

Benefit Choice Period: May 1 - May 31, 2018

The Benefit Choice Period will be May 1 through May 31, 2018 for eligible members. Members are employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), COBRA participants, annuitants and survivors not enrolled in the Medicare Advantage TRAIL Prescription Drug Program. Elections will be effective July 1, 2018.

For more information on your benefit options, go to MyBenefits.illinois.gov.

ONLINE ENROLLMENT PLATFORM

Making benefit elections is simple through the MyBenefits website. Follow these steps to register.

1. Log on to MyBenefits.illinois.gov.
2. In the top right corner of the home page, click **Login**.
3. Enter your login ID and password. If you are logging in for the first time, click Register in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice Period materials mailed to your home.
4. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles or using the decision support tool.
5. After exploring your benefit options and determining which benefits you would like to elect, follow the prompts on the welcome page.

Consider Going Paperless! Provide your email address on the MyBenefits website to receive quick responses and notifications through electronic communications.

Contact MyBenefits Service Center (toll-free) 844-251-1777 or 844-251-1778 (TDD/TTY) with questions about navigating the MyBenefits website, or how to elect benefits. Representatives are available Monday – Friday, 8:00 AM – 6:00 PM CT.

What is Changing

Medical Care Assistance Plan (MCAP)

The MCAP maximum contribution amount will be \$2,650 for the FY19 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.

Life Insurance

Basic life insurance continues to be provided at no cost to all active members and annuitants. However, Member Optional Life insurance rates will be decreasing. Now is the the time to reevaluate your life insurance coverage. See page 6 for additional details.

What is Not Changing

The MyBenefits online enrollment platform, launched last year, will continue to be of service to all of our members. A simplified plan comparison and election process is provided through online enrollment at MyBenefits.illinois.gov or by calling the MyBenefits Service Center (toll-free) 844-251-1777.

Premiums

Employee and dependent premiums will remain the same for this Benefit Choice Period.

Plan Administrators

Plan administrators will remain the same for all plans including health, dental, vision, behavioral health, prescription drugs, Flexible Spending Accounts, and life insurance.

Health Plan Options

There will be no changes to your health plan options this Benefit Choice Period. **If you wish to keep your coverage, no action is needed unless you intend to enroll or re-enroll in a Flexible Spending Account.** If you wish to change your plan, carrier, or re-enroll in a Flexible Spending Account, go online at MyBenefits.illinois.gov.

DISCLAIMER

The health plan options outlined in this Benefit Choice book are subject to change pending final resolution of the collective bargaining process and litigation arising from that process. If that process results in significant changes in plan designs, benefit levels, or premiums, a second Benefit Choice Period may be held for any members impacted by such changes. If a second Benefit Choice Period is held, members will have the opportunity to change plans at that time with updated information. For the latest information, please continue to visit MyBenefits.illinois.gov and Benefitschoice.il.gov.

Members may make the following changes during the Benefit Choice Period on the MyBenefits website:

The Benefit Choice Period is May 1 through May 31, 2018 for all eligible members, with your elections becoming effective July 1, 2018.

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

- Change health plans.
- Add or drop dependent coverage.
- Elect to waive health, dental, vision, and prescription coverage (part-time employees 50% or greater, retirees, annuitants, and survivors).
- Re-enroll in the Program if coverage is currently terminated due to nonpayment of a premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums must be paid before coverage will be reinstated. Contact the Premium Collection Unit to discuss your options at 217-558-4783.
- Enroll or re-enroll in a Flexible Spending Account like MCAP and/or DCAP. **Employees must enroll each year; previous enrollment in the program does not continue into the new plan year.**

Go to the MyBenefits website 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 Evidence of Insurability (EOI) is required to add or increase Member Optional Life coverage or to add Spouse 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 the MyBenefits website or MyBenefits Service Center at the following address no later than June 11. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan. Note: Any documentation received after May 31, 2018, may result in a delay of ID cards.

