



STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

Benefit Choice

Discover Your Options

Many Changes
and NEW Options
INSIDE!

Benefit Choice Period • May 1-June 1, 2020
State Employees Group Insurance Program
Effective July 1, 2020



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ONLINE ENROLLMENT PLATFORM

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

1. Go to **MyBenefits.illinois.gov**.
2. In the top right corner of the home page, click **Login**.
3. 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 materials mailed to your home.
4. Enter your login ID and password. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles.
5. After exploring your benefit options and determining which benefits you would like to elect, click on the Benefit Choice Event, located on the Welcome page.

Need Help?

AVA, the interactive digital assistant, is available online at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov)

Or

Contact [MyBenefits Service Center](https://mybenefits.illinois.gov) (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY) with inquiries. Representatives are available Monday – Friday, 8:00 AM - 6:00 PM CT.

WHAT YOU NEED TO DO

1. Go to **MyBenefits.illinois.gov** to review your benefit options.
2. Choose the benefits you'd like to elect at **MyBenefits.illinois.gov** between May 1-June 1, 2020.
3. Consider going paperless. Provide, or update your email address at **MyBenefits.illinois.gov** to receive quick responses and notifications through electronic communications.
4. Take advantage of your new benefits which will become effective July 1, 2020.

Note: If you are not currently enrolled in benefits due to previous nonpayment of premiums, contact the Premium Collection Unit to discuss your enrollment options 217-558-4783.

DISCLAIMER

Monthly health insurance contributions are based on your March 1st salary, or initial salary for new hires. Your monthly contribution amount reflected within this site is based on the salary reported on your paycheck for the first pay period in March, and will be adjusted as necessary, if updated information is provided.

Benefit Choice Period

Elect Your Benefits May 1-June 1, 2020!



TAKE ACTION! Here is a quick view of benefit changes for the coming plan year. If you wish to keep your current coverage, no action is needed unless you intend to enroll or re-enroll in a Flexible Spending Account.

What's New

The following Benefit Changes effective July 1, 2020

Premium Changes (See page 3)

Contribution amounts will vary based on the member's March 1 salary, and the chosen health plan.

Consumer Driven Health Plan (CDHP) and Health Savings Account (HSA) for Active Employees Only (See page 9)

For FY21 Benefit Choice Open Enrollment period, a new high deductible health plan, known as the Consumer Driven Health Plan (CDHP) is available for active employees only, under the State Employees' Group Insurance Program. This plan is not available to retirees.

In addition to the implementation of the CDHP, the State is introducing the companion Health Savings Account (HSA). Employees choosing to enroll in the CDHP and an HSA, will receive a State contribution of one-third of the deductible into their HSA account (\$500 individual or \$1000 family). Employees may only enroll in an HSA when choosing the CDHP.

Telemedicine

You will now have telemedicine available to you under your HMO and OAP health plans for a reduced copayment. QCHP and CDHP enrollees will receive the benefit at the same coinsurance level; however, due to the reduction in the cost of the visit, you as the member, will experience significant savings.

Telemedicine provides quick access to a doctor over the phone, email or video call and can often eliminate visits to your primary care physician (PCP), urgent care center, or ER and the high costs associated with those visits. And, no waiting for an appointment in a room full of other sick people. When appropriate, the consulting doctor can prescribe a medication and send the prescription to the member's preferred pharmacy. Telemedicine coverage includes both General Practitioners and Behavioral Health providers. Your plan can provide you with additional information regarding this benefit.

Pharmacy

- **Maintenance Choice:** The Maintenance Choice tier is available to those members covered under an OAP, QCHP or CDHP. This tier allows members to obtain specific medications in a 90-day supply from a CVS Caremark® pharmacy or through the CVS Caremark® Mail Service Pharmacy for half of the copayment. Please contact CVS Caremark® to determine if your medication is available under this benefit.
- **Reduced Tier 1:** The Reduced Tier 1 pharmacy benefit is available through an HMO carrier. This tier allows members to obtain specific medications in either a 30- or 90-day supply for a reduction of the normal tier 1 applicable co-payment. Please contact your HMO to determine if your medication is available under this benefit.

Medical Care Assistance Plan (MCAP)

