

State of Illinois  
Pat Quinn, Governor

Department of Central Management Services  
Bureau of Benefits



# *Benefit Choice Options Period*

Enrollment Period May 1 - May 31, 2009

*State of Illinois*

Effective July 1, 2009 - June 30, 2010

# Plan Administrators

## Who to call for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
<b>Health Alliance HMO</b>	(800) 851-3379	(217) 337-8137	www.healthalliance.org
<b>Health Alliance Illinois</b>	(800) 851-3379	(217) 337-8137	www.healthalliance.org
<b>HealthLink OAP</b>	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
<b>HMO Illinois</b>	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
<b>Humana Benefit Plan of Illinois</b> (formerly OSF HealthPlans)	(888) 716-9138	(888) 817-0139	www.humanabenefitplanil.com
<b>Humana Benefit Plan of Winnebago</b> (formerly OSF Winnebago)	(888) 716-9138	(888) 817-0139	www.humanabenefitplanil.com
<b>PersonalCare</b>	(800) 431-1211	(217) 366-5551	www.personalcare.org
<b>UniCare HMO</b>	(888) 234-8855	(312) 234-7770	www.unicare.com

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
<b>Vision Plan</b>	<b>EyeMed</b> Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com/stil
<b>Quality Care Dental Plan (QCDP) Administrator</b>	<b>CompBenefits</b> Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY)	www.compbenefits.com
<b>Life Insurance Plan</b>	<b>Minnesota Life Insurance Company</b> 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
<b>Long-Term Care (LTC) Insurance</b>	<b>MetLife</b>	(800) 438-6388 (800) 638-1004 (TDD/TTY)	
<b>Flexible Spending Accounts (FSA) Program</b>	<b>Fringe Benefits Management Company</b> P.O. Box 1810 Tallahassee, FL 32302-1810	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax) (866) 440-7152 (toll-free fax)	www.myFBMC.com
<b>Commuter Savings Program (CSP)</b>			
<b>Health/Dental Plans, Medicare COB Unit, FSA and CSP Unit, Premium Collection Unit, Life Insurance, Adoption Benefit and Smoking Cessation Benefit</b>	<b>CMS Group Insurance Division</b> 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

Plan Administrator information continued on inside back cover.

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# Important Changes for Plan Year 2010



## (Enrollment Period May 1 – May 31, 2009)

The information below represents changes to the State of Illinois benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes. **The Benefit Choice Options Period is May 1 - May 31, 2009.** All elections will be effective July 1, 2009.

### Managed Care Plan (HMO/OAP)

- Prescription deductible of \$50 per plan participant per plan year remains the same
- Prescription co-payments for preferred brand and non-preferred brand increase to \$24/\$48 respectively (generic remains \$10)
- Inpatient hospitalization co-payment increases to \$275
- Outpatient surgery co-payment increases to \$175
- Employee and dependent health contributions have increased
- Audiologist fee benefit increases to \$150, available once every three plan years
- Hearing aid benefit increases to \$600, available once every three plan years

### Quality Care Health Plan (QCHP)

- Prescription deductible increases to \$75 per plan participant per plan year
- Prescription co-payments for preferred brand and non-preferred brand increase to \$26/\$52 respectively (generic remains \$11)
- New in-network hospital admission deductible of \$50 per plan participant
- Out-of-network hospital admission deductible increases to \$300 per plan participant
- Employee and dependent health contributions have increased
- Audiologist fee benefit increases to \$150, available once every three plan years
- Hearing aid benefit increases to \$600, available once every three plan years

### Quality Care Dental Plan (QCDP)

- Dental annual maximum benefit increases to \$2,250
- Orthodontia lifetime maximum increases to \$1,750
- Restorative Services have been enhanced

### OSF HealthPlans is now a part of Humana

The Humana Benefit Plan options will continue to provide the same benefits and same quality network of providers that you had available through OSF HealthPlans. If you are a current OSF member, you do not need to complete a Benefit Choice Election form unless you are changing to a plan other than Humana. If you are a current OSF member and decide to stay enrolled with Humana you will receive a new ID card from Humana prior to starting your new plan year July 1, 2009.

### Public Act 95-0958 – Coverage for Adult Children

Coverage for adult children will be effective July 1, 2009. Members must use a separate enrollment form to enroll adult children - **Do Not Use the Benefit Choice Election Form to add an adult child.** Go to [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov) and click on 'Dependent Coverage' for more information and an enrollment form, or contact your agency Group Insurance Representative.

**Benefit Choice changes will take effect July 1, 2009, for all programs, benefits/levels, co-payments and deductibles.**



# Message to Plan Members

The Benefit Choice Options Period will be held **May 1, 2009 through May 31, 2009**, for all members. Members include employees (full-time employees, part-time employees working 50% or greater, as well as employees on leave of absence), annuitants, survivors and COBRA participants. Elections will be effective July 1, 2009.

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form (located on page 29 and online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)). Members should complete the form **only if changes** are being made. Your agency/university Group Insurance Representative (GIR) will process the changes based upon the information indicated on the form. Members can access GIR names and locations by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

## Members may make the following changes during the Benefit Choice Options Period:

- Change health plans
- Add or drop dependent coverage
- Increase or decrease member Optional Life insurance coverage
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage
- Enroll an unrelated same-sex Domestic Partner, including those previously terminated for non-payment of premium (Domestic Partner Enrollment Packet available online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov))
- Elect to opt out (full-time employees, annuitants and survivors only). **The election to opt out will terminate the health, dental, vision and prescription coverage for the member and any covered dependents** (see page 24). **Note:** Members must provide proof of other comprehensive health coverage.

- Elect to waive health, dental, vision and prescription coverage (part-time employees 50% or greater, annuitants and survivors required to pay a portion of premiums)
- Elect to waive health, dental, vision and prescription coverage and become a dependent of a State-covered spouse (annuitants only)
- Re-enroll in the Program if previously opted out (full-time employees, survivors or annuitants)
- Re-enroll in the Program if previously waived (part-time employees 50% or greater, annuitants and survivors required to pay a portion of the premium)
- Re-enroll in the Program if coverage is currently terminated due to non-payment of premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums plus the July premium must be paid before coverage will be reinstated. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated for non-payment of premium.
- Elect to participate or not to participate in the dental plan
- Enroll in MCAP and/or DCAP. Employees must enroll each year; previous enrollment in the program does not continue into the new plan year.

# Member Responsibilities

You must notify the Group Insurance Representative (GIR) at your employing agency, university or retirement system 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) must be reported to your GIR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you made on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You go on a Leave of Absence or have time away from work.** When you go on a Leave of Absence and are not receiving a paycheck or are ineligible for payroll deductions, you are still responsible to pay for your Group Insurance coverage. You should immediately contact your Group Insurance Representative (GIR) 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 entering the leave. You will be billed by CMS for the cost of your current coverage. **Failure to pay the bill may result in a loss of coverage and/or the filing of an involuntary withholding order through the Office of the Comptroller.**

- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to your GIR when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.**
- **You get married or divorced**
- **You have a baby or adopt a child**
- **Your spouse's or dependent's employment status changes**

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

## Important Reminders

### **Continuity of Care After Health Plan Change:**

Members who change health plans and are then hospitalized, or have dependents that are hospitalized, 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.

**COBRA Participants:** During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage, which is not available to COBRA participants. COBRA health and dental rates for plan year 2010 (July 1, 2009 – June 30, 2010) will be available by May 1, 2009.

**Beneficiary Forms:** You should periodically review all Beneficiary forms and make the appropriate updates. Remember, you may have death benefits through various state-sponsored programs, each having a separate Beneficiary form:

- State of Illinois life insurance
- Retirement benefits
- Deferred Compensation

### **Documentation Requirements**

- Documentation is required when adding dependent coverage.
- An approved Statement of Health is required to add or increase member Optional Life coverage or to add Spouse Life or Child Life coverage.
- If opting out, proof of other major medical insurance provided by an entity other than the Department of Central Management Services is required.



# Health Plan

The State of Illinois offers its employees and annuitants health benefits through the State Employees Group Insurance Program. Prescription and vision coverage are included at no additional cost when enrolled in health coverage. With limited exceptions, the State makes monthly contributions toward your health premiums. Active employees and annuitants should refer to pages 18-19 for the monthly contribution amounts.

As an employee or annuitant of the State, you are offered a number of health insurance coverage plans:

- Health Maintenance Organization (HMOs)
- Open Access Plan (OAP)
- Quality Care Health Plan (QCHP) – a plan with both in-network and out-of-network benefits

The health insurance plans differ in the benefit levels they provide, the doctors and hospitals you can access and the cost to you. See pages 6-11 for information to help you determine which plan is right for you.

