

# Message to Plan Members

Go to the Benefits website at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov) for additional information and resources, including the Benefit Choice Options booklet and forms.

The Benefit Choice Period will be **May 1 through May 31, 2016**, for eligible members. Members are employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), COBRA participants, and annuitants and survivors **not** enrolled in the Medicare Advantage TRAIL Program (see page 3 for more information). **Elections will be effective July 1, 2016.**

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form available on the Benefits website. 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 their GIR name and contact information by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

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

- Change health plans.
- Add or drop dental coverage. Employees must be enrolled in a health plan in order to have dental coverage. Retirees may opt out of health coverage and remain enrolled in dental coverage.
- Add or drop dependent coverage. Note: Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member.
- Add, drop, increase or decrease Member Optional Life insurance coverage.
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage.
- Elect to opt out (applies only to full-time employees, including those on a leave of absence, annuitants and survivors). All members electing to opt out must provide proof of other comprehensive health coverage. **This election will terminate health, prescription, behavioral health and vision coverage for the member and any enrolled dependents.** Dental coverage for employees will also be terminated; however, annuitants and survivors will remain enrolled in the dental coverage unless they elect to cancel the coverage during the annual Benefit Choice Period.
- Elect to waive health, dental, vision and prescription coverage (part-time employees 50% or greater, annuitants and survivors).
- Re-enroll in the Program if previously opted out of or waived coverage. Members have the option of not electing dental coverage upon re-enrollment into the health plan.
- Re-enroll in the Program if coverage is currently terminated due to nonpayment of premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums plus the July 2016 premium must be paid before coverage will be reinstated. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated due to nonpayment 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. Note:** Survivors and annuitants are not eligible for MCAP or DCAP.

# Member Responsibilities

(Enrollment Period May 1 – May 31, 2016)

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 who are no longer eligible under the Group Insurance Program (Program), including divorced spouses or partners of a dissolved civil union or domestic partner relationship, 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 unpaid time away from work.** When you have unpaid time away from work, 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 have or gain other coverage.** If you have group coverage provided by a plan other than the Program, or if you or your dependents gain other coverage during the plan year.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to the Medicare Coordination of Benefits Unit at Central Management Services when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit of your Medicare eligibility may result in substantial financial liabilities.** The Medicare Unit's address and phone number can be found on page 36 of the Benefit Choice Options book.
- **You get married or enter into a civil union partnership; or your marriage, domestic partnership or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **Your employment status changes from full-time to part-time or vice versa, or the employment status of your dependent changes.**
- **You have a financial or medical power of attorney (POA) who you would like to be able to make decisions and get information on your behalf if you are incapacitated.**
  - **Financial POA – used by your agent to change your health plan elections.** The financial POA document would allow an agent to make health, dental and life insurance plan elections on your behalf and should be sent to your agency or retirement system group insurance representative.
  - **Medical POA – used by your agent to speak with your health, dental and vision plans about your coverage and claims.** A medical POA generally gives an agent the authority to make medical decisions on your behalf; therefore, in order for your agent to speak with your health, dental and/or vision plan(s), you would need to submit the medical POA document to each plan for them to have on file.

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

## Documentation Requirements

- Documentation, including the SSN, 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.
- Documentation must be submitted to your GIR no later than June 10.

# What You Should Know for Plan Year 2017

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It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections. Members should carefully review all the information in the Benefit Choice Options book (available at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)) to be aware of the benefit changes for the upcoming plan year.

- **Medicare Advantage 'TRAIL' Program:** The State now provides coverage to eligible annuitants and survivors through the Medicare Advantage program. This program, referred to as the 'TRAIL' (Total Retiree Advantage Illinois), is available for annuitants and survivors enrolled in both Medicare Parts A and B.

Each fall, annuitants and survivors who meet the criteria for enrollment in the Medicare Advantage 'TRAIL' Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. **These members will be required to choose a Medicare Advantage plan or opt out of the State's coverage (opting out includes the termination of health, prescription and vision coverage). Members eligible for the TRAIL plans are no longer eligible for the plans offered during the Benefit Choice Period.**

For more information regarding the Medicare Advantage 'TRAIL' Program, including eligibility criteria, go to [www.cms.illinois.gov/thetrail](http://www.cms.illinois.gov/thetrail).

- **Federal Healthcare Reform:** As a result of the Affordable Care Act (ACA), prescription deductibles and copayments paid by members apply toward the annual out-of-pocket maximum. Once the maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year. The out-of-pocket maximum amount for each type of health plan varies and is outlined on page 12 of the Benefit Choice Options book.
- **Medical Care Assistance Plan (MCAP) Rollover:** The MCAP maximum contribution amount will remain \$2,550 for the 2017 plan year with a \$500 maximum rollover. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover. Those who do not re-enroll will forfeit any amount eligible for rollover. See page 32 of the Benefit Choice Options booklet for more information.

## Basic Insurance Terms Explained

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**What is an Insurance Premium?** Insurance premiums are the deductions taken out of your paycheck for your part of the insurance cost. In most cases, the State picks up the majority of your premium.