MyBenefits Service Center, 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

The State of Illinois offers retirees, annuitants and survivors a healthcare program referred to as the TRAIL. This program provides eligible members and their covered dependents comprehensive medical and prescription drug coverage through State-sponsored Medicare Advantage Prescription Drug Plans. In order to be eligible for the TRAIL MAPD program, a member (and all covered dependents) must be enrolled in Medicare Parts A and B and be a resident of the United States (or a US territory). The Department of Central Management Services (CMS) will notify all eligible members by mail prior to the start of the TRAIL Open Enrollment Period this fall. The TRAIL Open Enrollment Period runs from the middle of October through the middle of November each year. All elections made during the TRAIL Open Enrollment Period will be effective January 1st. **All newly eligible members must enroll** into a State-sponsored TRAIL plan or opt out of State insurance coverage during the fall open enrollment period. Members already enrolled in a TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes.



For more information regarding the Medicare Advantage 'TRAIL' Program, go to MyBenefits.illinois.gov or contact the State of Illinois Medicare COB Unit, PO Box 19208, Springfield, Illinois 62794-9208, Fax: 217-557-3973.

Your Health Plan Options

The State of Illinois offers comprehensive health plan options, all of which include prescription drug, behavioral health, and vision coverage.

Consider your health needs as you select between QCHP, HMO, and OAP plans.

- Quality Care Health Plan (QCHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP in-network provider. QCHP has a nationwide network of providers through Aetna for medical services, CVS/caremark for prescription drug benefits, and Magellan Health Services for behavioral health services.
- Health Maintenance Organizations (HMO) members are required to stay within the health plan provider network. No out-of-network services are available. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization.

- Open Access Plans (OAP) members will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted.
 - Tier I offers a managed care network which provides enhanced benefits and operates similar to an HMO.
 - Tier II offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
 - Tier III covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involves higher out-of-pocket costs. Furthermore, members who use out-of-network providers will be responsible for any amount that is more than the charges allowed by the plan for services (allowable charges), which could result in substantial out-of-pocket costs.

Members enrolled in an OAP can mix and match providers and tiers.

Additional health plan or prescription drug information can be viewed and compared online through the MyBenefits website at MyBenefits.illinois.gov. Click the Health Plan tile on the home page.

HMO Administrators	OAP Administrators	QCHP Administrators
<ul style="list-style-type: none">• Aetna HMO• BlueAdvantage HMO• Health Alliance HMO• HMO Illinois	<ul style="list-style-type: none">• Aetna OAP• HealthLink OAP• <i>Prescription Drug Coverage through CVS/caremark</i>	<ul style="list-style-type: none">• Quality Care Health Plan (Aetna)• <i>Prescription Drug Coverage through CVS/caremark</i>• <i>Behavioral Health Services through Magellan Health Services</i>

Benefits are outlined in the plan's Summary Plan Document (SPD) located on the providers' websites. It is the member's responsibility to know and follow the specific requirements of the plan. Contact the plan administrator for a copy of the SPD.