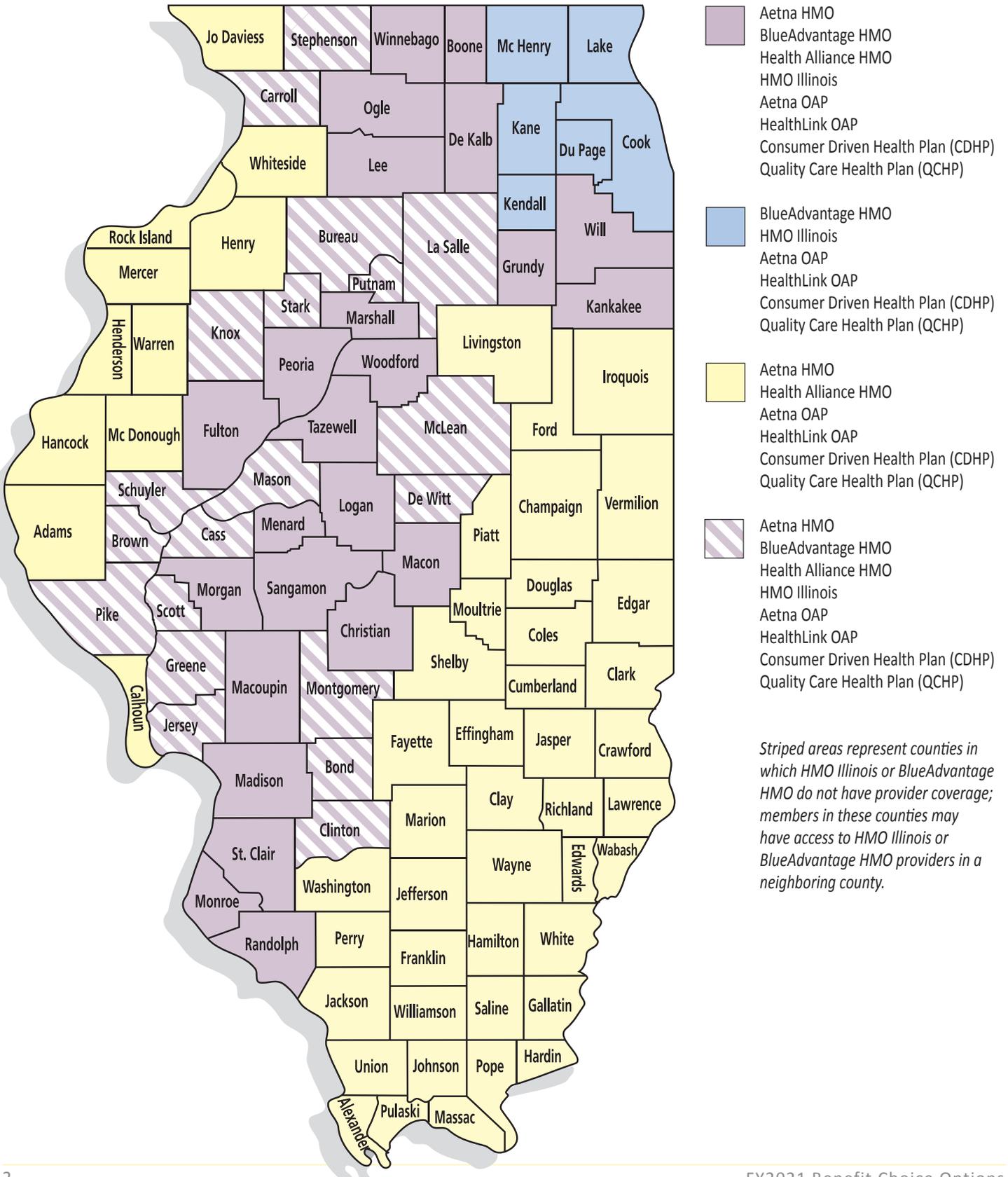
The MCAP maximum contribution amount will be \$2,750 for the FY21 plan year with a \$500 maximum rollover. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover. *You must enroll or re-enroll in a Flexible Spending Account each plan year. The MCAP benefit is not available if enrolling in an HSA.*

Hearing Instruments and related services

Beginning July 1, 2020, a \$2,500 benefit for hearing instruments and related services every 24 months is available through all plans when a hearing care professional prescribes a hearing instrument. Contact plan for additional details.

What is Available in Your Area in FY21

Review the following map and charts to identify plans available in your county. Then, review your monthly contribution and plan benefits 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 charts outline monthly contribution rates for full-time members. Part-time members are required to pay a percentage of the State's portion of the monthly contribution in addition to their own. Special rules apply for non-IRS dependents (see MyBenefits.illinois.gov for more information).

Employee Annual Salary	Aetna HMO	Blue Advantage HMO	Health Alliance HMO	HMO Illinois	Aetna OAP	HealthLink OAP	Consumer Driven Health Plan	Quality Care Health Plan
\$0 to \$30,200	\$ 95	\$ 74	\$ 95	\$ 77	\$ 90	\$101	\$ 75	\$107
\$30,201 - \$45,600	\$114	\$ 93	\$114	\$ 96	\$109	\$120	\$ 94	\$126
\$45,601 - \$60,700	\$133	\$112	\$133	\$115	\$128	\$139	\$113	\$144
\$60,701 - \$75,900	\$150	\$129	\$150	\$132	\$145	\$156	\$130	\$162
\$75,901 - \$100,000	\$169	\$148	\$169	\$151	\$164	\$175	\$149	\$181
\$100,001 - \$125,000	\$222	\$201	\$222	\$204	\$217	\$228	\$202	\$234
\$125,001 & Over	\$254	\$233	\$254	\$236	\$249	\$260	\$234	\$266

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.

