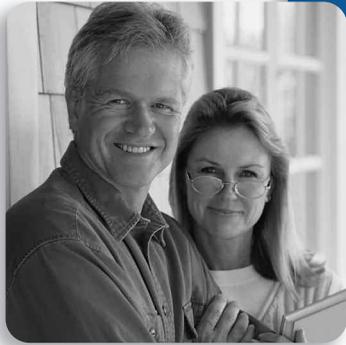




State of Illinois
Department of Central Management Services
Bureau of Benefits



Benefit Choice Options Period

Enrollment Period May 1 - May 31, 2010



Local Government Health Plan

Effective July 1, 2010 - June 30, 2011

Plan Administrators

Who to call for information

Health Care Plan Name/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
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
Local Care Dental Plan (LCDP) Administrator	CompBenefits Group Number 960 P.O. Box 14285 Lexington, KY 40512-4285	(800) 999-1669 (312) 829-1298 (TDD/TTY)	www.compbenefits.com
Health/Dental Plans, Medicare COB Unit and Smoking Cessation Benefits	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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Benefit Choice Period is May 1-31, 2010

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

All Benefit Choice changes should be made on the Benefit Choice Election Form. Members should complete the form **only** if changes are being made. The Local Government Health Plan will process the changes based upon the information indicated on the form.

Documentation Requirements

Documentation is required when adding dependent coverage. Members should refer to the documentation requirements chart on the Benefit Choice Election Form Instruction Sheet on page 16.

During the annual Benefit Choice Period, members may:

- Change health plans
- Add or drop dependent coverage

Important Changes for Plan Year 2011

(July 1, 2010 through June 30, 2011)

The information below presents changes to the Local Government Health Plan (LGHP). Please carefully review all the information in this Benefit Choice Options booklet. Members should review this publication each year to be aware of benefit changes. Benefit Choice is May 1 - 31, 2010. All elections made during Benefit Choice will be effective July 1, 2010.



Managed Care Plan (HMO/OAP) Changes

- Outpatient surgery co-payment increases to \$200
- Prescription co-payments for preferred brand and non-preferred brand increase to \$24/\$48 respectively (generic remains \$10)

Local Care Health Plan (LCHP) Changes

- Prescription co-payments increase to \$12/\$24/\$48
- Plan year deductible increases to \$500 per plan participant
- New in-network hospital admission deductible of \$100 per plan participant
- Out-of-network, out-of-pocket maximum (individual) increases to \$4,500
- Out-of-network, out-of-pocket maximum (family) increases to \$9,000
- Professional and other services (out-of-network) is 70% of U&C
- Durable Medical Equipment (in-network) is 80%
- Durable Medical Equipment (out-of-network) is 70% of U&C
- Lab and X-ray (out-of-network) is 70% of U&C
- Licensed Ambulatory Surgical Treatment Centers (out-of-network) is 70% of U&C
- Out-of-network hospital admission is 70% of U&C (mileage restriction no longer applies)

Local Care Dental Plan (LCDP) Changes

- Increase in benefit levels of preventive, diagnostic and some restorative services

Behavioral health benefits have been adjusted. See page 3 for details.

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.



Local 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 Local Care Health Plan benefit schedule on pages 8 and 9 for in-network and out-of-network providers. Magellan Behavioral Health continues as the plan administrator for behavioral health services under the Local 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 6 and 7. 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.

Member Responsibilities

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

Notify the Health Plan Representative (HPR) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
 - birth/adoption of a child;
 - marriage, divorce, legal separation, annulment;
 - death of spouse or dependent;
 - an employment status change for the member, the member's spouse or any dependent(s) that affects eligibility under the plan;
 - dependent(s) loss of eligibility;
 - a court order results in the gain or loss of a dependent;
 - a change in Public Aid recipient status;
 - dependent becomes covered by other group health or dental coverage
- Gain or loss of other group coverage
- Leave of absence
- Change in Medicare status
- Change to or addition of other group health insurance coverage
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their Coordination of Benefits (COB) information to their HPR as soon as possible.