**What is a Copayment?** A copayment (or copay) is a fixed-dollar amount that you pay each time you have certain medical visits such as to an emergency room, or for certain procedures, such as physical therapy.

**What is a Deductible?** The deductible is the amount that you must pay toward your medical expenses before your plan will pay for any nonpreventive services.

**What is Coinsurance?** Coinsurance is your share of the cost for a covered service, calculated as a percentage of the allowed amount for the service. You pay coinsurance after you've met your deductible.

**What is an Out-of-Pocket (OOP) Maximum?** The OOP maximum is the most you will pay for eligible medical services and prescription drugs in a plan year. Once you meet your OOP maximum, the plan will pay 100% of eligible services. Coinsurance, copayments and deductibles all apply toward your out-of-pocket maximum.

# Member and Dependent Monthly Contributions

## Full-time Employee Monthly Health Plan Contributions\*

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. 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 Amounts	
\$30,200 & below	Managed Care: \$68	Quality Care: \$93
\$30,201 - \$45,600	Managed Care: \$86	Quality Care: \$111
\$45,601 - \$60,700	Managed Care: \$103	Quality Care: \$127
\$60,701 - \$75,900	Managed Care: \$119	Quality Care: \$144
\$75,901 - \$100,000	Managed Care: \$137	Quality Care: \$162
\$100,001 & above	Managed Care: \$186	Quality Care: \$211

## Dependent Monthly Health Plan Contributions\*

The monthly dependent contribution is in **addition** to the member health plan contribution. Dependents must 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.

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
BlueAdvantage HMO (Code: CI)	\$ 96	\$132	\$ 75	\$110
Coventry HMO (Code: AS)	\$111	\$156	\$ 88	\$130
Coventry OAP (Code: CH)	\$111	\$156	\$ 88	\$130
Health Alliance HMO (Code: AH)	\$113	\$159	\$ 89	\$133
HealthLink OAP (Code: CF)	\$126	\$179	\$102	\$149
HMO Illinois (Code: BY)	\$100	\$139	\$ 79	\$116
Quality Care Health Plan (Code: D3)	\$249	\$287	\$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
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\* Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see the Benefits website for more information).

# Member and Dependent Monthly Contributions

## Retiree, Annuitant and Survivor Monthly Health Plan Contributions

20 years or more of creditable service	\$0.00
Less than 20 years of creditable service and, <ul style="list-style-type: none"> <li>• SERS/SURS annuitant/survivor on or after 1/1/98, or</li> <li>• TRS annuitant/survivor on or after 7/1/99</li> </ul>	Five percent (5%) of the costs of the basic program of group health benefits for each year of service less than 20 years.

Call the appropriate retirement system for applicable premiums.  
**SERS:** (217) 785-7444; **SURS:** (800) 275-7877; **TRS:** (800) 877-7896

## Monthly Life Plan Contributions

Optional Term Life Rate	
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	1.28
Ages 70 and above	2.06

Spouse Life Monthly Rate	
Spouse Life \$10,000 coverage (Annuitants under age 60 and Employees)	6.00
Spouse Life \$5,000 coverage (Annuitants age 60 and older)	3.00

AD&D Monthly Rate Per \$1,000	
Accidental Death & Dismemberment	0.02

Child Life Monthly Rate	
Child Life \$10,000 coverage	0.70

## Special Notice Regarding 2017 Plan Year Rates


The premium levels listed in this benefits flyer are for FY 2016 (July 1, 2015 – June 30, 2016). Personnel should be aware that these premiums may be subject to an increase, pending the outcome of an ongoing legal dispute between the State and AFSCME and that this premium increase may be applied retroactively to July 1, 2016. In other words, once the legal dispute is resolved, a higher premium likely will apply – not only going forward, but also for the period from July 1, 2016, to the date of the increase. For bargaining unit employees, your Union has the full details regarding the State's proposal. Unless another manner of retroactive payment of the premiums owed is negotiated with your Union, the increased premium difference owed for the period from July 1, 2016, through the date of the increase will be deducted on a pro rata basis out of the paychecks remaining in the fiscal year. This means that there will be two deductions for health insurance from an employee's paycheck once the increase has been set: one deduction at the new rate and a second deduction to make up what is owed for the prior period (i.e., the difference between the prior rate and the new rate). By electing coverage under this group health plan, an employee is consenting to all such payroll deductions. Employees represented by unions that have already ratified their agreements will not have any premium increases applied retroactively. Those employees represented by unions that have not yet ratified agreements should contact their union representatives to determine whether such increases may be applied retroactively.