Number of Dependents	Aetna HMO	Blue Advantage HMO	Health Alliance HMO	HMO Illinois	Aetna OAP	HealthLink OAP	Consumer Driven Health Plan	Quality Care Health Plan
1 Dependent	\$158	\$125	\$158	\$129	\$151	\$164	\$135	\$252
2+ Dependents	\$203	\$161	\$204	\$168	\$196	\$217	\$179	\$290
1 Medicare A & B Primary Dependent	\$135	\$104	\$134	\$108	\$128	\$140	\$112	\$145
2+ Medicare A & B Primary Dependents	\$177	\$139	\$178	\$145	\$170	\$187	\$153	\$206

DISCLAIMER

The above listed premiums are comprehensive of increases to health insurance premium contributions for Members and Dependents to be effective January 1, 2020 which were deferred, and increases scheduled to go into effect on July 1, 2020.

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY21. 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.

Adding a Dependent

If you add a dependent for the first time, or re-enroll a dependent previously terminated due to the Dependent Eligibility Verification Audit during open enrollment, you must provide the required documentation to complete enrollment no later than June 10, 2020. Failure to provide adequate documentation by this deadline, will result in dependents not being added to your plan. Note: Any documentation received after June 1, 2020, may result in a delay of ID cards.

Opt-Out

Full-time employees, retirees, annuitants, and survivors have the option to opt-out of health coverage if they have other comprehensive coverage provided by an entity other than the Department of Central Management Services. Proof of other coverage and appropriate documentation must be submitted by June 10, 2020 for changes effective July 1, 2020. Be advised that if you have previously opted-out, or waived benefits, you can re-enroll during the Benefit Choice Period or if you experience a Qualifying Change in Status.

Qualifying Changes in Status

After the Benefit Choice Period ends, you will only be able to change your benefits if you have a qualifying change in status.

You must report a qualifying change in status and provide the required documentation to [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) within 60 days of the event. To report a leave of absence, unpaid time away from work, a financial or medical power of attorney, or address change, please contact your Group Insurance Representative (GIR).

Transition of Care after Health Plan Change

Members and their dependents who elect to change health plans and are then hospitalized prior to July 1 and discharged on or after July 1, are involved in an ongoing course of treatment, or have entered the third trimester of pregnancy, should contact their new plan administrator before July 1 to coordinate the transition of services.



HMO Benefits

Health Maintenance Organization (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. 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. For a copy of the SPD, contact the plan administrator (see page 15).

HMO Plan Design

Plan Year Out-of-Pocket Maximum	\$3,000 Individual	\$6,000 Family
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Hospital Services

	In-Network	Out-of-Network
Emergency Room Services	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$375 copayment per admission	Not covered
Inpatient Alcohol and Substance Abuse	\$375 copayment per admission	Not covered
Inpatient Psychiatric Admission	\$375 copayment per admission	Not covered
Outpatient Surgery	\$275 copayment per visit	Not covered
Skilled Nursing Facility	100% covered	Not covered
Diagnostic Lab and X-ray	100% covered	Not covered
Complex Imaging (CT/Pet Scans/MRIs)	\$25 copayment	Not covered

Transplant Services

Organ and Tissue Transplants	\$375 copay, limited to network transplant facilities as determined by the medical plan administrator. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.
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Professional and Other Services

	In-Network	Out-of-Network
Preventive Care/Well-Baby/Immunizations	100% covered	Not covered
Physician Office Visit	\$25 copayment per visit	Not covered
Specialist Office Visit	\$35 copayment per visit	Not covered
Telemedicine	\$10 copayment	Not covered
Outpatient Psychiatric and Substance Abuse	\$25 or \$35 copayment per visit	Not covered
Durable Medical Equipment	80% covered	Not covered
Home Health Care	\$35 copayment per visit	Not covered

Prescription Drugs

	Plan Year Pharmacy Deductible – \$125 per enrollee		Preventive Prescription Drugs – \$0	
	Reduced Tier I *	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$4.00	\$13.00	\$31.00	\$55.00
Copayments (90-day supply)	\$10.00	\$32.50	\$77.50	\$137.50

* Applies to specific medications as defined by plan.
Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

Open Access Plan (OAP) members will have three tiers of providers from which to choose to obtain services.

- **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).

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. For a copy of the SPD, contact the plan administrator (see page 15).