Health Plan

The Local Government Health Plan (LGHP) offers its members and annuitants health, prescription, behavioral health, dental and vision coverage.

As a member of LGHP, you are offered a number of health insurance coverage plans:

- Health Maintenance Organization (HMOs)
- Open Access Plan (OAP)
- Local Care Health Plan (LCHP) – 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 5-10 for information to help you determine which plan is right for you.



If you change health plans during the Benefit Choice Period, your new health insurance ID cards will be mailed to you directly from your health insurance carrier. 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.

Managed Care Plans in Illinois Counties

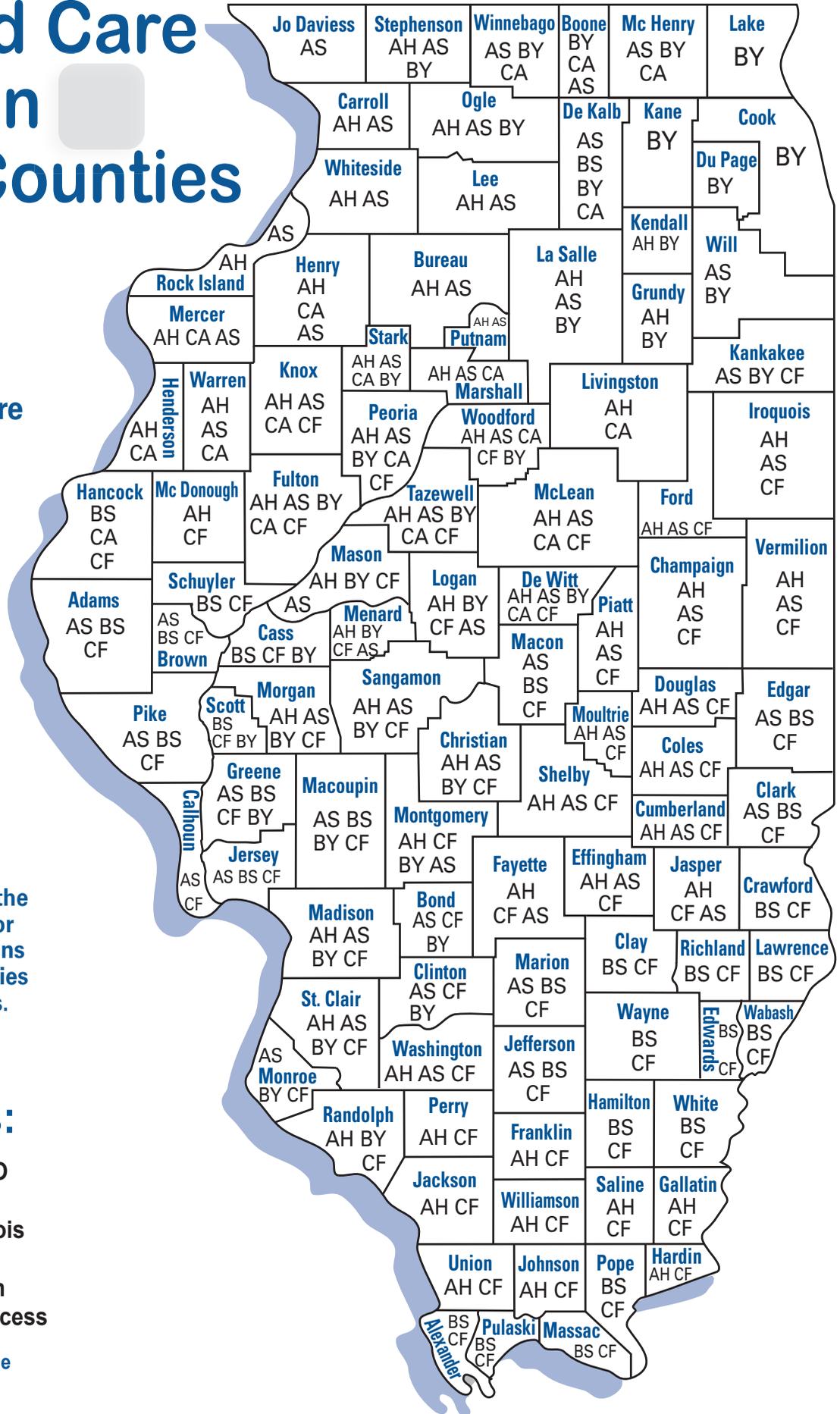
LGHP Managed Care Health Plans For Plan Year 2011

