



CMS

Illinois Department of
**Central
 Management
 Services**

FY 2015

BENEFIT CHANGES/COMPARISONS

Quality Care Health Plan

ANNUAL DEDUCTIBLES	FY 2014		FY 2015		
	Individual	Family	Individual	Family	
Employee	\$60,700 or less	\$350	\$875	\$375	\$937.50
	\$60,701 - \$75,900	\$450	\$1,125	\$475	\$1,187.50
	\$75,901 and above	\$500	\$1,250	\$525	\$1,312.50
Retiree/Annuitant/Survivor		\$350	\$875	\$375	\$937.50
Dependents		\$350	N/A	\$375	N/A
ANNUAL DEDUCTIBLES					
Inpatient Hospitalization (In-Network)		\$75		\$100	
Inpatient Hospitalization (Out-of-Network)		\$400		\$500	
Emergency Care - Hospital		\$425		\$450	
Individual Out-of-Pocket Maximum (In-Network)		\$1,500		\$1,500	
Individual Out-of-Pocket Maximum (Out-of-Network)		\$6,000		\$6,000	
Family Out-of-Pocket Maximum (In-Network)			\$3,750		\$3,750
Family Out-of-Pocket Maximum (Out-of-Network)			\$12,000		\$12,000
BENEFIT LEVELS					
After all applicable deductibles met (In-Network)		90%		85%	
After all applicable deductibles met (Out-of-Network)		60%		60%	
After Out-of-Pocket Maximums met		100%		100%	
Note: Percentages are based on the allowable charge for covered services.					
PRESCRIPTIONS					
Deductibles		\$100		\$125	
Copayment Generic (30 day supply)		\$10		\$10	
Copayment Preferred Brand (30 day supply)		\$30		\$30	
Copayment Non-preferred Brand (30 day supply)		\$60		\$60	
Copayment mail order 90 day supply (Generic)		\$25		\$25	
Copayment mail order 90 day supply (Preferred)		\$75		\$75	
Copayment mail order 90 day supply (Non-Preferred)		\$150		\$150	
Note: The plan will process in accordance with plan provisions including annual deductibles and will no longer pay for services excluded by the plan even if Medicare pays.					

Vision

	FY 2014		FY 2015	
Vision Eye Exam- available every 12 months	\$20		\$25	
Vision Lenses - available every 12 months (beginning July 1, 2014)	\$20		\$25	
Vision Standard Frames - available every 24 months	\$20		\$25	

Dental

	FY 2014		FY 2015	
Annual Deductible	\$150		\$175	
Annual Max (in-network)	\$2,500		\$2,500	
Annual Max (out-of-network)	\$2,500		\$2,000	
Ortho Max (in-network)	\$2,000		\$2,000	
Ortho Max (out-of-network)	\$1,500		\$1,500	
Note: Max Benefit is \$2,500 e.g. If you use \$2000 out-of-network services you only have \$500 in-network services left				