Benefit	Tier I	Tier II	Tier III (Out-of-Network)**
Plan Year Out-of-Pocket Maximum • Per Individual • Per Family	\$3,000 (includes eligible charges from Tier I and Tier II combined) \$6,000 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Plan Year Deductible (must be satisfied for all services)	\$0	\$275 per enrollee*	\$375 per enrollee*
Hospital Services (Percentages listed represent how much is covered by the plan)			
Emergency Room Services	\$275 copayment per visit	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$375 copayment per admission	90% of network charges after \$425 copayment per admission*	60% of allowable charges after \$525 copayment per admission*
Inpatient Alcohol and Substance Abuse	\$375 copayment per admission	90% of network charges after \$425 copayment per admission*	60% of allowable charges after \$525 copayment per admission*
Inpatient Psychiatric Admission	\$375 copayment per admission	90% of network charges after \$425 copayment per admission*	60% of allowable charges after \$525 copayment per admission*
Outpatient Surgery	\$275 copayment per visit	90% of network charges after \$275 copayment*	60% of allowable charges after \$275 copayment*
Skilled Nursing Facility	100% covered	90% of network charges*	Not covered
Diagnostic Lab and X-ray	100% covered	90% of network charges *	60% of allowable charges*
Complex Imaging (CT/Pet Scans/MRIs)	\$25 copay	90% of network charges*	60% of allowable charges*
Transplant Services			
Organ and Tissue Transplants	Tier I: 100% covered. Tier II: 90% of network charges. Tier III: Not covered. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.		
Professional and Other Services			
Preventive Care/Well-Baby /Immunizations	100% covered	100% covered	Not covered
Physician Office Visits	\$25 copayment	90% of network charges*	60% of allowable charges*
Specialist Office Visits	\$35 copayment	90% of network charges*	60% of allowable charges*
Telemedicine	\$10 copayment	Not covered	Not covered
Outpatient Psychiatric and Substance Abuse	\$25 or \$35 copayment	90% of network charges*	60% of allowable charges*
Durable Medical Equipment	80% of network charges	80% of network charges*	60% of allowable charges*
Home Health Care	\$35 copayment	90% of network charges*	Not covered
Prescription Drugs			
Plan Year Pharmacy Deductible – \$125 per enrollee		Preventive Prescription Drugs – \$0	
	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$13.00	\$31.00	\$55.00
Copayments (90-day supply)	\$32.50	\$77.50	\$137.50
Maintenance Choice (90-day supply)***	\$16.25	\$38.75	\$68.75

* A plan year deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region.

*** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Quality Care Health Plan (QCHP) Benefits

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 PPO. 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 QCHP. For a copy of the SPD, contact the plan administrator (see page 15).

Plan Year Maximums and Deductibles		
Employee's Annual Salary (based on each employee's annual salary as of March 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
\$60,700 or less	\$400	\$1,000
\$60,701 - \$75,900	\$500	\$1,250
\$75,901 and more	\$550	\$1,375
Retiree/Annuitant/Survivor	\$400	\$1,000
Dependents	\$400	N/A

Out-of-Pocket Maximum Limits			
In-Network Individual	In-Network Family	Out-of-Network Individual	Out-of-Network Family
\$1,625	\$4,063	\$6,500	\$12,750

Hospital Services (Percentages listed represent how much is covered by the plan)

	In-Network	Out-of-Network*
Emergency Room Services	\$450 per visit; Deductible applies	\$450 per visit; Deductible applies
Inpatient Hospitalization	85% of network charges; Deductible applies after \$150 per admission	60% of allowable charges; Deductible applies after \$600 per admission
Inpatient Alcohol and Substance Abuse	85% of network charges; Deductible applies after \$150 per admission	60% of allowable charges; Deductible applies after \$600 per admission
Inpatient Psychiatric Admission	85% of network charges; Deductible applies after \$150 per admission	60% of allowable charges; Deductible applies after \$600 per admission
Outpatient Surgery	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Skilled Nursing Facility	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies

Transplant Services

Organ and Tissue Transplants	85% after \$150 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services.
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Professional and Other Services

	In-Network	Out-of-Network*
Preventive Care/Well-Baby/Immunizations	100% covered	60% of allowable charges; Deductible applies
Physician Office Visit	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Specialist Office Visit	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Telemedicine (See page 1)	85% of network charges; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Durable Medical Equipment	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Home Health Care	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies

Prescription Drugs

	Plan Year Pharmacy Deductible – \$150 per enrollee		Preventive Prescription Drugs – \$0	
	Tier I	Tier II	Tier II	Tier III
Copayments (30-day supply)	\$15.00	\$35.00	\$35.00	\$65.00
Copayments (90-day supply)	\$37.50	\$87.50	\$87.50	\$162.50
Maintenance Choice (90-day supply)**	\$18.75	\$43.75	\$43.75	\$81.25

* Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region.

** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Consumer Driven Health Plan (CDHP) Benefits

This is a high-deductible health plan as defined by the IRS. Consumer Driven Health Plan (CDHP) 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 CDHP in-network provider. CDHP has a nationwide network of providers through Aetna PPO. 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 CDHP. For a copy of the SPD, contact the plan administrator (see page 15).

