Benefit Levels Comparison** | | | | | | | | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | | | | |
| Emergency Room | 90% of network charges after $400 per visit | 90% of allowable charges after $400 per visit | 90% of network charges | 70% of allowable charges | $200 | $200 | $200 | $200 |
| Preventive Services including immunizations | 100% | 60% of allowable charges | 100% | No coverage | 100% | 100% | 100% | Covered under Tier I and Tier II only |
| Inpatient | 90% of network charges after $250 per visit | 60% of allowable charges after $500 per visit | 90% of network charges | 70% of allowable charges | $250 copayment | $250 copayment | 90% of network charges after $300 copayment | 80% of allowable charges after $400 copayment |
| Outpatient Surgery | 90% of network charges | 60% of allowable charges | 90% of network charges | 70% of allowable charges | $200 copayment | $200 copayment | 90% of network charges after $200 copayment | 80% of allowable charges after $200 copayment |
| Diagnostic Lab and X-ray | | | | | 100% | 100% | 90% of network charges | 80% of allowable charges |
| Durable Medical Equipment | | | | | 80% of network charges | 80% of network charges | 80% of network charges | 80% of allowable charges |
| Physician Office Visit | | | | | $30 copayment | $30 copayment | 90% of network charges | 80% of allowable charges |

* The annual plan deductible must be met before benefit levels will be applied.

**Note: Network charges** are the amount the plan determines is the appropriate charge for a covered service. **Allowable Charges** are applied to services when a member utilizes an out-of-network provider. Members who use out-of-network providers should contact their health plan administrator for information regarding out-of-network charges before obtaining services.

# Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

**Effective July 1, 2015, in accordance with the Affordable Care Act (ACA)**, prescription coinsurance and copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **Local Care Health Plan:***
  - Annual medical plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - LCHP additional medical deductibles
- **Local Consumer-Driven Health Plan:***
  - Annual medical plan year deductible
  - Medical and prescription coinsurance

*Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

- **HMO Plans:**
  - Medical and prescription copayments
  - Medical coinsurance
- **OAP Plans: (only applies to Tier I and Tier II providers):**
  - Annual medical plan year deductible (Tier II)
  - Medical and prescription copayments
  - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

Certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges that do not count toward the out-of-pocket maximum include:

- Amounts over allowable charges for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

**CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM**

| PLAN | Out-of-Pocket Maximum Limits | Annual Plan Year Deductible | Additional Deductibles (LCHP)/ Copayments | Medical Coinsurance | Pharmacy Coinsurance/ Copayments | Amounts over Allowable Charges (LCDHP and LCHP out-of-network providers and OAP Tier III providers) |
|---|---|---|---|---|---|---|
| LCDHP | **In-Network**<br>Individual $3,000<br>Family $6,000 | X | N/A | X | X | **Amounts over the plan's allowable charges are the member's responsibility and do not go toward the out-of-pocket maximum.** |
| | **Out-of-Network**<br>Individual $6,000<br>Family $12,000 | X | N/A | X | X | |
| LCHP | **In-Network**<br>Individual $1,750<br>Family $3,500 | X | X | X | X | |
| | **Out-of-Network**<br>Individual $4,750<br>Family $9,500 | X | X | X | X | |
| HMO | Individual $3,000<br>Family $6,000 | N/A | X | X | X | |
| OAP Tier I | Individual $6,250<br>Family $12,750<br>Tiers I and Tier II charges combined | X | X | X | X | |
| OAP Tier II | | X | X | X | X | |
| OAP Tier III | N/A | N/A | N/A | N/A | N/A | |

**Note:** Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles, as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum.

# Prescription Benefit

Plan participants enrolled in any LGHP health plan have prescription drug benefits included in the coverage. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's prescription benefit manager (PBM) for coordination of benefits (COB) information. Please note that when a 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.