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
- CF – HealthLink Open Access

Note: LCHP available Statewide



HMO Benefits



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, the member pays only a co-payment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Hospital Services

Inpatient hospitalization	100% after \$250 co-payment per admission
Alcohol and substance abuse	100% after \$250 co-payment per admission
Psychiatric admission	100% after \$250 co-payment per admission
Outpatient surgery	100% after \$200 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 \$20 co-payment per visit
Specialist Office visit	100% after \$20 co-payment per visit
Well Baby Care (first year of life)	100% after \$20 co-payment per visit
Outpatient Psychiatric and substance abuse	100% after \$20 co-payment per visit
Prescription drugs	\$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 based on a calendar year schedule.

Open Access Plan (OAP) Benefits

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. It is important to remember the level of benefits is determined by the selection of healthcare providers. Members enrolled in the OAP can mix and match providers. 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.

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	\$0 \$0	\$1,000 \$2,500	\$2,000 \$5,000
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$500 per enrollee*

Hospital Services

Inpatient	100% after \$250 co-payment per admission	90% of network charges after \$300 co-payment per admission	80% of U&C after \$400 co-payment per admission
Inpatient Psychiatric	100% after \$250 co-payment per admission	90% of network charges after \$300 co-payment per admission	80% of U&C after \$400 co-payment per admission
Inpatient Alcohol and Substance Abuse	100% after \$250 co-payment per admission	90% of network charges after \$300 co-payment per admission	80% of U&C after \$400 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 \$200 co-payment per visit	90% of network charges after \$200 co-payment	80% of U&C after \$200 co-payment
Diagnostic Lab and X-ray	100%	90% of network charges	80% of U&C

Physician and Other Professional Services

Physician and Specialist Office Visits	100% after \$20 co-payment	90% of network charges	80% of U&C
Preventive Services, including immunizations, Well Baby care, allergy testing and treatment	100% after \$20 co-payment	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		
	Generic \$10	Preferred Brand \$24	Non-Preferred Brand \$48
Durable Medical Equipment	80% of network charges	80% of network charges	80% of U&C
Skilled Nursing Facility	80% of network charges	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$20 co-payment	80% 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 Local Care Health Plan (LCHP)

LCHP (administered by CIGNA) is the medical plan that offers a comprehensive range of benefits. Under the LCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a LCHP network provider.

The LCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the LCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The LCHP and the HealthLink OAP are separate health plans with a separate plan design.

LCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits.

Plan participants can access plan benefit and participating 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.

Plan Year Maximums and Deductibles

Plan Year Maximum	Unlimited								
Lifetime Maximum	Unlimited								
Plan Year Deductible	\$500 per participant								
Additional Deductibles*	<table border="0"> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>LCHP hospital admission</td> <td>\$100</td> </tr> <tr> <td>Non-LCHP hospital admission</td> <td>\$400</td> </tr> <tr> <td>Transplant deductible</td> <td>\$250</td> </tr> </table>	Each emergency room visit	\$400	LCHP hospital admission	\$100	Non-LCHP hospital admission	\$400	Transplant deductible	\$250
Each emergency room visit	\$400								
LCHP hospital admission	\$100								
Non-LCHP hospital admission	\$400								
Transplant deductible	\$250								
* These are in addition to the plan year deductible.									

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: \$1,500 per individual \$3,750 per family per plan year	Out-of-Network: \$4,500 per individual \$9,000 per family per plan year
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The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits 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).

LCHP - Medical Plan Coverage

Hospital Services

LCHP Network Hospitals	90% after annual plan deductible. \$100 deductible per hospital admission.
Non-LCHP Hospitals	70% after annual plan deductible. \$400 deductible per hospital admission.