You also have the option of opting out of health coverage if you have other comprehensive health coverage. Electing to opt out includes the termination of health, dental, vision and prescription coverage. See page 24 for details. If you do not have other comprehensive health coverage, you must enroll in the State's health plan, even if your spouse is a State employee enrolled in health coverage.

If you change health plans during the Benefit Choice Period, or elect health coverage after opting out, 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. You should expect your new ID cards by the beginning of the plan year, July 1, 2009. If you need to have services provided on or after July 1, 2009, 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.

Most expenses that you or your dependent incur outside what your elected health plan covers, such as co-payments and deductibles, are reimbursable through the pre-tax Medical Care Assistance Plan (MCAP). See the Flexible Spending Accounts section on page 20 for details.

## Disease Management Programs

Disease Management Programs are utilized by CIGNA and the managed care health plans as a way to improve plan participants' health. You may be contacted by your plan to participate in these programs.

# Managed Care Plans



There are 8 managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.

## Health Maintenance Organizations (HMOs)

Members must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a co-payment applies. No annual plan deductibles apply for medical services; however, **there is an annual \$50 prescription deductible applied for each plan participant.** The minimum level of HMO coverage provided by all plans is described on page 8. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

## Open Access Plan (OAP)

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with co-payments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. Tier II and Tier III require a deductible for medical services. **Regardless of the tier used, an annual \$50 prescription deductible will be applied to each plan participant for prescription coverage.** It is important to remember that the level of benefits is determined by the healthcare provider selected. Members enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 9.

## Important Reminders About Managed Care Plans

### Primary Care Physician (PCP) Leaves the Network:

If a member's PCP leaves the managed care plan's network, the member has three options:

- Choose another PCP within that plan;
- Change managed care plans; or
- Enroll in the Quality Care Health Plan.

The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

**Provider Network Changes:** Managed care plan provider networks are subject to change. Members should always call the respective plan to verify participation of specific providers, even if the information is printed in the plan's directory.

**Dependents:** Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on this type of coverage.

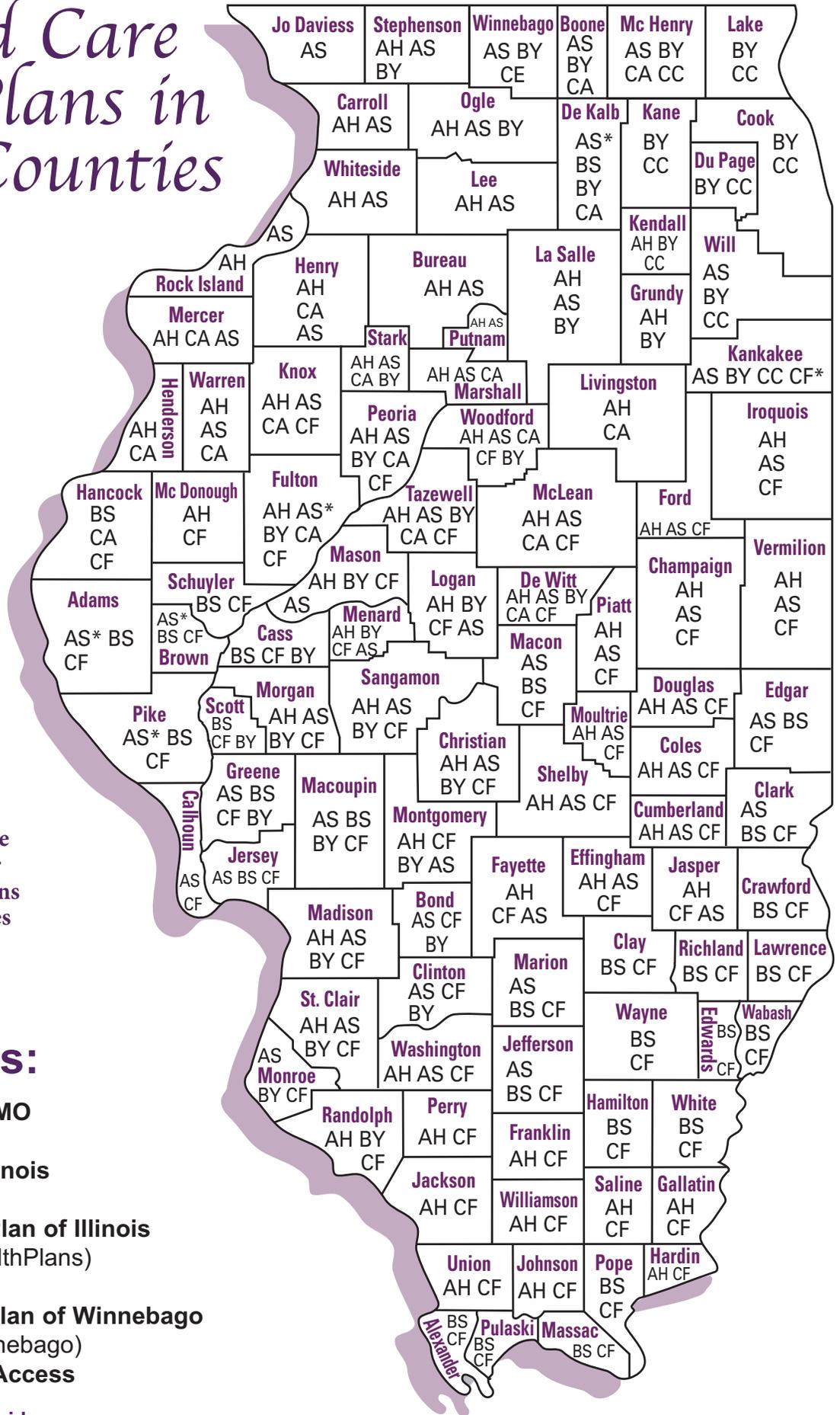
**Plan Year Limitations:** Managed care plans may impose benefit limitations based on a calendar year schedule. In certain situations, the State's plan year may not coincide with the managed care plan's year.

**Behavioral Health Services:** Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are available through the member's health plan.

# Managed Care Plans in Illinois Counties

## State Managed Care Health Plans For Plan Year 2010

\* Plan is new to this county



The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.

## HMO & OAP Carrier Codes:

- AH – Health Alliance HMO
- AS – PersonalCare
- BS – Health Alliance Illinois
- BY – HMO Illinois
- CA – Humana Benefit Plan of Illinois (formerly OSF HealthPlans)
- CC – UniCare HMO
- CE – Humana Benefit Plan of Winnebago (formerly OSF Winnebago)
- CF – HealthLink Open Access

Note: QCHP available Statewide

# 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. A \$50 prescription deductible applies to each plan participant (see page 12 for details).

## HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

## Hospital Services

Inpatient hospitalization	100% after \$275 co-payment per admission
Alcohol and substance abuse (maximum number of days determined by the plan)	100% after \$275 co-payment per admission
Psychiatric admission (maximum number of days determined by plan)	100% after \$275 co-payment per admission
Outpatient surgery	100% after \$175 co-payment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after \$200 co-payment per visit

## Professional and Other Services

Physician Office visit (including physical exams and immunizations)	100% after \$15 co-payment per visit
Specialist Office visit	100% after \$20 co-payment per visit
Well Baby Care (first year of life)	100%
Psychiatric care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Alcohol and substance abuse care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Prescription drugs (\$50 deductible applies; formulary is subject to change during plan year)	\$10 co-payment for generic \$24 co-payment for preferred brand \$48 co-payment for non-preferred brand
Durable Medical Equipment	80%
Home Health Care	\$20 co-payment per visit

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

# Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in the 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 HealthLink for a copy of the SPD. A \$50 prescription deductible applies to each plan participant (see page 12 for details).

