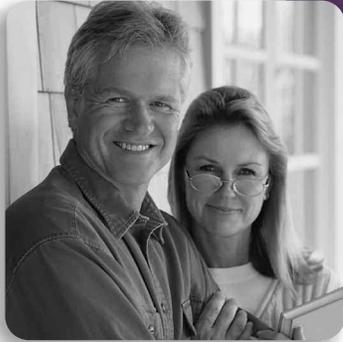




State of Illinois
Department of Central Management Services
Bureau of Benefits



Benefit Choice Options Period

Enrollment Period May 1 - May 31, 2010



State of Illinois

Effective July 1, 2010 - June 30, 2011

Plan Administrators

Who to call for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
Humana Health Plan	(866) 427-7478	(800) 833-3301	http://stateofil.humana.com
Humana-Winnebago	(866) 427-7478	(800) 833-3301	http://stateofil.humana.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	EyeMed 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
Quality Care Dental Plan (QCDP) Administrator	CompBenefits Group Number 950 P.O. Box 14285 Lexington, KY 40512-4285	(800) 999-1669 (312) 829-1298 (TDD/TTY)	www.compbenefits.com
Life Insurance Plan	Minnesota Life Insurance Company 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
Long-Term Care (LTC) Insurance	MetLife	(800) 438-6388 (800) 638-1004 (TDD/TTY)	
Flexible Spending Accounts (FSA) Program	Fringe Benefits Management Company 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
Commuter Savings Program (CSP)			
Health/Dental Plans, Medicare COB Unit, FSA and CSP Unit, Premium Collection Unit, Life Insurance, Adoption Benefit and Smoking Cessation Benefit	CMS Group Insurance Division 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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Message to Plan Members



The Benefit Choice Options Period will be held **May 1, 2010 through May 31, 2010**, for all members. Members include employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), annuitants, survivors and COBRA participants. **Elections will be effective July 1, 2010.**

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form. 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 may obtain 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.

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

- Change health plans.
- Add or drop dental coverage.
- Add or drop dependent coverage, including sponsored adult children and veteran adult children.
- 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).

- 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 26). **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).
- Re-enroll in the Program if previously opted out (full-time employees, survivors or annuitants). Members have the option of not electing dental coverage upon re-enrollment.
- 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). Members have the option of not electing dental coverage upon re-enrollment.
- 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.
- Enroll in MCAP and/or DCAP. Employees must enroll each year; previous enrollment in the program does not continue into the new plan year.

Important Changes for Plan Year 2011

(Enrollment Period May 1 – May 31, 2010)

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, 2010.** All elections will be effective July 1, 2010.



Quality Care Dental Plan (QCDP)

- Dental annual plan year maximum benefit increases to \$2,500
- Orthodontia lifetime maximum benefit increases to \$2,000

Vision Plan (see page 19 for detail)

- In and out-of-network benefit for contact lenses and standard frames increases
- Out-of-network benefit for single, bifocal and trifocal lenses increases

Flexible Spending Accounts Program

In accordance with the Patient Protection and Affordable Care Act, over-the-counter medicines and drugs purchased without a physician's prescription will not be eligible for reimbursement through the Medical Care Assistance Program (MCAP) beginning January 1, 2011.

Behavioral health benefits have been adjusted. See page 7 for details.

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 make 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 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 beginning 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.

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, 2010, and remain in effect until June 30, 2011. 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*	
\$29,800 & below	Managed Care: \$47.00	Quality Care: \$72.00
\$29,801 - \$45,000	Managed Care: \$52.00	Quality Care: \$77.00
\$45,001 - \$59,900	Managed Care: \$54.50	Quality Care: \$79.50
\$59,901 - \$74,900	Managed Care: \$57.00	Quality Care: \$82.00
\$74,901 & 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"> • SERS/SURS annuitant/survivor on or after 1/1/98, or • TRS annuitant/survivor on or after 7/1/99 	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	0.44
Ages 60 - 64	0.66
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
HMO Illinois (Code: BY)	\$ 83	\$116	\$ 79	\$116
PersonalCare (Code: AS)	\$ 92	\$130	\$ 88	\$130
Humana Health Plan (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-Winnebago (Code: CE)	\$107	\$152	\$104	\$152
Quality Care Health Plan (Code: D3)	\$196	\$226	\$142	\$203

Member Monthly Quality Care Dental Plan (QCDP) Contributions*

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

Contribution Calculation Worksheet

Member Monthly Health Contribution: \$ _____
(see chart on page 4)

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 4)

My Total Monthly Contribution: \$ _____

Note: An interactive Premium Calculation Worksheet is available for full-time employees online at www.benefitschoice.il.gov.