State Employees Group Insurance Program Medicare Requirements

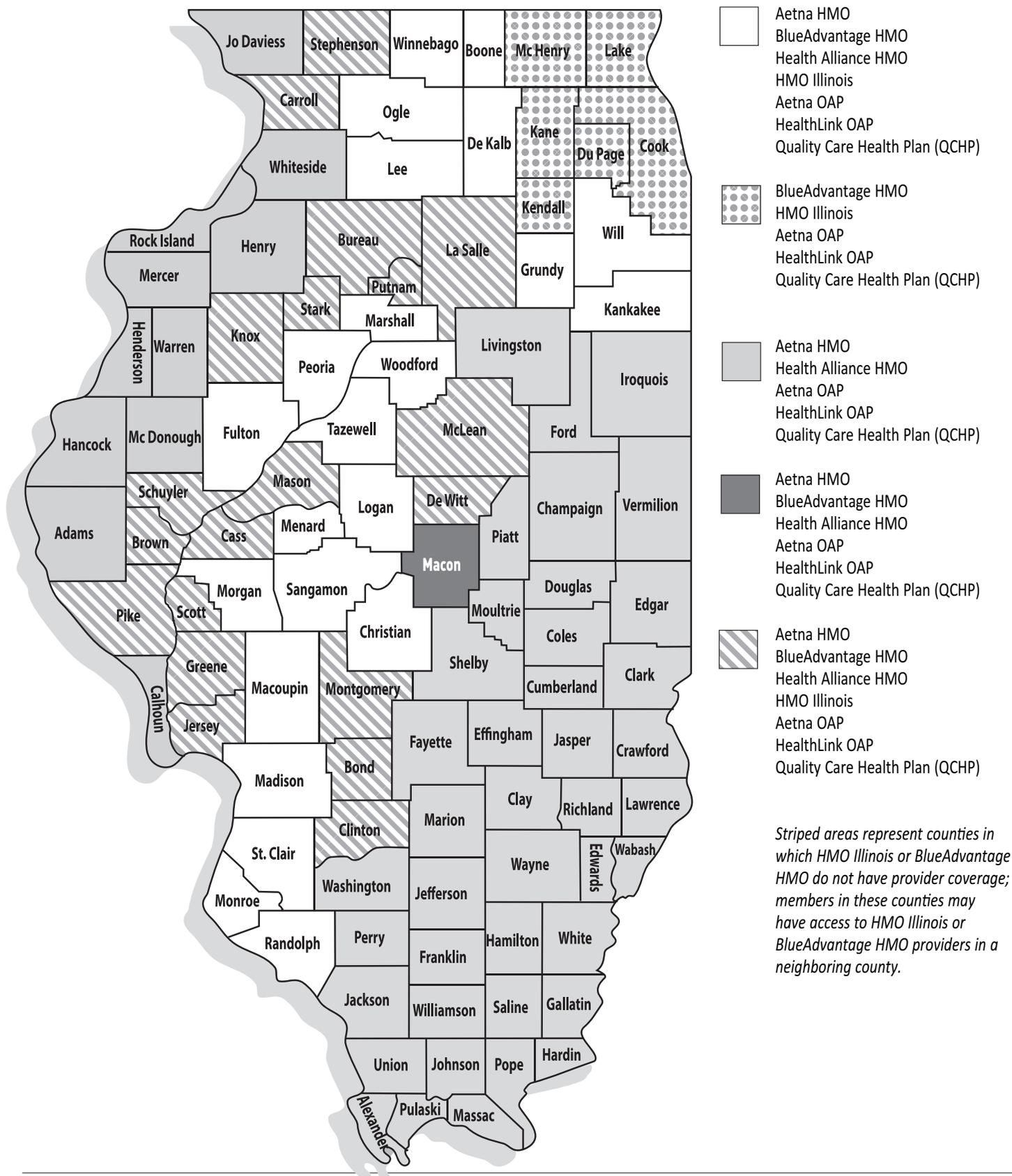
Each member and dependent must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that the member and/or dependent is eligible for Medicare Part A at a premium-free rate, the member and/or dependent is required by the State to enroll in Medicare Part A. Retirees and survivors, as well as employees without current employment status (on a disability leave of absence), must also enroll in Medicare Part B, if eligible. Once enrolled in Medicare, the member and/or dependent is required to send a

front side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a member 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 member must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty.

What is Available in Your Area in FY19

Review the following map and charts to compare plans. Then, review your monthly contribution and out-of-pocket maximums to determine which plan is best for you.



Monthly Contributions

The State shares the cost of health coverage with you. While the State covers the majority of the cost, you must make monthly contributions determined by your annual salary. The following chart outlines monthly contribution rates for full-time members. Note that part-time members are required to pay a percentage of the State's portion of the monthly contribution in addition to their own.

Employee Annual Salary	Employee Monthly Health Plan Contribution Amounts	
	Managed Care	Quality Care
\$30,200 & below	\$68	\$93
\$30,201 - \$45,600	\$86	\$111
\$45,601 - \$60,700	\$103	\$127
\$60,701 - \$75,900	\$119	\$144
\$75,901 - \$100,000	\$137	\$162
\$100,001 & above	\$186	\$211

Members who retire, accept a 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 members who return to work after having a 10-day or greater break in State service after terminating employment. This does not apply to members who have a break in coverage due to a leave of absence.