The maximum fill that LCHP and OAP plan participants can obtain at a retail pharmacy is 60 days worth of medication; however, plan participants can obtain a 90-day supply of medication through the mail order pharmacy. A 90-day supply through the mail order pharmacy will cost two copayments instead of three. The maximum fill that an HMO plan participant can obtain at a retail pharmacy varies by health plan. Contact your health plan for more information.

To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan they are considering.

### Specialty Drug Category

A specialty drug is a medication that typically costs $500 or more per dose or $6,000 or more per year and has one or more of the following characteristics:

- Is a complex therapy for a complex disease;
- Is used for specialized patient training and coordination of care (services, supplies or devices) and is required prior to therapy initiation and/or during therapy;
- Has unique patient compliance and safety monitoring requirements;
- Has unique requirements for handling, shipping and storage; or
- Has a potential for significant waste.

### Prescription Drug Step Therapy

Applies to Local Care Health Plan (LCHP), HealthLink and Coventry Open Access Plans (OAPs).

Members who receive prescription benefits through the LCHP or one of the OAPs will be subject to prescription drug step therapy (PDST) for specific drugs. PDST requires the member to try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their physician may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still effectively treat the member's condition.

**Formulary Lists:** All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred. Each category has a different copayment (or coinsurance for the LCDHP) amount. Coverage for specific prescription drugs may vary depending upon the health plan. **Formulary lists are subject to change any time during the plan year;** therefore, when a prescribed medication the plan participant is currently taking is reclassified into a different formulary list category either the health plan or the PBM will notify plan participants by mail. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Express Scripts: (800) 899-2587
Website: www.express-scripts.com

# Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the LGHP health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams and replacement lenses are covered once every 12 months from the last date the exam benefit was used. Standard frames are available once every 24 months from the last date used. Copayments are required.

| Service | Network Provider Benefit | Out-of-Network** Provider Benefit | Benefit Frequency |
|---|---|---|---|
| Eye Exam | $25 copayment | $30 allowance | Once every 12 months |
| Spectacle Lenses* (single, bifocal and trifocal) | $25 copayment | $50 allowance for single vision lenses<br>$80 allowance for bifocal and trifocal lenses | Once every 12 months |
| Standard Frames | $25 copayment (up to $175 retail frame cost; member responsible for balance over $175) | $70 allowance | Once every 24 months |
| Contact Lenses (All contact lenses are in lieu of spectacle lenses) | $120 allowance | $120 allowance | Once every 12 months |

* 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.

** Out-of-network claims must be filed within one year from the date of service.

EyeMed Vision Care: (866) 723-0512
TDD/TTY: (800) 526-0844
Website: www.eyemedvisioncare.com/stil

# Dental Plan

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected.

### Dental Benefit

The Local Care Dental Plan (LCDP) is a dental plan that offers a comprehensive range of benefits administered by Delta Dental of Illinois. The LCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive'. The annual plan deductible is $100 per participant per plan year. Once the deductible has been met, the plan participant has a maximum annual dental benefit of $2,000 for all dental services.

Plan participants enrolled in the dental plan can choose any dental provider for services; however, plan participants may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a plan participant may utilize for dental services in addition to out-of-network providers: the Delta Dental PPO℠ network and the Delta Dental Premier℠ network.

- **Delta Dental PPO℠ Network** If you receive services from a PPO-level dentist you can maximize your dental benefits and minimize your out-of-pocket expenses because these providers accept a lower negotiated PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.

#### Deductible and Plan Year Maximum

| | |
|---|---|
| Annual Deductible for Preventive Services | N/A |
| Annual Deductible for All Other Covered Services | $100 |
| Plan Year Maximum Benefit* | $2,000 |

- **Delta Dental Premier℠ Network** If you receive services from a Premier-level dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier-level fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for the difference.
- **Out-of-Network** If you receive services from a dentist who does not participate in either the PPO or Premier network, you will receive benefits as provided by the Schedule of Benefits. You will likely pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

Plan participants can access LCDP network information, explanation of benefits (EOB) statements and other valuable information online by registering with Delta Dental of Illinois Member Connection.