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	Not Applicable	\$600 \$1,200	\$1,500 \$3,500
Annual Plan Deductible (must be satisfied for all services)	\$0	\$200 per enrollee*	\$300 per enrollee*

## Hospital Services

Inpatient	100% after \$275 co-payment per admission	90% of network charges after \$325 co-payment per admission	80% of U&C after \$425 co-payment per admission
Inpatient Psychiatric	100% after \$275 co-payment per admission, up to 30 days per plan year	90% of network charges after \$325 co-payment per admission up to 30 days per plan year	80% of U&C after \$425 co-payment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	100% after \$275 co-payment per admission, up to 10 days rehabilitation per plan year	90% of network charges after \$325 co-payment per admission up to 10 days rehabilitation per plan year	80% of U&C after \$425 co-payment per admission, up to 10 days rehabilitation per plan year
Emergency Room	100% after \$200 co-payment per visit	90% of network charges after \$200 co-payment per visit	80% of U&C after lesser of \$200 co-payment per visit, or 50% of U&C
Outpatient Surgery	100% after \$175 co-payment per visit	90% of network charges after \$175 co-payment	80% of U&C after \$175 co-payment
Outpatient Psychiatric and Substance Abuse	100% after \$15 co-payment, up to 30 visits per plan year	90% of network charges after \$15 co-payment, up to 30 visits per plan year	80% of U&C after \$15 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	100%	90% of network charges	80% of U&C

## Physician and Other Professional Services

Physician Office Visits	100% after \$15 co-payment	90% of network charges	80% of U&C
Specialist Office Visits	100% after \$20 co-payment	90% of network charges	80% of U&C
Preventive Services, including immunizations, allergy testing and treatment	100% after \$15 co-payment	90% of network charges	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	90% of network charges	Covered under Tier I and Tier II only

## Other Services

	Prescription Drugs – Covered through State of Illinois administered plan, Medco; \$50 deductible applies		
	Generic \$10	Preferred Brand \$24	Non-Preferred Brand \$48
Durable Medical Equipment	100%	90% of network charges	80% of U&C
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$20 co-payment	90% of network charges	Covered under Tier I and Tier II only

\* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan co-payments and deductibles do not count toward the out-of-pocket maximum.

# The Quality Care Health Plan (QCHP)

QCHP (administered by CIGNA) is the medical plan that offers a comprehensive range of benefits. Under the QCHP, plan participants can choose any physician or hospital for medical services and any pharmacy for prescription drugs. A \$75 prescription deductible applies to each plan participant on the plan (see page 12 for details). Plan participants receive enhanced benefits resulting in lower out-of-pocket amounts when receiving services from a QCHP network provider. The QCHP has a nationwide network that consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail pharmacy network) and behavioral health services (Magellan behavioral health network). Notification to Intracorp, the QCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction.

Plan participants can access plan benefit and participating QCHP network information, Explanation of Benefits (EOB) statement and other valuable health information online. To access online links to plan administrators, visit the Benefits website at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

## Plan Year Maximums and Deductibles

Plan Year Maximum	Unlimited								
Lifetime Maximum	Unlimited								
Plan Year Deductible	The plan year deductible is based upon each employee's annual salary (see chart below for current plan year information)								
Additional Deductibles*	<table border="0"> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>QCHP hospital admission</td> <td>\$50</td> </tr> <tr> <td>Non-QCHP hospital admission</td> <td>\$300</td> </tr> <tr> <td>Transplant deductible</td> <td>\$100</td> </tr> </table>	Each emergency room visit	\$400	QCHP hospital admission	\$50	Non-QCHP hospital admission	\$300	Transplant deductible	\$100
Each emergency room visit	\$400								
QCHP hospital admission	\$50								
Non-QCHP hospital admission	\$300								
Transplant deductible	\$100								
* These are in addition to the plan year deductible.									

## Plan Year Deductibles

Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Member Plan Year Deductible	Family Plan Year Deductible Cap
\$59,300 or less	\$300	\$750
\$59,301 - \$74,200	\$400	\$1,000
\$74,201 and above	\$450	\$1,125
Retiree/Annuitant/Survivor	\$300	\$750
Dependents	\$300	N/A

## Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: a general one and one for non-QCHP hospital charges. Coinsurance and deductibles apply to one or the other, but not both. After the out-of-pocket 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.

<b>General:</b> <b>\$1,200 per individual</b> <b>\$3,000 per family per plan year</b>	<b>Non-QCHP Hospital:</b> <b>\$4,400 per individual</b> <b>\$8,800 per family per plan year</b>
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### The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits, deductibles or co-payments.
- Behavioral Health benefits, coinsurance or co-payments.
- Notification penalties.
- Ineligible charges (amounts over Usual and Customary (U & C), charges for non-covered services and charges for services deemed not to be medically necessary).
- The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay.

# QCHP - Plan Benefits

## Hospital Services

QCHP Hospital Network	<ul style="list-style-type: none"> <li>• 90% after annual plan deductible.</li> <li>• \$50 deductible per hospital admission.</li> </ul>
Non-QCHP Hospitals	<ul style="list-style-type: none"> <li>• \$300 deductible per hospital admission.</li> <li>• If the member resides in Illinois or within 25 miles of a QCHP hospital and the member chooses to use a non-QCHP hospital and/or voluntarily travels in excess of 25 miles when a QCHP hospital is available within the same travel distance, the plan pays 65% after the annual plan deductible.</li> <li>• If the member resides in Illinois and has no QCHP hospital available within 25 miles and voluntarily chooses to travel further than the nearest QCHP hospital, the plan pays 65% after the annual plan deductible.</li> <li>• If the member does not reside in Illinois or within 25 miles of a QCHP hospital, the plan pays 80% after the annual plan deductible.</li> </ul>

## Outpatient Services

Lab/X-ray	90% of U&C after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible.
Licensed Ambulatory Surgical Treatment Centers	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.

## Professional and Other Services

QCHP Physician Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in the QCHP Network	70% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.

## Transplant Services

Organ and Tissue Transplants	80% of negotiated fee after \$100 transplant deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
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**Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.**

# Prescription Drug Benefit

Plan participants enrolled in any State health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred drug list (“formulary list”) maintained by each health plan's Prescription Benefit Manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount. A plan year deductible applies to each plan participant on the health plan.

## PRESCRIPTION DRUG CO-PAYS FOR A 30-DAY SUPPLY

Deductible Applies to All Plans	PRESCRIPTION PLAN	
	QCHP	All Other Plans
Generic	\$11	\$10
Preferred (Formulary) Brand	\$26	\$24
Non-Preferred Brand	\$52	\$48
Deductible	\$75	\$50

All plan participants are responsible for a prescription deductible. Plan participants enrolled in a managed care plan have a prescription deductible of \$50; plan participants enrolled in the Quality Care Health Plan have a prescription deductible of \$75. Annual prescription deductibles must be satisfied before the prescription co-payments apply. However, if the cost of the drug is less than the plan's co-payment, the plan participant will pay the cost of the drug.

### Example 1 – Generic Drug Costs Less than the Deductible

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Co-payment	Total Payment
<b>QCHP First Fill</b>	\$55	\$55	\$20	\$0	\$55
<b>QCHP Next Fill</b>	\$55	\$20	\$0	\$11	\$31
<b>Managed Care First Fill</b>	\$37	\$37	\$13	\$0	\$37
<b>Managed Care Next Fill</b>	\$37	\$13	\$0	\$10	\$23

### Example 2 – Generic Drug Costs More than the Deductible

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Co-payment	Total Payment
<b>QCHP First Fill</b>	\$100	\$75	\$0	\$11	\$86
<b>QCHP Next Fill</b>	\$100	\$0	\$0	\$11	\$11
<b>Managed Care First Fill</b>	\$100	\$50	\$0	\$10	\$60
<b>Managed Care Next Fill</b>	\$100	\$0	\$0	\$10	\$10

# Prescription Drug Benefit

Coverage for specific drugs may vary depending upon the health plan. **Each plan applies a prescription deductible to each plan participant each plan year.** It is important to note that formulary lists are subject to change any time during the plan year. 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. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. Plan participants should consult with their physician to determine if a change in prescription is appropriate.



Plan participants who have additional prescription drug coverage, including Medicare, should contact the managed care plan or Medco for Coordination of Benefits (COB) information.

## *Non-Medco Administered Prescription Drug Benefit*

**Health Alliance HMO, HMO Illinois, Humana Benefit Plan of Illinois (formerly OSF HealthPlans), PersonalCare and UniCare HMO** all use a Prescription Benefit Manager (PBM) other than Medco to administer their drug benefits. Members who elect one of these plans must utilize a pharmacy participating in the plan's pharmacy network or the full retail cost of the medication will be charged. Partial reimbursement may be provided if the plan participant files a paper claim with the health plan. It should be noted that most plans do not cover over-the-counter drugs or drugs prescribed by a medical professional, including dentists, other than the plan participant's primary care physician, even if purchased with a prescription. **Members should direct prescription benefit questions to the respective health plan administrator.**



## *Medco-Administered Prescription Drug Benefit*

**Health Alliance Illinois, HealthLink OAP, Humana Benefit Plan of Winnebago (formerly OSF Winnebago) and the Quality Care Health Plan (QCHP)** have prescription benefits administered through the PBM, Medco. For participants enrolled in HealthLink OAP or QCHP, prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or out-of-pocket maximums. In order to receive the best value, plan participants enrolled in one of the Medco-administered prescription drug plans should carefully review the various prescription networks outlined on page 14. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. If a plan participant elects a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the generic co-payment.