Outpatient Services

Lab/X-ray	90% of negotiated fee or 70% of U&C, as applicable, after plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	90% of negotiated fee or 70% of U&C, as applicable, after plan deductible.
Licensed Ambulatory Surgical Treatment Centers	90% of negotiated fee or 70% of U&C, as applicable, after plan deductible.

Professional and Other Services

Provider Services included in the LCHP Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Provider Services not included in the LCHP 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 70% of U&C, as applicable, after plan deductible.

Transplant Services

Organ and Tissue Transplants	80% of negotiated fee after \$250 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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Behavioral Health Services

Magellan administers the LCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.

Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.

Health Plan Comparison

Benefit	LCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000

Patient Responsibilities

Annual Out-of-Pocket Maximum	In-Network: \$1,500 per enrollee \$3,750 per family/plan year Out-of-Network: \$4,500 per enrollee \$9,000 per family/plan year	\$3,000 per enrollee \$6,000 per family/plan year Not applicable	Not applicable Not applicable	\$1,000 per enrollee \$2,500 per family/plan year Not applicable	\$2,000 per enrollee \$5,000 per family/plan year Not applicable
Annual Plan Deductible Must be satisfied for all services	\$500 per enrollee	\$0	\$0	\$300 per enrollee	\$500 per enrollee
Other Deductibles/Co-payments:					
• Emergency Room	\$400	\$200	\$200	90% network charges** after \$200 co-payment	80% of U&C* after \$200 co-payment
• LCHP Network Hospital Admission	\$100	Not applicable	Not applicable	Not applicable	Not applicable
• Out-of-Network Hospital Admission	\$400	No coverage	See Tier III for benefit level	See Tier III for benefit level	80% of U&C* after \$400 co-payment

Plan Benefit Levels Comparison

Physician Office Visit	90% LCHP network 70% of U&C* Out-of-Network	\$20 co-payment	\$20 co-payment	90% of network charges**	80% of U&C*
Preventive Services	100% for specific tests 90% LCHP network 70% of U&C* Out-of-Network	\$20 co-payment	\$20 co-payment	90% of network charges**	Covered under Tier I and Tier II only
Inpatient	90% LCHP network 70% of U&C* Out-of-Network	\$250 co-payment	\$250 co-payment	90% of network charges** after \$300 co-payment	80% of U&C* after \$400 co-payment
Outpatient Surgery	90% LCHP network 70% of U&C* Out-of-Network	\$200 co-payment	\$200 co-payment	90% of network charges** after \$200 co-payment	80% of U&C* after \$200 co-payment
Diagnostic Lab and X-ray	90% LCHP network 70% of U&C* Out-of-Network	100%	100%	90% of network charges**	80% of U&C*
Durable Medical Equipment	90% LCHP network 70% of U&C* Out-of-Network	80% of network charges**	80% of network charges**	80% of network charges**	80% of U&C*

* Usual & Customary (U&C) is an amount determined by the health plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition.

**Network charges are the amount the plan determines is the appropriate charge for a covered service.

Prescription Drug Benefit

Plan participants enrolled in any LGHP 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. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic co-payment. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for Coordination of Benefits (COB) information. LCHP plan participants can receive a 90-day supply of maintenance medication through the Mail Order Program for two co-payments.

PRESCRIPTION DRUG CO-PAYS FOR A 30-DAY SUPPLY

	PRESCRIPTION PLAN	
	LCHP	All Other Plans
Generic	\$12	\$10
Preferred (Formulary) Brand	\$24	\$24
Non-Preferred Brand	\$48	\$48

Coverage for specific prescription drugs may vary depending upon the health plan. 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 they are considering. 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.

Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the LGHP health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. All vision 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**
Eye Exam	\$10 co-payment	\$20 allowance
Spectacle Lenses* (single, bifocal and trifocal)	\$10 co-payment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses
Standard Frames	\$10 co-payment (up to \$90 retail frame cost; member responsible for balance over \$90)	\$20 allowance
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	\$20 co-payment for medically necessary \$50 co-payment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance

* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

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



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

Dental Plan

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected. Participants may go to any dental provider for services.