**It is strongly recommended that plan participants obtain a pretreatment estimate for any service over $200, regardless of whether that service is to be received from an in-network or an out-of-network provider. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.** A pretreatment estimate is a review by Delta Dental of a dental provider's proposed treatment, including diagnostic, x-ray and laboratory reports, as well as the expected charges. This treatment plan is sent to Delta Dental for verification of eligible benefits. Obtaining a pretreatment estimate to verify coverage will help you make decisions regarding your dental services and help you avoid unanticipated out-of-pocket costs. Questions regarding a pretreatment estimate can be addressed by Delta Dental.

* Orthodontics + all other covered services = Plan Year Maximum Benefit

# Dental Plan (cont.)

### Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist.

**Example of PPO, Premier and Out-of-Network Dentist Payments** (this is a hypothetical example only and assumes the deductible has been met).

| Delta Dental PPO Dentist* | | Delta Dental Premier Dentist* | | Out-of-Network Dentist | |
|---|---|---|---|---|---|
| Dentist submitted fee | $1,000 | Dentist submitted fee | $1,000 | Dentist submitted fee | $1,000 |
| PPO maximum allowed fee | $790 | Premier maximum allowed fee | $900 | No negotiated fee | n/a |
| Schedule of Benefits amount | $781 | Schedule of Benefits amount | $781 | Schedule of Benefits amount | $781 |
| Your Out-of-Pocket Cost | $9 | Your Out-of-Pocket Cost | $119 | Your Out-of-Pocket Cost | $219 |

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

### Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is $1,500. This lifetime maximum is based on the length of treatment (see 'Length of Orthodontia Treatment' chart below). This lifetime maximum applies to each plan participant regardless of the number of courses of treatment. **Note:** The annual plan year deductible must be satisfied each plan year that the plan participant is receiving orthodontia treatment unless it was previously satisfied for other dental services incurred during the plan year.

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

### Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures, implants and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by LCDP.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

Delta Dental: (800) 323-1743
TDD/TTY: (800) 526-0844
Website: http://soi.deltadentalil.com

# Plan Participants (Members and Dependents) Eligible for Medicare

## What is Medicare?

Medicare is a federal health insurance program for the following:

- Participants age 65 or older
- Participants under age 65 with certain disabilities
- Participants of any age with End-Stage Renal Disease (ESRD)

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is premium-free for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for members who are retired or who have lost "current employment status" and are eligible for Medicare.
- **Medicare Part C** (also known as Medicare Advantage): Part C is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D (if the plan covers prescription drugs). An individual must already be enrolled in Medicare Parts A and B in order to enroll into a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Medicare Part D** (Prescription Drug Insurance): Medicare Part D coverage requires a monthly premium contribution, unless the participant qualifies for extra-help assistance as determined by the SSA.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

## Local Government Health Plan Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, **LGHP requires** that the plan participant accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Plan participants who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare Parts A or B.

**To ensure that healthcare benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, each plan participant who becomes eligible for Medicare is required to submit a copy of his or her Medicare card to his or her Health Plan Representative (HPR).**

# Plan Participants Eligible for Medicare (cont.)

## Employees with Current Employment Status

Members (as well as his or her applicable dependents) who are actively working and become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must accept the premium-free Medicare Part A coverage, but may delay the purchase of Medicare Part B coverage. The Local Government Health Plan (LGHP) will remain the primary insurance until the date the member retires or loses "current employment status" (such as no longer working due to a disability-related leave of absence). Upon such an event, Medicare Part B is required by the LGHP.

## Members without Current Employment Status

Members (as well as his or her applicable dependents) who are retired or who have lost current employment status (such as no longer working due to a disability related leave of absence) that are eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) **are required to enroll in the Medicare Program**. In most cases, Medicare is the primary payer for health insurance claims over the Local Government Health Plan.

## Medicare Parts A and B Reduction

Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary payer will result in a reduction of benefits under the Local Government Health Plan and will result in additional out-of-pocket expenditures for health-related claims.