* Part-time employees are required to pay a percentage of the State's portion of the contribution.

Health Plan

The State of Illinois offers its employees and annuitants health benefits through the State Employees Group Insurance Program. Prescription, behavioral health 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 4-5 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 8-13 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 provided by an entity other than the Department of Central Management Services.

Electing to opt out includes the termination of health, dental, vision, behavioral health and prescription coverage. See page 26 for details. If you do not have other comprehensive health coverage, you must enroll in the State's health plan.

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, 2010. If you need to have services provided on or after July 1, 2010, 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 22 for details.

Important Reminders

Continuity of Care After Health Plan Change:

Members who change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, 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 the 2011 plan year (July 1, 2010 – June 30, 2011) will be available on or after May 1, 2010, by calling 217-558-6194.

Beneficiary Designations: You should periodically review all beneficiary designations 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 comprehensive health coverage provided by an entity other than the Department of Central Management Services is required.

Behavioral Health Services

The coverage of behavioral health services (mental health and substance abuse) under the benefit plan is being adjusted for the FY 2011 plan year to comply with the federal Mental Health Parity and Addiction Equity Act of 2008. The federal law requires health plans to cover behavioral health services at levels equal to those of the plan's medical benefits.



Quality Care Health Plan:

Behavioral health services will now be included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services will no longer be subject to separate co-payments, limits or other specific provisions. Instead, covered services for behavioral health which meet the plan administrator's medical necessity criteria will be paid in accordance with the Quality Care Health Plan benefit schedule on pages 12 and 13 for in-network and out-of-network providers.

Magellan Behavioral Health continues to be the plan administrator for behavioral health services under the Quality Care Health Plan. Please contact Magellan for specific benefit information.

Managed Care Plans:

Behavioral health services will continue to be provided under the managed care plans; however, restrictions on the number of allowable visits and hospital days will be eliminated. Covered services for behavioral health must still meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 10 and 11. Please contact the managed care plan for specific benefit information.

Disease Management Programs and Wellness Offerings

Disease Management Programs:

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



Wellness Offerings:

Wellness options and preventive measures are offered and encouraged by CIGNA and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside covers of this book and on the Benefits website.

Managed Care Plans

There are 7 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 10. 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) offers members flexibility in selecting healthcare providers, but requires higher out-of-pocket costs. A deductible applies for medical services under Tier II and Tier III. **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 11.