# Medco-Administered Prescription Drug Benefit (cont.)

## Non-Maintenance Medication

**In-Network Pharmacy** - Retail pharmacies that contract with Medco and accept the co-payment amount for medications are referred to as in-network pharmacies. Plan participants who use an in-network pharmacy must present their Medco ID card/number or they will be required to pay the full retail cost. If, for any reason, the pharmacy is not able to verify eligibility (submit claim electronically), the plan participant must submit a paper claim to Medco. The maximum supply of **non-maintenance medication** allowed at one fill is 60 days, although two co-payments will be charged for any prescription that exceeds a 30-day supply. A list of in-network pharmacies, as well as claim forms, is available by contacting Medco.

**Out-of-Network Pharmacy** - Pharmacies that do not contract with Medco are referred to as out-of-network pharmacies. In most cases, prescription drug costs will be higher when an out-of-network pharmacy is used. If a medication is purchased at an out-of-network pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges must be obtained by submitting a paper claim and the original prescription receipt to Medco. Reimbursement will be at the applicable brand or generic in-network price minus the appropriate in-network co-payment. Claim forms are available by contacting Medco.



## Maintenance Medication

**The Maintenance Medication Program (MMP)** was developed to provide an enhanced benefit to plan participants who use **maintenance medications**. Maintenance medication is medication that is taken on a regular basis for conditions such as high blood pressure and high cholesterol. To determine whether a medication is considered a maintenance medication, contact a Maintenance Network pharmacist or contact Medco. A list of pharmacies participating in the Maintenance Network is available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov). When plan participants use **either** the Maintenance Network or the Mail Order Pharmacy for maintenance medications, they will receive a 90-day supply of medication (equivalent to 3 fills) for only two co-payments.

**The Maintenance Network** is a network of retail pharmacies that contract with Medco to accept the co-payment amount for maintenance medication. Pharmacies in this network may also be an in-network retail pharmacy as described in the Non-Maintenance Medication section. If a plan participant uses an in-network pharmacy not part of the Maintenance Network, only the first two 30-day fills will be covered at the regular co-payment amount. Subsequent fills will be charged double the co-payment rate.

**The Mail Order Pharmacy** provides participants the opportunity to receive medications directly from Medco. **Both maintenance and non-maintenance medications may be obtained through the mail order process.**

To utilize the Mail Order Pharmacy, plan participants must submit an original prescription from the attending physician. The prescription should be written for a 90-day supply, and include up to three (3) 90-day refills, totaling one-year of medication. The original prescription must be attached to a completed Medco Mail Order form and sent to the address indicated on the form. Order forms and refills can be obtained by contacting Medco.

 **Medco: (800) 899-2587**  
**Website: [www.medco.com](http://www.medco.com)**



# Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the state-sponsored health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Co-payments are required.

Service	Network Provider Benefit	Out-of-Network*** Provider Benefit	Benefit Frequency
<b>Eye Exam</b>	\$10 co-payment	\$30 allowance	Once every 12 months
<b>Spectacle Lenses*</b> (single, bifocal and trifocal)	\$10 co-payment	\$40 allowance for single vision lenses  \$60 allowance for bifocal and trifocal lenses	Once every 24 months
<b>Standard Frames</b>	\$10 co-payment (up to \$130 retail frame cost; member responsible for balance over \$130)	\$50 allowance	Once every 24 months
<b>Contact Lenses**</b> (All contact lenses are in lieu of standard frames and spectacle lenses)	\$100 allowance	\$100 allowance	Once every 24 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.

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

\*\*\* 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](http://www.eyemedvisioncare.com/stil)**

# Dental Options

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected. Participants may go to any dental provider for services. During the Benefit Choice Period, members have the option to elect not to participate in the Quality Care Dental Plan (QCDP). This election will remain in effect the entire plan year, without exception. The Benefit Choice Period is also the only time members may enroll or re-enroll in the dental plan if they previously elected not to participate.



## Dental Benefit

The QCDP 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. Members are responsible for all charges over the scheduled amount and/or over the annual maximum benefit.

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 \$125 per participant per plan year.** Once the deductible has been met, the plan participant has a maximum annual dental benefit of \$2,250 for all dental services.

## Preventive and Diagnostic Services

Annual Deductible	N/A
Plan Year Maximum Benefit*	\$2,250

## All Other Covered Dental Services

Annual Deductible	\$125
Plan Year Maximum Benefit*	\$2,250

## Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. There is a maximum lifetime benefit for child orthodontia of \$1,750. This maximum represents a \$250 increase from FY09 (see 'Length of Treatment' chart below). Children **currently undergoing a course of orthodontia treatment** are eligible for the additional \$250 benefit after the \$125 plan year deductible has been met for FY10. This lifetime maximum is subject to course of treatment limitations.

## Orthodontia Services

Annual Deductible	\$125
Lifetime Maximum Benefit	\$1,750
Plan Year Maximum Benefit*	\$2,250

## Length of Orthodontia Treatment

The lifetime maximum benefit for child orthodontics is based on the length of treatment. This lifetime maximum applies to each plan participant regardless of the number of courses of treatment.

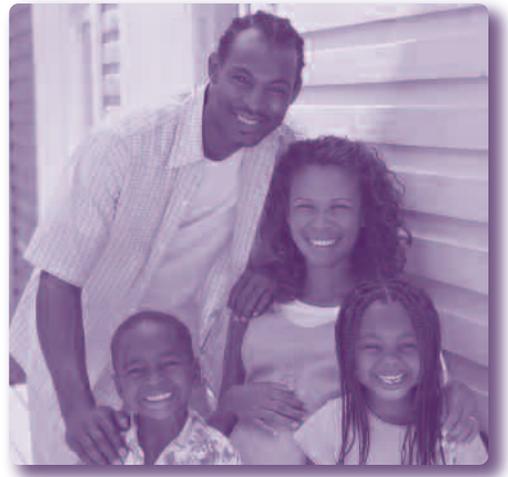
Length of Treatment	Maximum Benefit
0 - 36 Months	\$1,750
0 - 18 Months	\$1,592
0 - 12 Months	\$910

\* Orthodontics + all other covered services

**CompBenefits: (800) 999-1669**  
**TDD/TTY: (312) 829-1298**  
**Website: [www.compbenefits.com](http://www.compbenefits.com)**

# Life Insurance Plan

**Basic Life\*** insurance is provided at no cost to annuitants and active employees. This term life coverage is provided in an amount equal to the annual salary of active employees. The Basic Life amount for annuitants under age 60 is equal to the annual salary as of the last day of active State employment. For annuitants age 60 or older, the Basic Life amount is \$5,000. The life insurance plan offers eligible members the option to purchase additional life insurance to supplement the Basic Life insurance provided by the State.



## Optional Life

Optional Life\* coverage is available to all members. Annuitants under age 60 and active employees can elect coverage in an amount equal to 1-8 times their Basic Life amount; annuitants age 60 and older can elect 1-4 times their Basic Life amount. Members enrolled with Optional Life coverage should review the chart on page 18 to be aware of rate increases due to age. Rate increases due to age go into effect the first pay period following the member's birthday.

The maximum benefit allowed for Member Optional Life plus Basic Life coverage is \$3,000,000.

## Accidental Death & Dismemberment

Accidental Death and Dismemberment (AD&D)\* is available to members in either (1) an amount equal to their Basic Life amount or (2) an amount equal to their Optional Life coverage amount, up to four times their Basic Life amount.

## Spouse Life

Spouse Life\* coverage is available in a lump sum amount of \$10,000 for the spouse of active employees and annuitants under age 60. Spouse Life coverage and the corresponding premium decreases to \$5,000 for annuitants age 60 and older.

## Child Life

Child Life\* coverage is available in a lump sum amount of \$10,000 for each child. The monthly contribution for Child Life coverage applies to **all** dependent children regardless of the number of children enrolled.

## Statement of Health

Adding/increasing member Optional Life, as well as adding Spouse Life and/or Child Life coverage, is subject to prior approval by the Life Insurance Plan Administrator, Minnesota Life Insurance Company. Members must complete and submit a Statement of Health form to Minnesota Life for review. The Statement of Health form is available on page 31.

\* Survivors have different life insurance benefits. Contact your retirement system for details.