## Plan Participants Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD)

Plan participants of any age who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

## Plan Participants with Additional Insurance

Plan participants that are actively working (or retired) with additional insurance (other than what is provided through the Local Government Health Plan) must submit a copy of their insurance identification card along with the effective date of the other plan's coverage to the State of Illinois Medicare COB Unit in order to ensure the proper coordination of benefits for healthcare claims.

**Plan participants can contact the State of Illinois Medicare COB Unit concerning any questions via phone at (800) 442-1300 or (217) 782-7007.**

# Wellness Offerings

## Be Well, Get Well, Stay Well

The LGHP offers many valuable wellness programs to help keep our members healthy and help unhealthy members get healthier. The goal is for all LGHP members to lead better, more satisfying lives.

### Our Wellness Program

The LGHP is highlighting its current wellness program to provide even more assistance to you. The program focuses on improving lifestyle choices, including eating healthier, being more physically active, ending tobacco use, managing stress more effectively, and getting more sleep. The goal is to help you avoid chronic health problems (or help stabilize/improve them, if applicable), such as diabetes, heart disease, high blood pressure and high cholesterol.

### What You Can Do Now

Steps you can take to be healthier and live better:

- **Step 1: Get a checkup.** It is vitally important to have a preventive health exam each year, including (as applicable based on your age and gender) a Pap smear, prostate exam, mammogram, colonoscopy, cancer screening and immunizations. Your health plan covers many preventive services **at no cost to you**, as required under Federal Health Care Reform laws.
- **Step 2: Take advantage of your medical plan's resources.** Many LGHP-offered medical plans have valuable wellness resources such as health information libraries, online health coaching, dedicated nurse phone lines and wellness publications. Visit your plan's website to find out what's available to you.
- **Step 3: Know your numbers, know your risks.** A smart step to getting healthier and staying that way, is to…
  - **…Know your numbers:** Get **biometric screenings** from your doctor. These are simple and quick tests that measure your blood pressure, pulse rate, blood glucose (sugar), total cholesterol, body mass index (BMI), height and weight. You can get them when you go for an annual physical.
  - **…Take a Health Risk Assessment (HRA):** Complete a private, confidential **HRA** on your medical plan's website. It asks basic health-related questions like, "Did you get a flu shot?" and "Do you wear a seat belt?" There are no right or wrong answers. The information you provide—and HRA results—is not shared with the LGHP. You'll get instant results after you complete an HRA, including a personal action plan. (Using your biometric screening information will give you the most accurate results.) Share your results and action plan with your doctor. Discuss with him/her ways you can maintain good health or improve your health.

# Disease Management Programs

Disease Management Programs are utilized by the Local Care Health Plan (LCHP) and the Local Consumer-Driven Health Plan (LCDHP) plan administrator, as well as the managed care health plans as a way to improve the health of plan participants. Members and dependents identified with certain risk factors indicating diabetes, cardiac health and many other chronic health conditions will be contacted by the medical plans to participate in these programs. These **highly confidential programs** are based upon certain medical criteria and provide:

- Healthcare support available 24 hours a day, 7 days a week with access to a team of registered nurses (RNs) and other qualified health clinicians;
- Wellness tools, such as reminders of regular health screenings;
- Educational materials pertaining to your health condition, including identification of anticipated symptoms and ways to better manage these conditions;
- Valuable information and access to discounted services from weight-loss programs.