Plan Year Medical Deductibles			
In-Network Individual \$1,500	In-Network Family \$3,000	Out-of-Network Individual \$1,500	Out-of-Network Family \$3,000

Out-of-Pocket Maximum Limits			
In-Network Individual \$3,000	In-Network Family \$6,000	Out-of-Network Individual \$3,000	Out-of-Network Family \$6,000

Hospital Services (Percentages listed represent how much is covered by the plan)

	In-Network	Out-of-Network*
Emergency Room Services	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Inpatient Hospitalization	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Inpatient Alcohol and Substance Abuse	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Inpatient Psychiatric Admission	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Outpatient Surgery	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Skilled Nursing Facility	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies

Transplant Services

Organ and Tissue Transplants	90% after plan year deductible, limited to network transplant facilities as determined by the medical plan administrator. Not covered out-of-network. Benefits are not available unless approved by the Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services.
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Professional and Other Services

	In-Network	Out-of-Network*
Preventive Care/Well-Baby/Immunizations	100% covered	65% of allowable charges; Deductible applies
Preventive Services (IRS-allowed)**	90% of network charges; No Deductible	65% of allowable charges; Deductible applies
Physician Office Visit	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Specialist Office Visit	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Telemedicine (See page 1)	90% of network charges; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Durable Medical Equipment	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Home Health Care	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies

Prescription Drugs

Preventive Prescription Drugs – \$0	Preventive Prescription Drugs (IRS-allowed) ** - 90% covered; No Deductible		
	Tier I	Tier II	Tier III
Copayments (30-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Copayments (90-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Maintenance Choice (90-day supply)***	95%; Deductible Applies	95%; Deductible Applies	95%; Deductible Applies

* Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region.

** Contact Aetna for IRS-allowed services and prescriptions.

*** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Health Savings Accounts (HSA) for Active State Employees - Companion to CDHP Enrollment - ONLY

An HSA is like a 401(k) for healthcare, yet the HSA tax benefits are far greater. It is a tax-favored, interest bearing account that active State employees can use to pay for qualified medical expenses, now, or in the future. Active State employees who qualify (see Qualifying for an HSA below), can save or invest the account funds. Paired with the Consumer Driven Health Plan (CDHP), an HSA is a powerful financial tool that gives you more control of your healthcare decisions. An HSA offers triple tax savings.

- Pre-tax or tax deductible contributions
- Tax-free interest or investment earnings
- Tax-free distributions, when used for qualified medical expenses

The State will contribute a third of the deductible to an active State employees' HSA. You may also contribute an additional \$3,050 for individual; or \$6,100 for family, to your HSA through pre-tax payroll deductions or post-tax direct payment.

Active State employees can make tax-free withdrawals to pay for qualified medical expenses, for you and your eligible dependents. HSAs are portable. Unlike an FSA, there is no "use-it-or-lose it" rule with HSAs. Unused contributions remain in the account each year, earning tax-free interest. If the employee invests HSA funds, those funds remain in the investment account. HSAs offer the potential for long-term, tax-free savings that can be used for future healthcare expenses including; out-of-pocket expenses after retirement, Medicare and long-term care (LTC) premiums, up to IRS limits and certain LTC expenses. There are no income limitations.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must:

- Be covered under a high deductible health plan
- Have no other health coverage (except what is permitted under Other health coverage: https://www.irs.gov/publications/p969#en_US_2019_publink1000204039)
- Not be enrolled in Medicare. This includes Part A
- Can't be claimed as a dependent on someone else's tax return

Medical Care Assistance Program (MCAP) - Companion to your HMO, OAP, QCHP, or CDHP (if not enrolled in an HSA)

Save on eligible health, dental and vision expenses by setting aside pre-tax contributions per pay period for you and your eligible dependents. Expenses include doctor, dentist, glasses/contacts, or prescription drug copays, coinsurance, or other eligible out-of-pocket expenses. All active employees are eligible to enroll in MCAP during the Benefit Choice Period. MCAP is not available to retirees, annuitants, or anyone enrolled in an HSA. Participants will be provided a debit card at no cost. Documentation may be required to substantiate certain expenses paid with the debit card. The MCAP maximum contribution limit is \$2,750 for the FY21 plan year with a \$500 maximum rollover. Participants who do not re-enroll for the new plan year will forfeit any amount eligible for rollover.

Dependent Care (Day Care) Assistance Program (DCAP)

DCAP is an account that allows you to set aside pre-tax contributions per pay period to pay for dependent care (Day Care) expenses, for children age 12 and under, or care for a physically or mentally disabled dependent. DCAP cannot be used for dependent medical expenses or for children for which you are not considered the primary or custodial parent.

You must re-enroll every year to continue participating. Remember that your FSA elections do not carry over from year-to-year. Re-enroll by logging on to [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) and completing the enrollment process by June 1, 2020.

You have until September 30 to submit claims for services incurred from July 1 through June 30; otherwise, any money left in your account will be forfeited, with the exception of the \$500 MCAP maximum rollover.

You cannot be enrolled in both an HSA and the MCAP Flexible Spending Accounts.

Vision

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

Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	\$30 copayment	\$30 allowance	Once every 12 months
Standard Frames	\$30 copayment (up to \$175 retail frame cost; member responsible for balance over \$175)	\$70 allowance	Once every 24 months
Vision Lenses* (single, bifocal and trifocal)	\$30 copayment	\$50 allowance for single vision lenses \$80 allowance for bifocal and trifocal lenses	Once every 12 months
Contact Lenses (All contact lenses are in lieu of vision lenses)	\$120 allowance	\$120 allowance	Once every 12 months

* Vision Lenses: Member pays all optional lens enhancement charges. In-network providers may offer additional discounts on lens enhancements and multiple pair purchase.