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

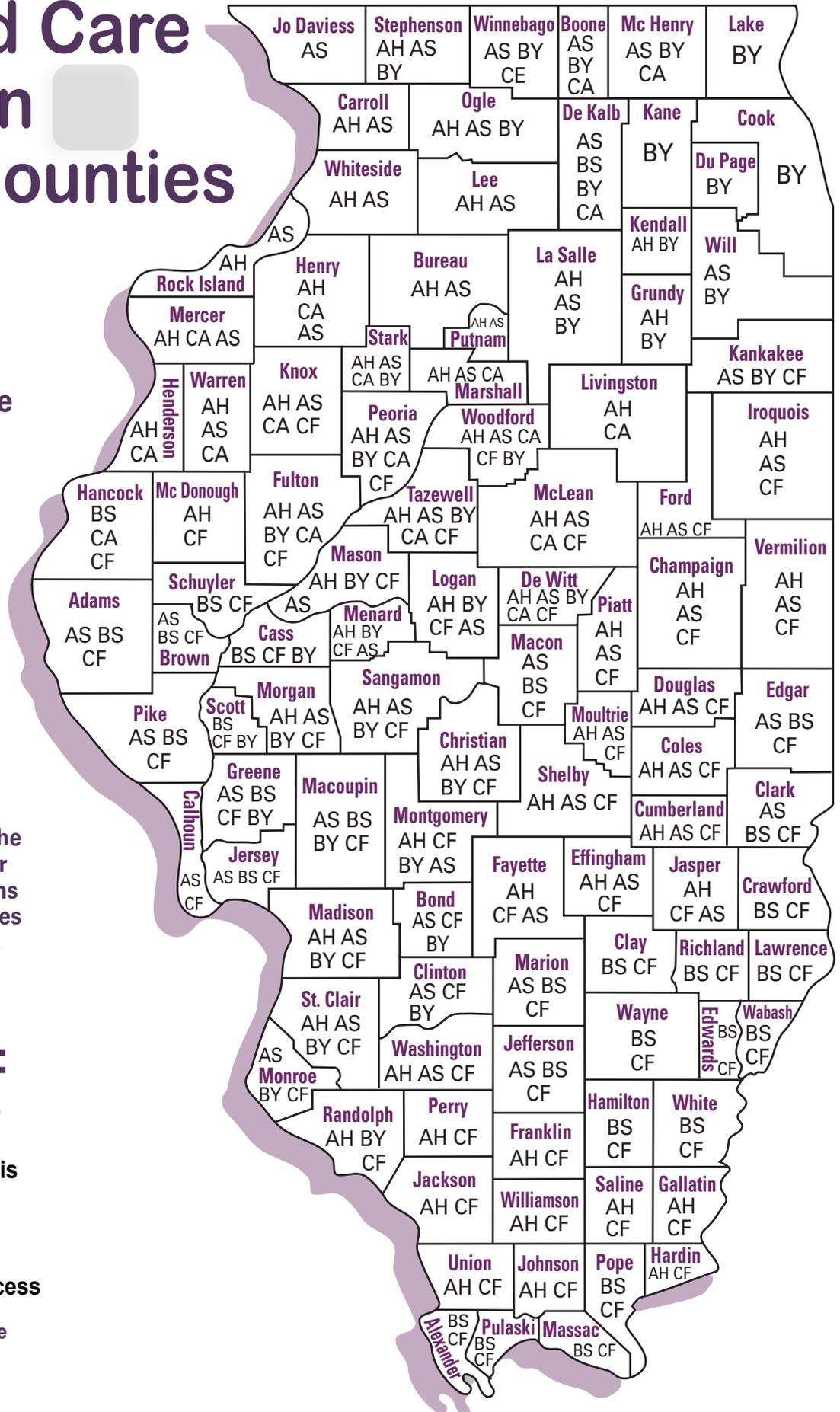
State Managed Care Health Plans For Plan Year 2011

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 Health Plan
- CE – Humana-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 18 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	100% after \$275 co-payment per admission
Psychiatric admission	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%
Outpatient Psychiatric and Substance Abuse	100% after \$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 18 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	90% of network charges after \$325 co-payment per admission	80% of U&C after \$425 co-payment per admission
Inpatient Alcohol and Substance Abuse	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
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
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
Outpatient Psychiatric and Substance Abuse	100% after \$20 co-payment	90% of network charges	80% of U&C

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, deductibles and amounts over usual and customary (U&C) 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; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP network provider.

The QCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. 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. **Note:** The QCHP and the HealthLink OAP are separate health plans with a separate plan design.

QCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits. A \$75 prescription deductible applies to each plan participant (see page 18 for details).

Plan participants can access plan benefit and participating QCHP network information, Explanation of Benefits (EOB) statements and other valuable health information online. To access website links to plan administrators, visit the Benefits website at 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)								
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
\$59,900 or less	\$300	\$750
\$59,901 - \$74,900	\$400	\$1,000
\$74,901 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: In-Network and Out-of-Network. 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.

In-Network: \$1,200 per individual \$3,000 per family per plan year	Out-of-Network: \$4,400 per individual \$8,800 per family per plan year
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The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits, deductibles 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"> • 90% after annual plan deductible. • \$50 deductible per hospital admission.
Non-QCHP Hospitals	<ul style="list-style-type: none"> • \$300 deductible per hospital admission. • 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. • 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. • 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.