 **Minnesota Life: (888) 202-5525**  
**TDD/TTY: (800) 526-0844**  
**Website: [www.lifebenefits.com](http://www.lifebenefits.com)**

# Member and Dependent Monthly Contributions

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. The salary-based contributions indicated below will begin July 1, 2009, and remain in effect until June 30, 2010. Employees who retire, accept a voluntary salary reduction or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this **does not** apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions	
\$29,500 & below	Managed Care: \$47.00	Quality Care: \$72.00
\$29,501 - \$44,600	Managed Care: \$52.00	Quality Care: \$77.00
\$44,601 - \$59,300	Managed Care: \$54.50	Quality Care: \$79.50
\$59,301 - \$74,200	Managed Care: \$57.00	Quality Care: \$82.00
\$74,201 & above	Managed Care: \$59.50	Quality Care: \$84.50

**Note:** Employees who reside in Illinois but do not have access to a managed care plan may be eligible for a lower health plan contribution. Contact the CMS Group Insurance Division, Analysis and Resolution Unit at (800) 442-1300 or (217) 558-4671, for assistance.

## Retiree, Annuitant and Survivor Monthly Health Plan Contribution

20 years or more of creditable service	\$0.00
Less than 20 years of creditable service and, <ul style="list-style-type: none"> <li>• SERS/SURS annuitant/survivor on or after 1/1/98,</li> <li>or</li> <li>• TRS annuitant/survivor on or after 7/1/99</li> </ul>	Required to pay a percentage of the cost of the basic coverage.

Call the appropriate retirement system for applicable premiums.

**SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896**

## Monthly Optional Term Life Plan Contributions

Member by Age	Monthly Rate Per \$1,000
Under 30	\$0.06
Ages 30 - 34	0.08
Ages 35 - 44	0.10
Ages 45 - 49	0.16
Ages 50 - 54	0.24
Ages 55 - 59	0.48
Ages 60 - 64	0.72
Ages 65 - 69	1.38
Ages 70 - 74	2.52
Ages 75 - 79	3.52
Ages 80 - 84	4.20
Ages 85 - 89	5.20
Ages 90 and above	6.50

## AD&D Monthly Rate Per \$1,000

Accidental Death & Dismemberment	0.02
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## Spouse Life Monthly Rate

Spouse Life \$10,000 coverage (Employees and Annuitants under age 60)	6.94
Spouse Life \$5,000 coverage (Annuitants age 60 and older)	3.47

## Child Life Monthly Rate

Child Life \$10,000 coverage	0.52
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# Member and Dependent Monthly Contributions

The monthly dependent contribution is **in addition** to the member health plan contribution. Dependents will be enrolled in the same plan as the member. **The Medicare dependent contribution applies only if Medicare is PRIMARY for both Parts A and B.** Members with questions regarding Medicare status may contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

## Dependent Monthly Health Plan Contributions

Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
Unicare HMO (Code: CC)	\$ 82	\$113	\$ 77	\$113
HMO Illinois (Code: BY)	\$ 83	\$116	\$ 79	\$116
PersonalCare (Code: AS)	\$ 92	\$130	\$ 88	\$130
Humana Benefit Plan of Illinois (formerly OSF HealthPlans) (Code: CA)	\$ 92	\$130	\$ 89	\$130
Health Alliance HMO (Code: AH)	\$ 94	\$133	\$ 89	\$133
Health Alliance Illinois (Code: BS)	\$103	\$145	\$100	\$145
HealthLink OAP (Code: CF)	\$105	\$149	\$102	\$149
Humana Benefit Plan of Winnebago (formerly OSF Winnebago) (Code: CE)	\$107	\$152	\$104	\$152
Quality Care Health Plan (Code: D3)	\$196	\$226	\$142	\$203

### Employee Monthly Quality Care Dental Plan (QCDP) Contributions

Employee Only	\$11.00
Employee plus 1 Dependent	\$17.00
Employee plus 2 or more Dependents	\$19.50

### Contribution Calculation Worksheet

**Member Monthly Health Contribution:** \$ \_\_\_\_\_  
(see chart on page 18)

**Dependent Monthly Health Contribution:** \$ \_\_\_\_\_  
(if insuring dependents, see chart above)

**Monthly Dental Contribution:** \$ \_\_\_\_\_  
(see chart to left)

**Monthly Optional Term Life Contribution:** \$ \_\_\_\_\_  
(see chart on page 18)

**My Total Monthly Contribution:** \$ \_\_\_\_\_

**Note:** An interactive Premium Calculation Worksheet is available for full-time employees online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).



# The Flexible Spending Accounts (FSA) Program

## Employee Benefit Only - Does NOT Apply to Annuitants

During the Benefit Choice Period, employees may enroll in a Flexible Spending Accounts (FSA) Program with an effective date of July 1, 2009. The great advantage is that you pay **no federal taxes** on your contributions. For example, if you put in \$1,000 and are in a 20% federal tax bracket, you save \$200 ( $\$1,000 \times 20\% = \$200$ ).

Elections do not automatically carry over each year. You must complete a new enrollment form each year to participate, even if you participated in the 2009 plan year. The minimum monthly amount for which an employee may enroll is \$20; the maximum monthly amount is \$416.66 (\$555.54 for university employees paid over 9 months). The first deduction for an FSA enrollment will be taken on a pre-tax basis from the first paycheck issued in July. Employees should carefully review their paycheck to verify the deduction was taken correctly. If you do not see the deduction on your paycheck stub, please contact your payroll office immediately.

## Medical Care Assistance Plan (MCAP)

**What is it?** The Medical Care Assistance Plan (MCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay for **health-related expenses not covered by insurance**. If you, or someone in your family (i.e., spouse and/or eligible dependents), goes to the doctor or dentist, takes medication or wears glasses, whether you have insurance or not, MCAP may save you money.

**How much should I contribute?** Contributions depend on household needs—think about how many co-pays you will have for physician visits or prescriptions. Will you pay a deductible? Perhaps you expect a large dental, orthodontic (e.g., braces) or vision expense (e.g., LASIK surgery).

### Examples of expenses you cannot claim

- Cosmetic services, vitamins, supplements
- Insurance premiums
- Vision warranties and service contracts

**You have until September 30, 2010, to submit claims for expenses that were incurred from July 1, 2009, through September 15, 2010; otherwise any money left in your account will be forfeited.**

**How does the MyFBMC Visa® work?** Employees who enroll in MCAP may elect the MyFBMC Visa® to pay for their plan year medical expenses. Simply check the 'MyFBMC Visa®' box on the MCAP Enrollment form. There is a \$20 non-refundable fee for the card. Documentation will be required to substantiate certain expenses paid with the card; therefore, you should review your monthly statement from the plan administrator, FBMC, carefully to ensure you are aware of the documentation requirements.

**Note:** MyFBMC Visa® Card will be replacing the EZ REIMBURSE® MasterCard®.



# The Flexible Spending Accounts (FSA) Program

## Dependent Care Assistance Plan (DCAP)

**This is not a plan to cover your dependent's health-related expenses. This is a plan to pay primarily for child care expenses of dependent children 12 years and under.\***

**What is it?** The Dependent Care Assistance Plan (DCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay primarily for **child care expenses\* of dependent children 12 years and under**. If you (and your spouse, if married), work full time and pay for day care, day camp or after-school programs, then DCAP may save you money.

Please note that if you claim the dependent care tax credit, it will be reduced, dollar for dollar, by the amount you contribute to DCAP. Also, depending on your household income, it might be advantageous to claim child care expenses on your federal income tax return. You cannot claim the expenses on your tax return and use DCAP. Please ask your tax adviser which plan is best for you.

\* In addition to child care, the Dependent Care Assistance Plan can be used to pay for the dependent care expenses for any individual living with you that is physically or mentally unable to care for themselves and is eligible to be claimed as a dependent on your taxes.

**How much should I contribute?** Contributions depend on household needs—think about how much you spend on child care every year. Will you use day care or a private nanny? Perhaps your child is going to nursery school or day camp this year.

### Examples of expenses you cannot claim

- Overnight camp
- Day care provided by another dependent
- Day care provided “off the books”
- Kindergarten tuition
- Private primary school tuition

**You have until September 30, 2010, to submit claims for services incurred from July 1, 2009, through June 30, 2010; otherwise any money left in your account will be forfeited.**



**FBMC: (800) 342-8017  
TDD/TTY: (800) 955-8771  
Website: [www.myFBMC.com](http://www.myFBMC.com)**



# Commuter Savings Program (CSP)

**Employee Benefit Only - Does NOT Apply to Annuitants**

The Commuter Savings Program (CSP) is a qualified transportation benefit that allows **employees** to pay for eligible transit and/or parking expenses through payroll deductions. These deductions will be taken before any Federal, State, FICA or Medicare taxes, resulting in more money in your pocket! The pre-tax limit for calendar year 2009 for both the transit and parking benefit is \$230.00 per month. **The CSP program is currently only available to employees who are paid through the Comptroller's Office.**

## Transit Benefit

**What is it?** The CSP transit benefit allows you to pay for your mass transit costs associated with your commute to and from work with pre-tax dollars. To enroll, just go online to [www.myFBMC.com](http://www.myFBMC.com) and register. After you register, click on My CSP and follow the prompts.