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

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 at MyBenefits.illinois.gov.

The dental plan has a plan year deductible. Once the deductible has been met, each member is subject to a combined maximum dental benefit, including orthodontia,* for both in-network and out-of-network providers.

Deductible and Plan Year Maximum

Plan year deductible for preventive services	N/A
Plan year deductible for all other covered services	\$175
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
In-network plan year maximum benefit	\$2,500
Out-of-network plan year maximum benefit	\$2,000

It is strongly recommended that plan members obtain a pretreatment estimate through Delta Dental for any service more than \$200. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.

Child Orthodontia Benefit

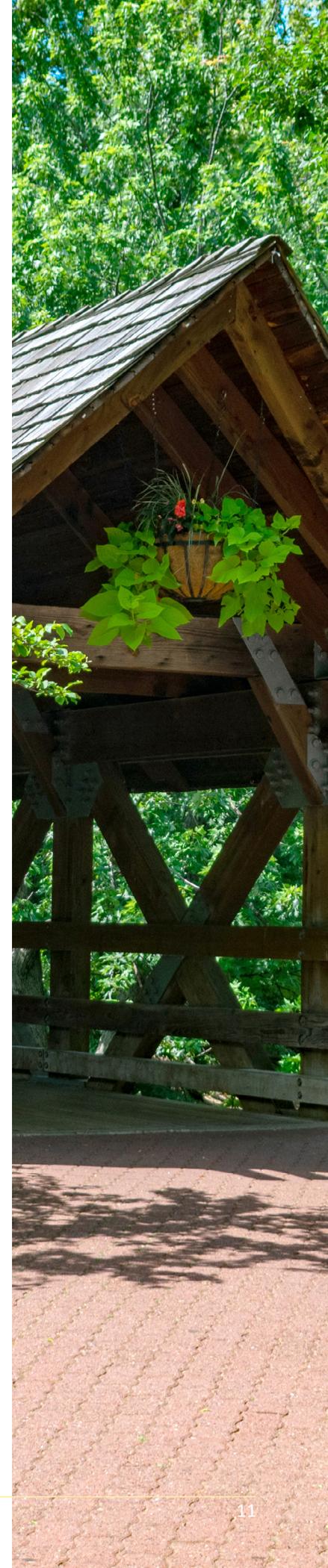
Length of Orthodontia Treatment	Maximum Benefit	
	In-Network	Out-of-Network
0 - 36 Months	\$2,000	\$1,500
0 - 18 Months	\$1,820	\$1,364
0 - 12 Months	\$1,040	\$780

Member Monthly Quality Care Dental Plan (QCDP) Contributions**

Member Only	Member + 1 Dependent	Member + 2 or More Dependents
\$12	\$19	\$21.50

* Orthodontia Treatments must start prior to age 19.

** 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, administered by Securian Financial, 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.

BENEFICIARY ELECTIONS

Don't forget to elect your beneficiaries and make the appropriate updates when necessary to ensure that your Life Insurance benefit is paid out according to your wishes. Remember, you may also have death benefits through various state-sponsored programs, each having a separate beneficiary form, including Life Insurance, retirement benefits, and the Deferred Compensation Program.

Member Optional Life coverage is available to active members, retirees and annuitants under age 60 at 1-8 times their Basic Life amount. Member Optional Life coverage is available for retirees and annuitants age 60 or older, at 1-4 times their Basic Life amount. The maximum benefit allowed for Member Optional Life plus Basic Life is \$3,000,000. Rate changes due to age, go into effect the first pay period following the member's birthday.

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 older	\$2.02

Accidental Death & Dismemberment (AD&D) is available to eligible members in an amount equal to either their Basic Life amount or the combined amount of their Basic and Member Optional Life. This is subject to a total maximum of 5 times their Basic Life amount or \$3,000,000, whichever is less.

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

Spouse Life coverage is available in a lump-sum amount of \$10,000 for the spouse of active members, retirees and annuitants under age 60. The spouse of retirees or, annuitants age 60 and older is available in the amount of \$5,000.

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 coverage is available in a lump-sum amount of \$10,000 per child. The monthly contribution applies to all dependent children regardless of the number of children enrolled. Eligible children include children age 25 and under or, children in the disabled category.

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

Underwriting

An EOI (Evidence of Insurability) is required for members to add/increase optional life or to add Spouse Life. An EOI is not needed to add Child Life coverage or AD&D.

State Employees Group Insurance Program

Medicare Requirements

Retirees and survivors must apply for Medicare benefits upon turning age 65. If the SSA determines that the member and/or dependent is eligible for Medicare Part A and/or Part B, the member and/or dependent is required by the State to enroll in Medicare Parts A and B. Those on a disability leave are also required to apply for Medicare Part A and B. Those on a disability leave are also required to apply for Medicare Part A and B. Once enrolled in Medicare, the member and/or dependent is required to fax or email the front-side copy of the Medicare identification card to the State of Illinois Medicare COB Unit (contact information below).