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

Provider Services included in the QCHP Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Provider 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.

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

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

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is a premium-free program for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for members who are retired or who have lost Current Employment Status and are eligible for Medicare.
- **Medicare Part D** (Prescription Drug Insurance): Part D coverage is **not required** for plan participants in the State Employees Group Insurance Program. Medicare Part D coverage requires a monthly premium, unless the participant qualifies for extra-help assistance.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call 1-800-772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

To ensure that benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, plan participants must notify the State of Illinois CMS Medicare COB Unit when they become eligible for Medicare. The Medicare COB Unit can be reached by calling 1-800-442-1300 or 217-782-7007.

State of Illinois Medicare Requirements

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

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

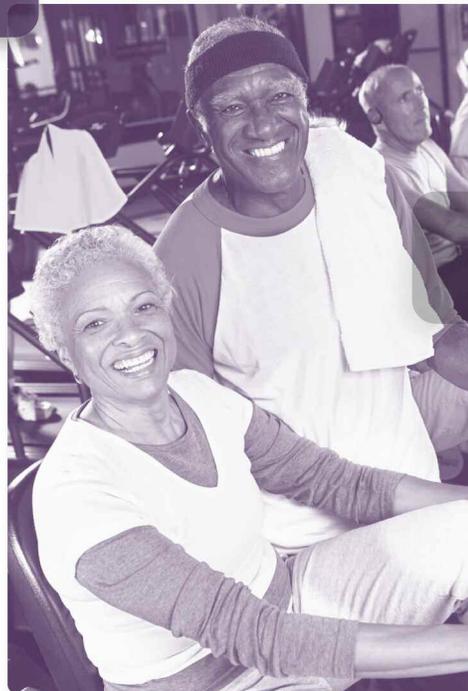
Employees with Current Employment Status (and their applicable Dependents)

Members who are actively working for the State of Illinois and become eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65) must accept the premium-free Medicare Part A coverage, but may delay the purchase of Medicare Part B coverage. The State group insurance program will remain the primary insurance for plan participants eligible for Medicare due to age or disability until the date the member retires or loses Current Employment Status (such as no longer working due to a disability-related leave of absence). Upon such an event, Medicare Part B is required by the State.

Plan Participants (Members and Dependents) Eligible for Medicare (cont.)

Retirees and Employees without Current Employment Status (and their applicable Dependents)

Members who are retired or who have lost Current Employment Status (such as no longer working due to a disability related leave of absence) and are eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the State group insurance program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the State group insurance plan and will result in additional out-of-pocket expenditures for health-related claims.**



Survivors (and their applicable Dependents)

Survivors (or their dependents) who become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the State group insurance program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the State group insurance plan and will result in additional out-of-pocket expenditures for health-related claims.**

If you are a survivor enrolled in Medicare Part A only, it is imperative that you contact the Medicare COB Unit to discuss the Medicare requirement.

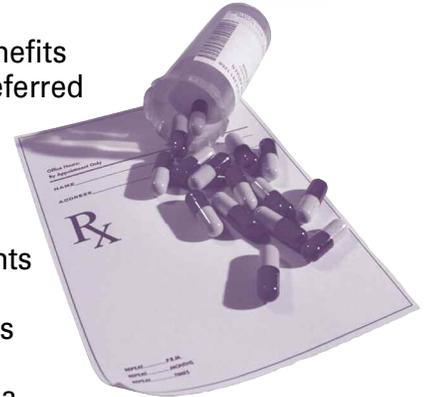
Plan Participants Eligible for Medicare on the Basis of End Stage Renal Disease (ESRD):

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

Each plan 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).

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). Each plan maintains a formulary list of medications. These 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 network pharmacies that participate in the various health plans, 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. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate. **Regardless of plan chosen, a prescription deductible applies to each plan participant each plan year (see page 18).**



Plan participants who have additional prescription drug coverage, including Medicare, should contact their healthcare plan for Coordination of Benefits (COB) information.