Local Care Dental Plan (LCDP)

- The Local Care Dental Plan (LCDP) reimburses only those services listed on the Dental Schedule of Benefits available on the Benefits website at www.benefitschoice.il.gov.
- Listed services are reimbursed at a predetermined maximum scheduled amount.
- A \$100 individual plan deductible applies for all services other than those listed as 'Preventive' and 'Diagnostic' in the Dental Schedule of Benefits.
- Members are responsible for all charges over the scheduled amount and/or over the annual maximum benefit.
- Once the deductible has been met, the plan participant has a maximum annual dental benefit of \$2,000 for all dental services.

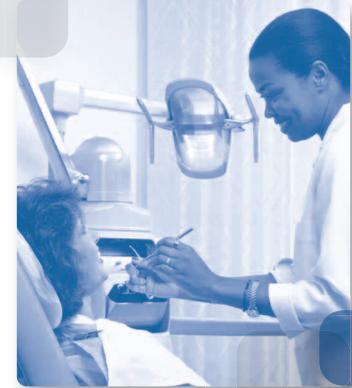
Preventive and Diagnostic Services

Annual Deductible	N/A
Plan Year Maximum Benefit*	\$2,000

All Other Covered Dental Services

Annual Deductible	\$100
Plan Year Maximum Benefit*	\$2,000

* Orthodontics + all other covered services



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 \$1,500.
- This lifetime maximum is subject to course of treatment limitations and begins once the \$100 plan year deductible has been met.

Orthodontia Services

Annual Deductible	\$100
Lifetime Maximum Benefit	\$1,500
Plan Year Maximum Benefit*	\$2,000

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	\$1,500
0 - 18 Months	\$1,364
0 - 12 Months	\$780

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

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

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

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is 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 Local Government Health Plan. 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.

Local Government Health Plan Medicare Requirements

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

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 Local Government Health Plan. **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 Local Government Health Plan and will result in additional out-of-pocket expenditures for health-related claims.**



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

Plan participants 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 Health Plan Representative (HPR).

LOCAL GOVERNMENT HEALTH PLAN (LGHP)
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: EMPLOYEE INFORMATION (required)

SSN: — —

Last Name	First Name	Phone Numbers	
		Home:	Work:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

Health Plan Election *	If you selected Managed Care Plan, <u>you must</u> complete the information below. To find the provider identifier, go to the health plan's website. See the instruction sheet on back for more information.
Elect One: Local Care Health Plan (LCHP) <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 map on page 5) Plan Name _____

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

SECTION C: DEPENDENT INFORMATION ¹ (dependents will be enrolled with the same coverage that you have)

HEALTH			Name	SSN	Birth Date	Relationship ²	Sex (M/F)	Provider Identifier
A (Add) / D (Drop) / Change (C)								
A	D	C						

Note: ¹ Documentation required to add dependents – see specific documentation requirements on the back.
² Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child, legal guardianship, sponsored adult child or veteran adult child.

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your unit's HPR by May 31, 2010.

BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are keeping your current coverage elections you do **not** need to complete the Benefit Choice Election Form.*

SECTION A – EMPLOYEE INFORMATION

Complete all fields.

SECTION B – HEALTH PLAN ELECTION

If you wish to change your **health** plan you must check either the Local Care Health Plan (LCHP) or the Managed Care 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 their website (see inside front cover 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 C – DEPENDENT INFORMATION

Complete this section if you are adding or dropping health coverage for a dependent. If you are adding dependent health coverage, you must provide the appropriate documentation as indicated below.

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child's parent and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	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	
Handicapped	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) is available on the Benefits Website at www.benefitschoice.il.gov .	

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR by **May 31, 2010**, in order for your elections to be effective July 1, 2010. Dependent documentation must be submitted to your HPR 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.**

Plan Administrators

Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	CIGNA Group Number 2457474 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
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of \$400 applies	Intracorp, Inc.	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator LCHP (1401LD3) Health Alliance Illinois (1401LBS) HealthLink OAP (1401LCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1401LD3, 1401LBS, 1401LCF 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
LCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	Magellan Behavioral Health Group Number 2457474 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits 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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Bureau of Benefits
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