# Map of Health Plans by Illinois County


July 1, 2016 through June 30, 2017

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


BlueAdvantage HMO . . . . CI  
 Coventry HMO . . . . . AS  
 Coventry OAP . . . . . CH  
 Health Alliance HMO . . . . AH  
 HealthLink OAP . . . . . CF  
 HMO Illinois . . . . . BY  
 Quality Care Health Plan (QCHP) . . . . . D3

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

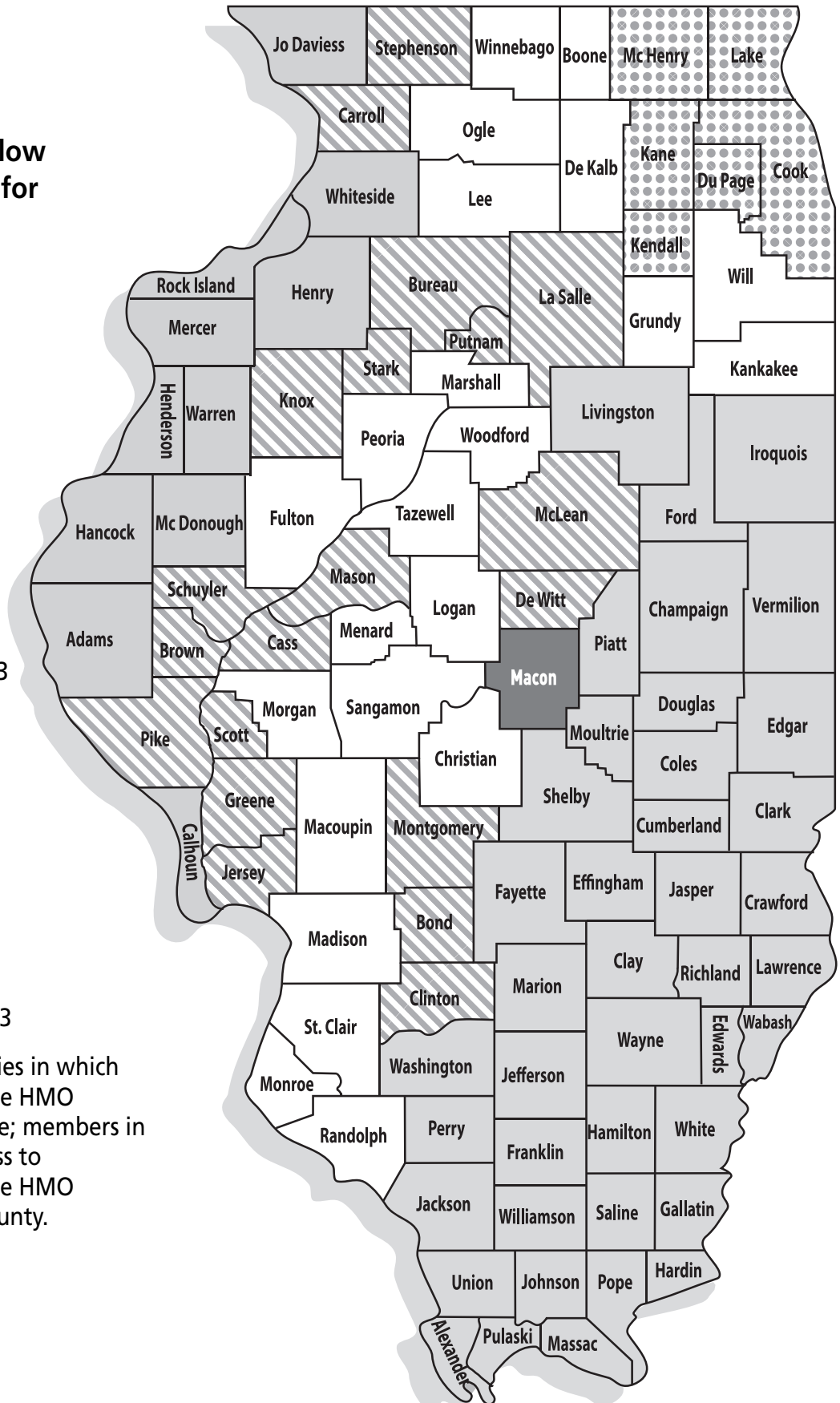
 BY, CF, CH, CI, D3

 AH, AS, CF, CH, D3

 AH, AS, CF, CH, CI, D3

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

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



# Federally Required Notices

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## Notice of Creditable Coverage

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

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

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

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

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

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

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

## Notice of Privacy Practices

The Notice of Privacy Practices were updated on the Benefits website effective July 1, 2015. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

# **Benefit Choice is May 1 - May 31, 2016**

**Benefit Choice Forms must be submitted to  
your Group Insurance Representative (GIR)  
no later than Tuesday, May 31st!**

**If you do not want to change your coverage,  
you do not need to submit a form.**

It is each member's responsibility to know their plan benefits and  
make an informed decision regarding coverage elections. The  
complete Benefit Choice Options booklet and Benefit Choice form  
can be found on the Benefits website at [www.benefitchoice.il.gov](http://www.benefitchoice.il.gov)

Go to the 'Latest News' section of the Benefits website at

[www.benefitchoice.il.gov](http://www.benefitchoice.il.gov)

for group insurance updates throughout the plan year.