Health Alliance HMO, HMO Illinois, Humana Health Plan and PersonalCare all use a separate Prescription Benefit Manager (PBM) to administer their prescription 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.**

Health Alliance Illinois, HealthLink OAP, Humana-Winnebago and the Quality Care Health Plan (QCHP) have prescription drug benefits administered through the Prescription Benefit Manager (PBM), Medco. 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 these plans should carefully review the various prescription networks outlined on page 17. 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: (800) 899-2587**
Website: www.medco.com

QCHP, Health Alliance Illinois, HealthLink OAP and Humana-Winnebago Prescription Drug Benefit

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, are available on the Benefits website.

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 may be obtained by submitting a paper claim and the original prescription receipt to Medco. Reimbursement will be provided at the applicable brand or generic in-network price minus the appropriate in-network co-payment. Claim forms are available by visiting the Benefits website.

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. 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. For maintenance medication, 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.

Special Note Regarding Medications for Nursing Home/Extended Care Facility QCHP Patients

Due to the large amounts of medication generally administered at nursing home and extended care facilities, many of these types of facilities cannot maintain more than a 30-day supply of prescriptions per patient.

In order to avoid being charged a double-copayment for a 30-day supply, the patient or person who is responsible for the patient's healthcare (such as a spouse, power of attorney or guardian) should submit a letter requesting an 'exception' to the double

co-payment for their medication. The request should be in the form of a letter, and must include the patient's name, a list of all medications the patient is taking and the dosage of each medication. The effective date of the exception is the receipt date of the request. Requests must be submitted to the Group Insurance Division, Member Services Unit, 201 E. Madison, P.O. Box 19208, Springfield, Illinois 62794-9208.

Note: Since each request is based on a specific list of medications, any newly prescribed medication(s) must be sent as another request.

Prescription Drug Benefit Co-Pays and Deductibles

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 covered by the health plan.

PRESCRIPTION DRUG CO-PAYS FOR A 30-DAY SUPPLY

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

PRESCRIPTION DRUG DEDUCTIBLE – APPLIES TO ALL PLANS

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

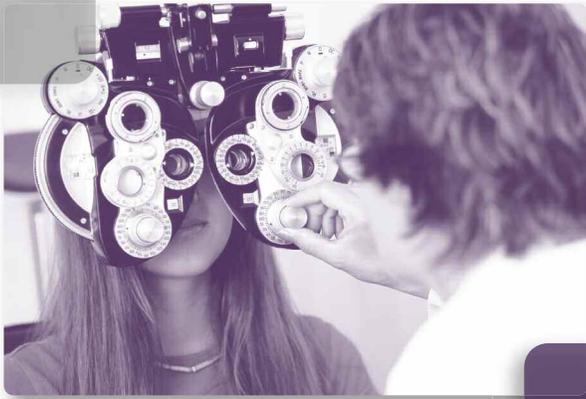
Example 1 – Generic Drug Costs Less than the Deductible

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Co-payment	Total Payment
QCHP First Fill	\$55	\$55	\$20	\$0	\$55
QCHP Next Fill	\$55	\$20	\$0	\$11	\$31
Managed Care First Fill	\$37	\$37	\$13	\$0	\$37
Managed Care Next Fill	\$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
QCHP First Fill	\$100	\$75	\$0	\$11	\$86
QCHP Next Fill	\$100	\$0	\$0	\$11	\$11
Managed Care First Fill	\$100	\$50	\$0	\$10	\$60
Managed Care Next Fill	\$100	\$0	\$0	\$10	\$10

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
Eye Exam	\$10 co-payment	\$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	\$10 co-payment	\$50 allowance for single vision lenses \$80 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	\$10 co-payment (up to \$175 retail frame cost; member responsible for balance over \$175)	\$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	\$120 allowance	\$120 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.