If the SSA determines that a member and/or dependent is not eligible for premium-free Medicare Part A based on their own work history or the work history of a spouse (current, ex-spouse or deceased) at least 62 years of age, 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.

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

The State of Illinois offers retirees, annuitants 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. Coverage in your current plan will be terminated effective 12/31. Members already enrolled in a TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes.



For more information regarding the Medicare Advantage Prescription Drug 'TRAIL' Program, go to [MyBenefits.illinois.gov](https://mybenefits.illinois.gov), or contact:

**State of Illinois Medicare COB Unit
PO Box 19208
Springfield, Illinois 62794-9208
CMS.Ben.MedicareCOB@illinois.gov
Fax: 217-557-3973**



The Department of Central Management Services (CMS), cares about you and your health. That's why it's important that you Live Your Best Life today and everyday.

CMS and its partners offer many wellness programs, phone-apps and opportunities for you and your dependents to take advantage, free of charge.

WHAT YOU CAN DO

- 1. Get annual preventive checkups and health screenings.** Your health plan covers many preventive services at no cost to you.
- 2. Know your numbers.** Get biometric screenings from one of our many high stations located around the state conveniently situated in a state agency near you, or from your doctor during your annual physical. Biometric screenings are quick and easy tests that measure your blood pressure, pulse rate, blood glucose, total cholesterol, and body mass index.
- 3. Visit [CMS.HealthChallenge.illinois.gov](https://www.cms.healthchallenge.illinois.gov)** and check out the many phone-apps and opportunities for health and wellness fairs, and challenges.
- 4. Take a Health Risk Assessment (HRA)** through your health plan administrator's website – a confidential assessment with health-related questions that, once completed, suggests a personal action plan to improve your health. Results are most accurate when combined with a biometric screening.

Wellness

The State offers wellness programs to help members lead better, healthier, and more satisfying lives. The following programs focus on improving lifestyle choices, including eating healthier, being more physically active, ending tobacco use, managing stress, and avoiding, stabilizing, or improving chronic health problems. Check out the following programs and consider which may be right for you.

Disease Management

Disease Management Programs target and assist those identified as having certain risk factors for chronic conditions, like diabetes and cardiac health. If you have been identified as having risk factors and meet the appropriate medical criteria, you may be contacted by your health plan administrator to participate in one of these highly confidential programs.

Behavioral Health Services

The State recognizes that the whole health of their members encompasses more than physical health, and offers behavioral health services automatically to those enrolled in a State health plan.

If you are enrolled in QCHP or CDHP, contact Magellan Health (see page 15). If you are enrolled in an HMO or OAP health plan, contact your plan administrator.

Employee Assistance Program (EAP) & Personal Support Program (PSP)

The Employee Assistance Program (EAP) is a free, voluntary, and confidential service for all active State members and their dependents experiencing hardship in managing relationships, finances, work, education, or other life issues. Counselors are available to provide problem identification, counseling, and referral services, regardless of the medical plan chosen. For EAP services, contact Magellan Health (see page 15).

Note that the EAP is for active members not represented by the collective bargaining agreement between the State and AFSCME Council 31.

The Personal Support Program (PSP) is similar and parallel to the EAP program, however, PSP is for members within the bargaining unit, and is administered by AFSCME (see page 15 for contact information).

Smoking Cessation

Quit smoking with the help of the State's Smoking Cessation Program. Eligible members are entitled to receive up to a \$200 rebate every year, upon the completion of the program. Please note that many managed care plans offer smoking cessation programs separate from the department's Smoking Cessation Program. Employees who utilize a smoking cessation program through their managed care plan are not eligible for a Smoking Cessation Program benefit through the Department. Visit [MyBenefits.illinois.gov](https://www.mybenefits.illinois.gov) for additional information.

Weight-Loss

Members who utilize weight-loss programs may be eligible for up to a \$200 rebate, once every three plan years. Visit [MyBenefits.illinois.gov](https://www.mybenefits.illinois.gov) for additional information.



Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits – Morneau Shepell 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	MyBenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285654) Aetna OAP (Group Number 285650) Consumer Driven Health Plan (CDHP) - Aetna PPO (Group Number 285658) Quality Care Health Plan (QCHP) - Aetna PPO (Group Number 285658) Address for all Aetna Plans: PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06800) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
	Health Alliance Medical Plans (Group Number 000010) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/stateofillinois
	HealthLink OAP (Group Number 160000) PO Box 411580, St. Louis, MO 63134	800-624-2356 877-232-8388 (TDD/TTY)	healthlink.com/soi/learn-more
	HMO Illinois (Group Number H06800) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
Prescription Drug Plan	CVS Caremark® (for QCHP, CDHP, or OAP Plans) Group Numbers: (QCHP 1400SD3) (CDHP 1400SD9) (Aetna OAP 1400SCH) (HealthLink OAP 1400SCF) Paper Claims: CVS Caremark® PO Box 52136, Phoenix, AZ 85072-2136 Mail Order Rx: CVS Caremark® PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 TTY users, call 711	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20240) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Life Insurance	Securian Financial PO Box 64136, St Paul, MN 55164-9987	888-202-5525 800-526-0844 (TDD/TTY)	lifebenefits.com/Illinois
Flexible Spending Accounts (FSA)	ConnectYourCare PO Box 622317, Orlando, FL 32862-2317	888-469-3363 800-526-0844 (TDD/TTY) 443-681-4602 (fax)	connectyourcare.com
Health Savings Accounts (HSA)	PayFlex Systems USA, Inc. 10802 Farnam Drive, Suite 100 Omaha, NE 68154	888-678-8242	payflex.com
Commuter Savings Program (CSP)	Commuter Check Direct Claims Administrator 320 Nevada Street, Newton, MA 02460	888-235-9223 844-878-0594 (TDD/TTY)	commutercheckdirect.com
Behavioral Health	Magellan Healthcare, Inc. PO Box 2216, Maryland Heights, MO 63043	800-513-2611 (nationwide) 800-456-4006 (TDD/TTY)	magellanascend.com
Employee Assistance Program (EAP)	Magellan Healthcare, Inc.	866-659-3848 (nationwide) 800-456-4006 (TDD/TTY)	magellanascend.com
Personal Support Program (PSP – AFSCME EAP)	AFSCME Council 31	800-647-8776 (statewide) 800-526-0844 (TDD/TTY)	afscme31.org
State Employees' Retirement System	2101 South Veterans Parkway PO Box 19255, Springfield, IL 62794-9255	217-785-7444 866-321-7625 (TDD/TTY)	srs.illinois.gov
State Universities Retirement System	1901 Fox Drive, Champaign, IL 61825-2710	800-275-7877 800-526-0844 (TDD/TTY)	surs.org
Teachers' Retirement System (TRS)	2815 West Washington Street PO Box 19253, Springfield, IL 62794-9253	877-927-5877 (877-9-ASK-TRS) 866-326-0087 (TDD/TTY)	trsil.org
CMS Bureau of Benefits Group Insurance	PO Box 19208, Springfield, IL 62794-9208	800-442-1300 800-526-0844 (TDD/TTY)	benefitschoice.il.gov

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 paper copy of the SBCs and glossary of terms from your health insurance company or group health plan. All State health plan SBCs are available on [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

Notice of Privacy Practices

The Notice of Privacy Practices will be updated at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov), effective July 1, 2020. 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](https://mybenefits.illinois.gov).



Illinois Department of
Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208

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Due to these unprecedented times, we ask that you please check our website at **BenefitsChoice.il.gov** under the Latest News section for any updates or cancellations to the dates and times of these Benefit Choice Fairs.

Benefit Choice Fair Dates & Locations

The CMS-sponsored Benefit Choice Open Enrollment Fairs are currently scheduled in 15 locations throughout the State of Illinois, May 1-22, from 9:00 AM to 3:30 PM, and are open to all active and retired members not enrolled in an MAPD Plan. CMS representatives, as well as benefit vendors, available in that area, will be present at each location to answer questions. Presentations regarding benefit changes will be at 10:00 AM, 12:00 PM and 3:00 PM respectively.

May 1, 2020

Illinois State Library

300 S. 2nd Street
Springfield, IL

May 4, 2020

University of Illinois

1900 S. 1st Street
I-Hotel & Conference Center
Champaign, IL

May 5, 2020

Illinois State University

100 N University Street
Bone Student Center
Circus Room
Normal, IL

May 6, 2020

DHS-Shapiro

100 East Jeffrey Street
Staff Development Building
Kankakee, IL

May 7, 2020

DHS-Elgin MHC

750 S. State Street
Rehab Building #110
Elgin, IL

May 8, 2020

Bilandic Building

160 N. LaSalle Street
C500 & N502 & N505
Chicago, IL

May 11, 2020

DHS-ISD

125 Webster
Jacksonville, IL

May 12, 2020

Western Illinois University

1 University Circle
Heritage Room
University Union
Macomb, IL

May 13, 2020

Western Illinois University

3300 River Drive
Riverfront Hall
Moline, IL

May 14, 2020

Northern Illinois University

340 Carroll Ave.
Holmes Student Center
Sandburg Auditorium
DeKalb, IL

May 15, 2020

IDOT

401 Main Street
6th Floor, Becker Building
Peoria, IL

May 18, 2020

IDOT

1102 Eastport Plaza Drive
Collinsville, IL

May 19, 2020

Southern Illinois University

1255 Lincoln Drive
Student Center, 2nd Floor,
Ballroom A
Carbondale, IL

May 21, 2020

Eastern Illinois University

1644 7th Street
Grand Ballroom, MLK Jr Union
Charleston, IL

May 22, 2020

Department of Agriculture

801 E. Sangamon Avenue
Springfield, IL