**How does it work?** Once you are enrolled, you will receive your benefit from the vendor prior to the benefit month. Your agency will then take payroll deductions beginning with the first pay period of the benefit month. The deadline to enroll is the 10th of

the month prior to the benefit month.

**Example:** Tom rides the METRA from Glen Ellyn to Ogilvie Center each day. A monthly transit pass for this commute is \$116.10. Tom enrolled prior to July 10th. The vendor sent Tom's August transit pass to his home on July 23rd for him to use on August 1st. Since Tom is paid semi-monthly, his agency will take the first payroll deduction of \$58.05 from the August 1-15 pay period.

## Parking Benefit

**What is it?** The CSP parking benefit allows you to pay for the parking costs associated with your work with pre-tax dollars. You can choose to have the payment for your parking expenses sent directly to your parking provider, or you can choose to be reimbursed for your parking expenses.

**How does paying the garage/lot directly work?** If you choose to have your parking lot or garage paid directly, the vendor will mail the payment to your parking provider prior to the benefit month. Your agency will then take payroll deductions beginning the first pay period of the benefit month. The deadline to enroll is the 10th of the month prior to the benefit month.

**Example:** Trisha parks at Joe's Parking Garage. The monthly fee to park is \$200. Trisha decides to save some money pre-tax and enrolls in the parking benefit prior to July 10th cut-off date. The vendor sends

Trisha's August parking fees to Joe's Garage at the end of July. Since Trisha is paid on a semi-monthly basis, her agency will take the first payroll deduction of \$100.00 from the August 1-15 pay period.

### How does the reimbursement option work?

Employees who park in a different lot each day or who plug a meter on a street may want to be reimbursed for their parking expenses. No receipts are required. Simply log on to [www.myFBMC.com](http://www.myFBMC.com) and click on My CSP – Reimburse Me and follow the prompts. Your reimbursement check will be sent directly to your house, or you may sign up for direct deposit.

**FBMC: (800) 342-8017**  
**TDD/TTY: (800) 955-8771**  
**Website: [www.myFBMC.com](http://www.myFBMC.com)**

# Optional Programs

## Employee Assistance Program

**Employee Benefit Only** – Does not apply to Annuitants

There are two separate programs that provide valuable resources for support and information during difficult times for active employees and their dependents: the Employee Assistance Program (EAP) and the Personal Support Program (PSP).

**The Employee Assistance Program (EAP)** is for active employees NOT represented by the collective bargaining agreement between the State and AFSCME Council 31. These employees must contact the EAP administered by Magellan Behavioral Health.

**The Personal Support Program (PSP)** is for bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME. These employees must access EAP services through the AFSCME Personal Support Program.

Both programs are free, voluntary and provide problem identification, counseling and referral services to employees and their covered dependents regardless of the health plan chosen. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed unless written permission is received from the employee. Management consultation is available when an employee's personal problems are causing a decline in work performance. See the inside back cover for website and other contact information.

## Adoption Benefit Program

**Employee Benefit Only** – Does not apply to Annuitants

State employees working full time or part time (50% or greater) may request reimbursement of eligible adoption expenses. The adoption must be final before reimbursement may be requested. The request for reimbursement must be received within one year from the end of the plan year the adoption became final.

**For more information see the Benefits Handbook.**

## Smoking Cessation Program

**Benefit applies to all Members**

Members and dependents are eligible to receive a rebate up to \$200 for completing an approved smoking cessation program, limited to one rebate per participant, per plan year. One-time procedures are not considered an approved program.

**For more information see the Benefits Handbook.**

## Long-Term Care (LTC)

**Benefit applies to all Members**

Members may choose an optional group long-term care insurance plan through Metropolitan Life Insurance Company (MetLife). Premiums for this plan are paid entirely by the insured directly to MetLife.

**Call MetLife toll-free at 800-GET-MET8 (800-438-6388) for an enrollment kit.**

## Hospital Bill Audit Program

**Program applies to only QCHP Members**

The Hospital Bill Audit Program applies to hospital charges. Under the Program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill, is eligible for 50% of the resulting savings. There is no cap on the savings amount. **Note:** Related non-hospital charges, such as radiologists and surgeons, are not eligible charges under the program. The program only applies when QCHP is the primary payer.

**For more information see the Benefits Handbook.**

# Opting Out of Health, Dental, Vision and Prescription Coverage

**In accordance with Public Act 92-0600**, full-time employees, retirees, annuitants and survivors may elect to Opt Out of the State Employees Health Insurance Program if proof is provided of other major medical insurance by an entity other than the Department of Central Management Services. **This election will terminate health, dental, vision and prescription coverage for the member and any dependents.**

Members who wish to Opt Out must complete Section B on the Benefit Choice Election form and attach proof of other insurance coverage (such as a copy of an insurance card from another health plan that names you as being insured). The form must be submitted to the Group Insurance Representative no later than May 31, 2009.

Members opting out of the Program continue to be enrolled with Basic Life insurance coverage only and may elect optional life coverage.

If you opt out of the Program you will **not be eligible** for the:

- Free influenza immunizations offered annually by the Department of Healthcare and Family Services
- COBRA continuation of coverage
- Smoking Cessation Program

However, if you are an employee, you will **be eligible** for the:

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

## Opt Out With Financial Incentive

### SERS Annuitants Only

**In accordance with Public Act 94-0109**, non-Medicare members receiving a retirement annuity from the State Employees' Retirement System (SERS) who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the Health Insurance Program and receive a financial incentive of \$150 per month. Opting out includes health, vision, dental and prescription coverage. **Marking 'Opt Out' on the Benefit Choice Election Form does not entitle you to receive the financial incentive.**

Contact the Insurance Section of the SERS at (217) 785-7150 for more information and to obtain a copy of the SERS Opt Out with Financial Incentive Form.

## Re-enrolling in the Health Plan

**Individuals who opt out under either Public Act may re-enroll** in the Program only during Benefit Choice, or within 60 days of experiencing an eligible qualifying change in status. Members who re-enroll, and their dependents, are subject to possible health benefit limitations for pre-existing conditions. A Certificate of Creditable Coverage from the previous insurance carrier must be provided to reduce the pre-existing conditions waiting period.

# Notice of Creditable Coverage

## Prescription Drug Information for State of Illinois Medicare Eligible Plan Participants

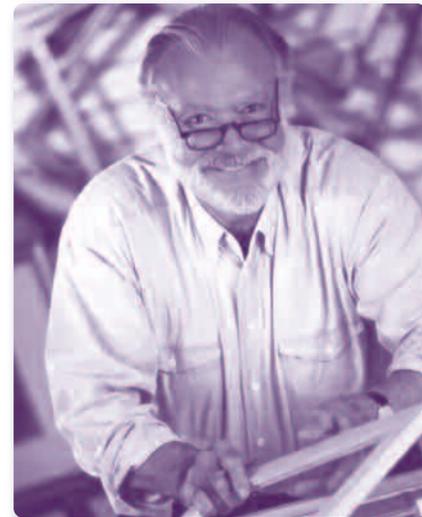
This notice confirms that your existing prescription drug coverage through the State Employees Group Insurance Program is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). **You can keep your existing group prescription coverage and choose not to 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 entire group coverage through the State Employees Group Insurance Program 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 State Employees Group Insurance 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.

**REMEMBER: KEEP THIS NOTICE**

# Plan Participants Eligible for Medicare



Medicare is a federal insurance program separated into three main parts:

- Medicare Part A (inpatient hospital services)
- Medicare Part B (outpatient and medical services)
- Medicare Part D (prescription services)

**Medicare Part A** is a premium-free program for participants with enough earned work quarters as determined by the Social Security Administration (SSA).

**Medicare Part B** is not free and requires a monthly premium contribution.

**Medicare Part D** is not required for plan participants in the State Employees Group Insurance Program.

**In order to ensure your medical claims are paid both accurately and optimally...**

Read all of the Medicare information sent to you. If you have questions or need clarification regarding the information presented, call the Medicare Coordination of Benefits (COB) Unit within the Department of Central Management Services at (217) 782-7007.

Each participant who becomes eligible for Medicare is **required** to submit a copy of his or her Medicare card to his or her Group Insurance Representative (GIR).