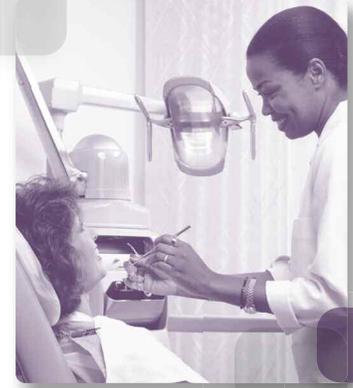
** Out-of-network claims must be filed within one year from the date of service.



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

Dental 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 drop dental coverage. The election to drop coverage will remain in effect the entire plan year, without exception. The Benefit Choice Period is also the only time members may elect dental coverage if they previously dropped the coverage.



Dental Benefit

The Quality Care Dental Plan (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 \$2,500 for all dental services.

Preventive and Diagnostic Services

Annual Deductible	N/A
Plan Year Maximum Benefit*	\$2,500

All Other Covered Dental Services

Annual Deductible	\$125
Plan Year Maximum Benefit*	\$2,500

* Orthodontics + all other covered services

Prosthodontic Limitations

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

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

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 \$2,000. This maximum represents a \$250 increase from FY10. 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 FY11. This lifetime maximum is subject to course of treatment limitations (see 'Length of Orthodontia Treatment' chart below).

Orthodontia Services

Annual Deductible	\$125
Lifetime Maximum Benefit	\$2,000
Plan Year Maximum Benefit*	\$2,500

Length of Orthodontia Treatment

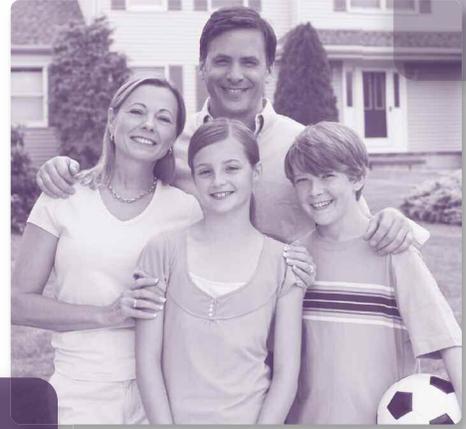
The lifetime maximum benefit for child orthodontics is based on the length of treatment. This lifetime maximum applies to each plan participant regardless of the number of courses of treatment.

Length of Treatment	Maximum Benefit
0 - 36 Months	\$2,000
0 - 18 Months	\$1,820
0 - 12 Months	\$1,040

CompBenefits: (800) 999-1669
TDD/TTY: (312) 829-1298
Website: 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 4 to be aware of rate variations among age groups. Rate changes 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 decreases to \$5,000 for annuitants age 60 and older. A corresponding premium applies.

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. Eligible children include:

- Children age 18 and under
- Children in the Student or Student on Medical Leave of Absence Categories
- Children in the Handicapped Category

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.

* Deferred Annuitants and 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

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, 2010. 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) over the course of the plan year.

FSA plan elections do not automatically carry over each year. You must complete a new FSA Enrollment Form each year to participate. 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
- Over-the-counter medicines and drugs will not be eligible for reimbursement beginning January 1, 2011, without a prescription

You have until September 30, 2011, to submit claims for expenses that were incurred from July 1, 2010, through September 15, 2011; otherwise, any money left in your account will be forfeited.

New this year: Employees who enroll in MCAP will automatically be issued the MyFBMC Visa® card at no cost to use for their FY11 plan year medical expenses. Documentation is 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.



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
- Before and after-school care expenses for dependents age 12 and older.

You have until September 30, 2011, to submit claims for services incurred from July 1, 2010, through June 30, 2011; otherwise, any money left in your account will be forfeited.