# Plan Administrators

## Who to contact for information

| Health Plan Administrators | Toll-Free Telephone Number | TDD/TTY Number | Website Address |
|---|---|---|---|
| **BlueAdvantage HMO** | (800) 868-9520 | (866) 876-2194 | www.bcbsil.com/stateofillinois |
| **Coventry Health Care HMO** | (800) 431-1211 | (217) 366-5551 | www.chcillinois.com |
| **Coventry Health Care OAP** | (800) 431-1211 | (217) 366-5551 | www.chcillinois.com |
| **Health Alliance HMO** | (800) 851-3379 | (800) 526-0844 | www.healthalliance.org/ stateofillinois |
| **HealthLink OAP** | (800) 624-2356 | (800) 624-2356 ext. 6280 | www.healthlink.com/ illinois_index.asp |
| **HMO Illinois** | (800) 868-9520 | (866) 876-2194 | www.bcbsil.com/stateofillinois |
| **Local Care Health Plan (Cigna)** | (800) 962-0051 | (800) 526-0844 | www.cigna.com/stateofil |
| **Local Consumer-Driven Health Plan (Cigna)** | (800) 962-0051 | (800) 526-0844 | www.cigna.com/stateofil |

| Plan Component | Administrator's Name and Address | Customer Service Phone Numbers | Website Address |
|---|---|---|---|
| **Vision Plan** | **EyeMed**<br>Out-of-Network Claims<br>P.O. Box 8504<br>Mason, OH<br>45040-7111 | (866) 723-0512<br>(800) 526-0844 (TDD/TTY) | www.eyemedvision care.com/stil |
| **Local Care Dental Plan (LCDP) Administrator** | **Delta Dental of Illinois**<br>Group Number 20241<br>P.O. Box 5402<br>Lisle, IL 60532 | (800) 323-1743<br>(800) 526-0844 (TDD/TTY) | http://soi.deltadentalil.com |
| **Health/Dental Plans, Medicare COB Unit, Smoking Cessation Benefit and Weight-Loss Benefit** | **CMS Group Insurance Division**<br>801 South 7th Street<br>P.O. Box 19208<br>Springfield, IL<br>62794-9208 | (217) 782-2548<br>(800) 442-1300<br>(800) 526-0844 (TDD/TTY) | www.benefitschoice.il.gov |

# Plan Administrators

## Who to contact for information

| Plan Component | Contact For | Administrator's Name and Address | Customer Service Contact Information |
|---|---|---|---|
| **LCDHP and LCHP Medical Plan Administrator** | Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits | **Cigna**<br>LCDHP Group #2499230<br>LCHP Group #2457474<br>**Cigna HealthCare**<br>P.O. Box 182223<br>Chattanooga, TN<br>37422-7223 | (800) 962-0051<br>(nationwide)<br>(800) 526-0844 (TDD/TTY)<br>www.cigna.com/stateofil |
| **LCDHP and LCHP Notification and Medical Case Management Administrator** | Notification prior to hospital services<br>Noncompliance penalty of $400 applies (out-of-network only) | **Cigna**<br>LCDHP Group #2499230<br>LCHP Group #2457474 | (800) 962-0051<br>(nationwide)<br>(800) 526-0844 (TDD/TTY) |
| **Prescription Drug Plan Administrator**<br>**LCDHP (1401LD9)**<br>**LCHP (1401LD3)**<br>**Coventry OAP (1401LCH)**<br>**HealthLink OAP (1401LCF)** | Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing | **Express Scripts**<br>Group Number:<br>1401LD9, 1401LD3<br>1401LCH, 1401LCF<br>**Paper Claims:**<br>Express Scripts<br>P.O. Box 14711<br>Lexington, KY 40512<br>**Mail Order Prescriptions:**<br>Express Scripts<br>P.O. Box 66577<br>St. Louis, MO 63166-6577 | (800) 899-2587<br>(nationwide)<br>(800) 759-1089 (TDD/TTY)<br>www.express-scripts.com |
| **LCDHP and LCHP Behavioral Health Administrator** | Notification, authorization, claim forms and claim filing/resolution for behavioral health services | **Magellan Behavioral Health**<br>LCDHP Group #2499230<br>LCHP Group #2457474<br>P.O. Box 2216<br>Maryland Heights, MO<br>63043 | (800) 513-2611<br>(nationwide)<br>(800) 526-0844 (TDD/TTY)<br>www.MagellanHealth.com |

**DISCLAIMER**

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 Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

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

Printed by the authority of the State of Illinois
3/15 600 IOCI 15-661
Printed on recycled paper