## Are You Eligible for Premium-Free Medicare Part A?

**If you are actively working for the State and are eligible for Medicare (due to a disability or being age 65 or older), then...**

Medicare Part A is required. Since you are still working you may delay purchasing Medicare Part B until the date you lose your Current Employment Status (CES). The State will remain your primary insurance coverage until you lose your CES. Once you lose CES, Medicare Part B must be in effect.

**If you do not have CES and are eligible for Medicare (due to a disability or being age 65 or older), then...**

You are required to have Medicare Parts A and B and Medicare will be the primary insurance. The State will be the secondary insurance. Failure to enroll in and maintain enrollment in Medicare Part B will result in a reduction of benefits under the State's group insurance plan and you will be responsible for significant out-of-pocket expenditures for medical claims.

**If you are age 65 or older and ineligible for premium-free Medicare Part A, then...**

You are required by the State to provide proof of your Medicare ineligibility. Medicare-ineligible plan participants should contact their local Social Security Administration and request written verification of their ineligibility for premium-free Medicare Part A benefits based on his/her own work record. The verification letter must be forwarded to the Medicare COB Unit at the Department of Central Management Services.

Medicare-ineligible plan participants who have a Medicare-eligible spouse must complete an SSA application for Medicare benefits based on the eligible spouse's work record. If the plan participant is eligible for Medicare based on the spouse's work record, they must accept the coverage.

Although benefits for Medicare Part B coverage will not be reduced for those that are ineligible for premium-free Part A, plan participants are encouraged to enroll in Medicare Part B to reduce possible out-of-pocket expenses.

**NOTE:** Plan participants that are eligible for Medicare benefits based on End Stage Renal Disease (ESRD) must contact the Medicare COB Unit at the Department of Central Management Services for information regarding the Medicare requirements and to ensure the proper calculation of the Coordination of Benefit Period.

## NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the Quality Care Health Plan (QCHP) and the Quality Care Dental Plan (QCDP)

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau), and the Department of Healthcare and Family Services are charged with the administration of the self-funded plans available through the State Employees Group Insurance Act. These plans include the Quality Care Health Plan and the Quality Care Dental Plan. The term “we” in this Notice means the Bureau, the Department of Healthcare and Family Services and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

The Department of Healthcare and Family Services contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on our behalf in performing their respective functions. When we seek help from individuals or entities in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Medco Health Solutions is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a notice from the HMO regarding its privacy practices.

#### **How We May Use or Disclose Your PHI:**

**Treatment:** We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party. We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

**Payment:** We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.

**Health Care Operations:** We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.

**Appointment Reminders:** Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

#### **Legal Requirements:**

We may use and disclose PHI **as required or authorized by law**. For example, we may use or disclose your PHI for the following reasons.

**Public Health:** We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

**Health Oversight Activities:** We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.

**Judicial and Administrative Proceedings:** We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.

**Law Enforcement:** We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

**Avert a Serious Threat to Health or Safety:** We may use or disclose PHI to stop you or someone else from getting hurt.

**Work-Related Injuries:** We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

**Coroners, Medical Examiners, and Funeral Directors:** We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

**Organ Procurement:** We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.

**Release of Information to Family Members:** In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

**Armed Forces:** We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

**National Security and Intelligence:** We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.

**Correctional Institutions and Custodial Situations:** We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.

**Research:** You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.

**Fundraising and Marketing:** We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

**Plan Sponsors:** Your employer is not permitted to use PHI for any purpose other than the administration of your benefit plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer’s behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate.

**Illinois Law:** Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

**Your Rights:**

You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing to the appropriate plan administrator. These plan administrators are as follows:

<p><b>For the Medical Plan Administrator and Notification/Medical Case Management:</b>          CIGNA HealthCare, Privacy Office          P.O. Box 5400          Scranton, PA 18503          800-762-9940</p>	<p><b>For Pharmacy Benefits:</b>          Medco Health Solutions, Privacy Services Unit          P.O. Box 800          Franklin Lakes, NJ 07417          800-987-5237</p>
<p><b>For Behavioral Health Benefits:</b>          Magellan Behavioral Health, Privacy Officer          1301 E. Collins Blvd.          Suite 100          Richardson, TX 75081          800-513-2611</p>	<p><b>For Dental Plan Benefits:</b>          CompBenefits, Privacy Officer          100 Mansell Court East,          Suite 400          Roswell, GA 30076          800-342-5209</p>

**Restrictions:** You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

**Communications:** You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are “in danger” and we will accommodate your request.

**Inspect and Access:** You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

**Amendment of your Records:** If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to amend. We will send you a letter stating how we handled your request.

**Accounting of Disclosures:** You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one Accounting in a 12-month period.

**Copy of Notice and Changes to the Notice:** 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. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within sixty (60) days of the material change. You can also access a revised Notice on our website at “<http://www.benefitschoice.il.gov/>”

**Complaints:** If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective plan administrator. If the Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C. if you feel your privacy rights have been violated. **EFFECTIVE DATE: July 1, 2009**

# BENEFIT CHOICE ELECTION FORM

Enrollment Period: May 1 – May 31, 2009  
 Complete This Form Only If Changing Your Benefits

## SECTION A: MEMBER INFORMATION (required)

SSN: \_\_\_\_\_

Last Name	First Name	Phone Numbers	
		Home:	Work:

## SECTION B: OPT OUT / OPT IN (this election applies to your and your dependents' health, dental, vision and prescription coverage)

### OPT OUT/OPT IN –

Opt Out     Opt In    See instructions on the back for requirements

## SECTION C: HEALTH PLAN ELECTIONS (this election applies to your and your dependents' health coverage)

Health Plan Election *	If you selected Managed Care Plan, you must complete the information below. To find the provider identifier, go to the health plan's website. See the instructions on back for more information.
<b>Elect One:</b> Quality Care Health Plan (QCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	Provider Identifier _____ (6 or 10 characters) Carrier Code _____ (2 characters – see page 7) Plan Name _____

\* If you have another health insurance plan, including Medicare, you must give a copy of your and/or your dependent's other insurance card to your GIR. The copy must include the front and back of the card.

## SECTION D: DENTAL PLAN OPTION (this election applies to your and your dependents' dental coverage)

**Dental Plan Option** – If you elect not to participate in the Dental plan, your Dental coverage (and any dependent dental coverage) will be terminated (health, vision and prescription coverage will remain active)

I choose not to participate in the dental plan     I choose to enroll/re-enroll in the dental plan

## SECTION E: OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING your life coverage elections)

OPTIONAL LIFE <sup>1</sup>	BASIC LIFE ONLY (free – equal to salary)	AD&D (Accidental Death & Dismemberment)	
	<input type="checkbox"/> BASIC + OPTIONAL (select increment below)	<input type="checkbox"/> NO AD&D	<input type="checkbox"/> BASIC AD&D only (Equal to Salary)
<input type="checkbox"/> 1 x Salary <input type="checkbox"/> 3 x Salary <input type="checkbox"/> 5 x Salary <input type="checkbox"/> 7 x Salary <input type="checkbox"/> 2 x Salary <input type="checkbox"/> 4 x Salary <input type="checkbox"/> 6 x Salary <input type="checkbox"/> 8 x Salary		<input type="checkbox"/> AD&D COMBINED* (Basic Life + Optional Life) * AD&D COMBINED maximum is Basic + 4 times the Optional amount	

## SECTION F: DEPENDENT INFORMATION <sup>2</sup> (dependents will be enrolled with the same health and dental coverage that you have)

NOTE: If you wish to add an adult child due to Public Act 95-0958, DO NOT ENTER YOUR DEPENDENT'S INFORMATION IN THIS SECTION. Instead, you must complete a Special Enrollment Period – Eligibility Certification Statement, available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

HEALTH			LIFE <sup>1</sup>		Name	SSN	Birth Date	Relationship <sup>3</sup>	Sex (M/F)	Provider Identifier
A (Add) / D (Drop) / Change (C)			A	D						
A	D	C	A	D						

**Note:** <sup>1</sup> Statement of Health form required when adding or increasing Optional Life or adding Spouse or Child Life.

Mail completed form to: **Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701.**

<sup>2</sup> Documentation required to add dependents – see specific documentation requirements on the back.

<sup>3</sup> Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize premiums as established annually to be deducted from my pay for those plans I have selected. I understand that if my paycheck is insufficient or if I am not on payroll, I will be direct billed. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate and that if my deductions are not correct I must immediately contact my GIR. Falsification of the information contained on this form may result in discipline up to and including discharge.

MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GIR/GIP SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Give completed form to your GIR in your Benefits Office by May 31, 2009**

# BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are not changing you current coverage elections **DO NOT** complete this Benefit Choice Election Form*

## SECTION A – MEMBER INFORMATION (Complete all fields)

### SECTION B – OPT OUT OF/OPT INTO Health, Dental, Vision and Prescription Coverage

*Opting out will discontinue all health, dental, vision and prescription coverage; Opting in will establish health, dental, vision and prescription coverage. Whether you opt out or opt in, life coverage will not change.*

If you wish to OPT OUT of or OPT IN to the State Employees' Group Insurance Program you must mark the appropriate box in Section B and submit a completed Opt Out/Opt In Election Certificate (available on [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)). Elections to opt out also require proof of other health coverage (other coverage cannot be provided by Central Management Services). Submit the completed forms and documentation to your agency/university Group Insurance Representative (GIR).

### SECTION C – HEALTH PLAN ELECTIONS

*Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan directly in order to make this change.*

If you wish to change your **health** plan you must check either the Quality Care Health Plan (QCHP) or the Managed Care Plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see map on page 7 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on the plan's website (see inside front cover of this booklet for website addresses).

### SECTION D – DENTAL PLAN OPTION

*This election applies to both the member's and their dependent's dental coverage.*

- If you **wish not to participate** in the dental plan, check the 'I choose not to participate in the dental plan' box. Proof of other dental coverage is not required. This election will remain in effect until you re-enroll. Re-enrollment is **only** allowed during a future Benefit Choice election period.
- If you **wish to enroll/re-enroll** in the dental plan, check the 'I choose to enroll/re-enroll in the dental plan' box. Benefit Choice is the only time you can enroll/re-enroll in the dental plan.

### SECTION E – OPTIONAL LIFE INSURANCE <sup>1</sup>

*Complete this section to add/drop/increase or decrease Optional Life or AD&D coverage. See Section F for Spouse and Child Life.*

**Note:** Optional Life coverage is subject to \$3,000,000 maximum (Basic Life + Optional Life).

### SECTION F – DEPENDENT INFORMATION <sup>1</sup>

*Complete this section if you are adding or dropping (1) dependent health/dental/vision coverage or (2) Spouse/Child Life coverage. If you are adding dependent coverage, you must provide the appropriate documentation as indicated below.*

**NOTE:** If you wish to add an adult child due to Public Act 95-0958 **DO NOT ENTER YOUR DEPENDENT'S INFORMATION IN THIS SECTION. Instead, you must complete a Special Enrollment Period – Eligibility Certification Statement, available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).**

Spouse	Marriage certificate.
Natural Child through Age 18	Birth certificate.
Stepchild	Birth certificate indicating your spouse is the child's parent, marriage certificate and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138) <sup>2</sup> , and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138) <sup>2</sup> , and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19 (age 23 if enrolled as a full-time student), 2) a diagnosis from a physician with an ICD-9 diagnosis code <u>and</u> 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
<sup>1</sup> Adding and/or increasing Optional Life, Spouse Life or Child Life requires a signed Statement of Health application. <i>Mail the completed application to: Minnesota Life, 1 North Old Capitol Plaza, Suite 305, and Springfield, IL 62701.</i>	
<sup>2</sup> The Dependent Coverage Certification Statement (CMS-138) is available through your agency Group Insurance Representative (GIR) or online at <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> .	

**SIGNATURE:** In order for your elections to be effective July 1, 2009, you must sign and date the Benefit Choice Election Form and submit it to your agency GIR by **May 31, 2009**. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**

**State of Illinois Policy Number 32491-G  
Group Life Insurance Statement of Health**

**MINNESOTA LIFE**

Mail to: Minnesota Life Insurance Company - A Securian Company  
Springfield Branch Office • 1 North Old Capitol Plaza, Suite, 305 • Springfield, Illinois 62701

**EMPLOYEE INFORMATION**

First name	Middle initial	Last name	Date of birth	Social Security number
Street address			City	State   Zip code
Date employed	Member status (check all that apply) <input type="checkbox"/> Actively working <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Annuitant <input type="checkbox"/> Immediate <input type="checkbox"/> Deferred <input type="checkbox"/> Survivor			
Height	Weight	Occupation	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

**TOTAL INSURANCE DESIRED - Check the boxes which indicate your total coverage level desired.**

<b>Optional Life (member-paid)*</b> <input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary <input type="checkbox"/> 3x salary <input type="checkbox"/> 4x salary <input type="checkbox"/> 5x salary <input type="checkbox"/> 6x salary <input type="checkbox"/> 7x salary <input type="checkbox"/> 8x salary <small>* Annuitants age 60 and over are not eligible for 5-8x salary.</small>	<b>Dependent Life (member-paid)</b> <input type="checkbox"/> Spouse life coverage equal to \$10,000* <small>* Spouses of annuitants age 60 and over receive \$5,000 coverage.</small>	<input type="checkbox"/> Child life coverage equal to \$10,000 <input type="checkbox"/> Adding another child
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**SPOUSE INFORMATION - Complete only if applying for spouse coverage.**

**SPOUSE**

First name	Middle initial	Last name	Social Security number
Date of birth	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

**DEPENDENT CHILD(REN) INFORMATION - Complete only if applying for dependent coverage.**

Child's Name	Sex	Birth Date	Social Security Number	If Age 19+ / Full Time Student
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No

**HEALTH QUESTIONS - Complete only if changing coverage.**

EMPLOYEE	SPOUSE	CHILD(REN)	
YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	3. Have you ever been treated or diagnosed by a physician as having AIDS, or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment on the reverse side of this form.

**NOTE: EMPLOYEE/APPLICANT MUST SIGN AND DATE THE REVERSE SIDE OF THIS FORM**

**FOR HOME OFFICE USE ONLY:**

Employee <input type="checkbox"/> New hire <input type="checkbox"/> Benefit choice enrollment <input type="checkbox"/> Change of status			
Optional in force <input type="checkbox"/> NONE <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x <input type="checkbox"/> 7x <input type="checkbox"/> 8x	Annual base salary \$	Agency name	Date
Spouse coverage in force <input type="checkbox"/> Yes <input type="checkbox"/> No	Child coverage in force <input type="checkbox"/> Yes <input type="checkbox"/> No	GIR name	Organizational processing code
<b>Employee</b>	<b>Spouse</b>	<b>Child</b>	
<input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	<input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	<input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	
By	Date	By	Date

**CONSUMER PRIVACY NOTICE**

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

**For further information about your file or your rights, you may contact:**

Group Division Underwriting  
 Minnesota Life Insurance Company  
 400 Robert Street North  
 St. Paul, Minnesota 55101-2098  
 Telephone: (800) 872-2214

**For information about the MIB, you may contact:**

MIB  
 50 Braintree Hill, Suite 400  
 Braintree, MA 02184-8734  
 MIB Telephone: (866) 692-6901  
 MIB TTY: (866) 346-3642  
 Website: www.mib.com

**ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR APPLICANT, SPOUSE OR CHILD.**

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT
Employee				
Spouse				
Child(ren)				

The answers provided on this application are representations of each person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months unless withdrawn by me in writing. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice above, and I understand that I can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

Employee signature <b>X</b>	Daytime telephone number ( )	Evening telephone number ( )	Date signed
Spouse signature <b>X</b>	Daytime telephone number ( )	Evening telephone number ( )	Date signed

# Plan Administrators

## Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
<b>Quality Care Health Plan (QCHP) Medical Plan Administrator</b>	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	<b>CIGNA</b> Group Number 3181456 <b>CIGNA HealthCare</b> P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>QCHP Notification and Medical Case Management Administrator</b>	Notification prior to hospital services  Non-compliance penalty of \$800 applies	<b>Intracorp, Inc.</b>	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>Prescription Drug Plan Administrator</b> QCHP (1400SD3) Health Alliance Illinois (1400SBS) Humana Benefit Plan of Winnebago (formerly OSF Winnebago) (1400SCE) HealthLink OAP (1400SCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	<b>Medco</b> Group Number: 1400SD3, 1400SBS, 1400SCE, 1400SCF <b>Paper Claims:</b> Medco Health Solutions P.O. Box 14711 Lexington, KY 40512  <b>Mail Order Prescriptions:</b> Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide)  (800) 759-1089 (TDD/TTY)  <a href="http://www.medco.com">www.medco.com</a>
<b>QCHP Behavioral Health Administrator</b>	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	<b>Magellan Behavioral Health</b> Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>
<b>Employee Assistance Program (EAP)</b>	Confidential assistance and assessment services	<b>Magellan Behavioral Health</b> -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>
<b>Personal Support Program (PSP – AFSCME EAP)</b>	Confidential assessment and assistance services	<b>AFSCME Council 31</b> -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) <a href="http://www.afscme31.org">www.afscme31.org</a>

### 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 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**

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