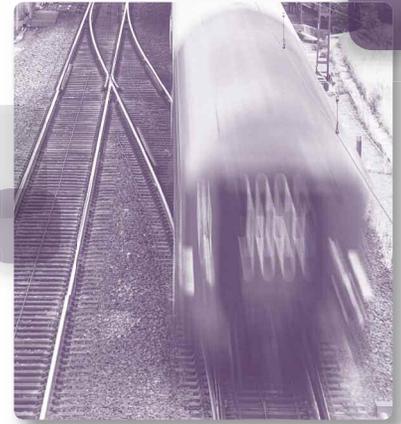


FBMC: (800) 342-8017
TDD/TTY: (800) 955-8771
Website: www.myFBMC.com

Commuter Savings Program (CSP)

Employee Benefit Only - Does NOT Apply to Annuitants or University Employees

The Commuter Savings Program (CSP) is a qualified transportation benefit that allows **employees** to pay for eligible transit and/or parking expenses associated with their work commute 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 2010 for both the transit and parking benefit is \$230.00 per month. **The CSP program is only available to employees who are paid through the Comptroller's Office. CSP benefits may be elected, changed or cancelled anytime.**



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 CSP prior to the July 10th cut-off date for the August benefit month. 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 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.

Transit Benefit

What is it? The CSP transit benefit allows you to pay mass transit costs associated with your work commute with pre-tax dollars. To enroll, just go online to 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 monthly 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 for the August benefit month. The vendor sent Tom's August transit pass to his home on July 23rd for him to use on or after 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.

 **FBMC: (800) 342-8017**
TDD/TTY: (800) 955-8771
Website: 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 in which the adoption became final.

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.

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.



Opt Out and Annuitant Waiver

Opt Out

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 of other major medical insurance by an entity other than the Department of Central Management Services is provided. **This election will terminate health, dental, vision and prescription coverage for the member and any dependents.**

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 **still be eligible** for the:

- Flexible Spending Account (FSA) Program
- Commuter Savings Program (CSP)
- Paid maternity/paternity benefit
- Employee Assistance Program
- Long-Term Care Program
- Adoption Benefit Program

Opt Out With Financial Incentive

SERS Annuitants not eligible for Medicare

In accordance with Public Act 94-0109, members not eligible for Medicare 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 for the annuitant and any dependents. Make sure to mark the 'Opt Out with Financial Incentive' box on the Benefit Choice Election Form if you are interested in this option. The Insurance Section of SERS will send you additional forms to complete that are required for this election.

Annuitant Waiver

When both spouses are covered by the State Group Insurance Program

Public Act 93-553 changed the State Employees Group Insurance Act to allow annuitants who were currently enrolled as a dependent of their State-covered spouse to remain a dependent and waive coverage in their own right, thereby decreasing the cost of coverage for an annuitant with less than 20 years of service.

New annuitants who are currently enrolled as a dependent who wish to remain enrolled as a dependent once becoming an annuitant must complete the 'Waiving Annuitant Group Insurance Coverage Notification and Election Form' which acknowledges they are waiving health, dental and vision coverage as an annuitant. The annuitant's spouse cannot carry Spouse Life on the annuitant; however, the annuitant will have Basic Life coverage and may apply for additional Optional Life coverage, if eligible.

Re-enrolling in the Health Plan

Individuals who opt out or waive 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.

Any outstanding premiums must be paid before you will be allowed to re-enroll. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated for non-payment of premium.

FY2011 BENEFIT CHOICE ELECTION FORM

(Instruction Sheet on Back)

Enrollment Period: May 1 – May 31, 2010

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/WAIVE or OPT IN (applies to your and your dependents' health, dental, vision and prescription coverage)

See instructions on the back for additional documentation requirements

<input type="checkbox"/> Opt Out/Waive Coverage if currently enrolled in the Program <input type="checkbox"/> Opt In or Elect Coverage if not currently enrolled	<input type="checkbox"/> Opt Out with Financial Incentive – only SERS Annuitants who are not eligible for Medicare can elect this option
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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.
Elect One: Quality Care Health Plan (QCHP) <input type="checkbox"/> <p style="text-align: center;">~ Or ~</p> Managed Care Plan (HMO or OAP) <input type="checkbox"/>	PCP/Provider Identifier _____ (6 - 10 characters) Carrier Code _____ (2 characters – see map) Carrier/Plan Name _____

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

SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your current dental coverage election)

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 <u>and</u> prescription coverage will remain active)	
<input type="checkbox"/> I am currently enrolled in the dental plan and would like to drop the dental coverage	<input type="checkbox"/> I am not currently enrolled in the dental plan and would like to elect the dental coverage

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

OPTIONAL LIFE ¹	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) <small>* AD&D COMBINED maximum is Basic + 4 times Salary</small>
Annuitants age 60 and over are not eligible for 5 – 8 times Salary		

SECTION F: DEPENDENT INFORMATION ² (will have the same health, vision, prescription and dental coverage as the member)

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

Note: ¹ Statement of Health form required when adding or increasing Optional Life or adding Spouse or Child Life. Form available online.
² Documentation required for add dependents – see specific documentation requirements on the back.
³ Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child, legal guardianship, sponsored or veteran adult child.