Dependent Monthly Health Plan Contributions

In addition to monthly contributions for their own health coverage, members must make additional monthly contributions for dependents they cover. Dependents must be enrolled in the same plan as the member. The Medicare dependent monthly contribution applies only if Medicare is primary for both Parts A and B.

Health Plan Name and Code	1 Dependent	2+ Dependents	1 Medicare A and B Primary Dependent	2+ Medicare A and B Primary Dependents
Aetna HMO	\$111	\$156	\$ 88	\$130
Aetna OAP	\$111	\$156	\$ 88	\$130
BlueAdvantage HMO	\$ 96	\$132	\$ 75	\$110
Health Alliance HMO	\$113	\$159	\$ 89	\$133
HealthLink OAP	\$126	\$179	\$102	\$149
HMO Illinois	\$100	\$139	\$ 79	\$116
Quality Care Health Plan (Aetna)	\$249	\$287	\$142	\$203

Adding a Dependent

If you add a dependent for the first time this year, you must provide the required documentation to complete enrollment, no later than June 11, 2018. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan. Note: Any documentation received after May 31, 2018, may result in a delay of ID cards.

Retiree, Annuitant and Survivor Monthly Health Plan Contributions

20 years or more of creditable service

\$0

Less than 20 years of creditable service and SERS/ SURS annuitant/survivor on or after 1/1/98 or TRS annuitant/survivor on or after 7/1/99.

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: 877-927-5877

DISCLAIMER

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY19. For future years, the State reserves the right to designate the plan options which constitute the basic program of health benefits and to require additional contributions in accordance with the law for any optional coverage elected by an annuitant, retiree, or survivor.

Dental

The State's Quality Care Dental Plan (QCDP) offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits on the MyBenefits website.

Member Monthly Quality Care Dental Plan (QCDP) Contributions*

Member Only	Member + 1 Dependent	Member + 2 or More Dependents
\$11	\$17	\$19.50

* 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 MyBenefits.illinois.gov for more information).

Life

Basic Life Insurance is provided at no cost to all active members, retirees and annuitants. Active employees receive an amount equal to their annual salary. Retirees and annuitants under age 60 receive an amount equal to their annual salary on their last day of active employment. Retirees and annuitants age 60 or older receive a \$5,000 benefit.

Optional Term Life Rate	
Member Age	Monthly Rate Per \$1,000
Under 30	\$0.02
30 – 39	\$0.06
40 – 49	\$0.08
50 – 54	\$0.16
55 – 59	\$0.36
60 – 64	\$0.62
65 – 69	\$1.22
70 and above	\$2.02

Spouse Life Monthly Rates

Spouse Life \$10,000 Coverage (Members, retirees and annuitants under age 60)	\$6.00
Spouse Life \$5,000 Coverage (Retirees and annuitants age 60 and older)	\$3.00

Child Life Monthly Rate

Child Life \$10,000 Coverage	\$0.70
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AD&D Monthly Rate Per \$1,000

\$0.02

Vision

Vision coverage is provided at no cost to all members enrolled in a State health plan. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for State of Illinois Medicare-eligible Plan Participants

This Notice confirms that the State Employees Group Insurance Program (SEGIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through SEGIP 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.

Because your existing coverage is 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 coverage through SEGIP 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 SEGIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your SEGIP coverage ends.

If you keep your existing group coverage through SEGIP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a Benefits Confirmation Statement as a Notice of Creditable Coverage by contacting the MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY).

Summary of Benefits and Coverage (SBC) and 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 summary 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 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 SBCs, along with the glossary, are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated on the MyBenefits website, effective July 1, 2018. 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 by the 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 MyBenefits.illinois.gov.



STATE OF ILLINOIS
Department of Central
Management Services
Bureau of Benefits

MARK YOUR CALENDAR: MAY 1-31, 2018

Benefit Choice Period

State Employees Group Insurance Program

Discover Your Options

Printed on Recycled Paper



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Department of Central Management Services
Bureau of Benefits