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, 2010

BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

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

SECTION A – MEMBER INFORMATION (Complete all fields)

SECTION B – OPT OUT/WAIVE or OPT INTO Health, Dental, Vision and Prescription Coverage

Opting out or waiving coverage will discontinue all health, dental, vision and prescription coverage; Opting in will establish health, dental, vision and prescription coverage; however you may elect to waive the dental coverage at the time you opt into the health, vision and prescription coverage. Whether you opt out, waive or opt in, your life coverage elections will remain the same.

- **Full-time employees, annuitants and survivors** may opt out of the coverage by submitting a completed Opt Out Election Certificate along with proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services).
- **Part-time employees, annuitants and survivors required to pay a percentage of the State's portion of the premium** may elect to waive the coverage without proof of other coverage.
- **Non-Medicare SERS annuitants** may be eligible to receive a \$150.00 financial incentive when they opt out of the State's coverage and provide proof of other comprehensive health coverage (other coverage cannot be provided by Central Management Services). Once you elect this option to opt out you will be mailed a packet by SERS. The packet will include additional required forms. Note: This option is NOT available for annuitants of SURS, TRS, GARS or JARS.
- The completed forms and documentation must be submitted to your Group Insurance Representative (GIR).

SECTION C – HEALTH PLAN ELECTIONS

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 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 (at least 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).

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.

SECTION D – DENTAL PLAN OPTION

Your election decision will apply to both your and your dependents' dental coverage.

- If you are currently enrolled in the dental plan and **wish to drop the coverage**, check the appropriate box. This election will remain in effect until you re-elect the dental coverage, which is **only** allowed during a future Benefit Choice election period.
- If you are currently **not** enrolled in the dental plan and **wish to elect the coverage**, check the appropriate box. The Benefit Choice Period is the only time you can elect dental coverage if you previously dropped the coverage. Members must be enrolled in the health plan in order to elect this option.

SECTION E – MEMBER OPTIONAL LIFE INSURANCE

*Complete this section to add/drop/increase or decrease Member Optional Life or AD&D coverage. **Note:** Life coverage is subject to a \$3,000,000 maximum (Basic Life + Optional Life). Adding and/or increasing Optional Life requires a signed Statement of Health application* for the member. Annuitants age 60 and older are not eligible for 5 – 8 times of Optional Life coverage.*

SECTION F – DEPENDENT INFORMATION

Complete this section if you are adding or dropping (1) dependent health/dental/vision/prescription coverage or (2) Spouse/Child Life coverage. Adding Spouse Life and/or Child Life requires a signed Statement of Health application for that dependent. *If you are adding a dependent for the first time, you must provide your GIR/P with the appropriate documentation as indicated below:**

Spouse	Marriage certificate.
Natural Child through Age 18	Birth certificate.
Stepchild through Age 18	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 through Age 18	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardianship through Age 18	Court documentation signed by a judge.
Student and Student Medical LOA	Birth certificate, Eligibility Certification Statement (CMS-138)* and documentation as indicated on the 'Documentation Requirements' page of the Eligibility Certification Statement.
Sponsored Adult Child	
Veteran Adult Child (IRS/non-IRS)	
Handicapped	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) and the Statement of Health application are available on the Benefits Website at www.benefitschoice.il.gov .	

SIGNATURE: In order for your elections to be effective July 1, 2010, you must sign and date the Benefit Choice Election Form and submit it to your agency GIR by **May 31, 2010**. 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 dependent(s) will not be added.**

Plan Administrators

Who to call for information

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

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.



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