

Benefit Choice is May 1 - May 31, 2013

**Benefit Choice Forms must be submitted to
your group insurance representative (GIR)
no later than Friday, May 31st!**

It is each member's responsibility to know 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.benefitschoice.il.gov**

Go to the 'Latest News' section of the Benefits website at
www.benefitschoice.il.gov
for group insurance updates throughout the plan year.

Message to Plan Members

Go to the Benefits website at
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, 2013**, for all members. Members include employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), annuitants, survivors and COBRA participants. **Elections will be effective July 1, 2013.**

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 GIR names and locations by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at www.benefitschoice.il.gov.

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

- Change health plans.
- Add or drop 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 (full-time employees (including those on leave of absence), annuitants and survivors only). **The election to opt out will terminate the health, dental, vision and prescription coverage for the member and any covered dependents** (see page 9 of the Benefit Choice Options booklet for details). **Note:** Members must provide proof of other comprehensive health coverage in order to opt out.
- 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 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.**

If you keep your existing State of Illinois group insurance coverage, it is **not** necessary to join a Medicare prescription drug plan this year. See the 'Federally Required Notices' page for more information.

Benefit Changes for Plan Year 2014

(Enrollment Period May 1 – May 31, 2013)

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 this flyer to be aware of the benefit changes for the upcoming plan year. **The Benefit Choice Period will be May 1 through May 31, 2013.** All elections will be effective July 1, 2013.

Managed Care Plan (HMO/OAP) Changes

- Health contributions have increased
- Dependent health contributions have increased
- Primary care physician (PCP) office visit copayments increased to \$18
- Specialist office visit and home health visit copayments increased to \$25
- Emergency room visit copayment increases to \$225
- Inpatient surgery copayment increases to \$325
- Outpatient surgery copayment increases to \$225
- Prescription deductible increases to \$75 per individual per plan year
- Prescription copayments for generic, preferred brand and nonpreferred brand will be \$8/\$26/\$50 respectively
- Mail-order prescription cost for a 90-day supply increases to 2.5 times the 30-day supply copayment amount

Quality Care Health Plan (QCHP) Changes

- Health contributions and plan year deductibles have increased
- Dependent health contributions have increased
- In-network, out-of-pocket maximum (individual) increases to \$1,500
- In-network, out-of-pocket maximum (family) increases to \$3,750
- Out-of-network, out-of-pocket maximum (individual) increases to \$6,000
- Out-of-network, out-of-pocket maximum (family) increases to \$12,000
- Coinsurance for out-of-network physicians is reduced from 70% to 60% (in-network coinsurance remains 90%)
- Emergency room visit copayment increases to \$425
- In-network hospital admission deductible increases to \$75
- Out-of-network hospital admission deductible increases to \$400
- Prescription deductible increases to \$100 per individual per plan year
- Prescription copayments for generic, preferred brand and nonpreferred brand will be \$10/\$30/\$60 respectively
- Mail-order prescription cost for a 90-day supply increases to 2.5 times the 30-day supply copayment amount

Quality Care Dental Plan (QCDP) Changes

- Dental deductible increases to \$150 per plan participant per plan year
- Out-of-network annual maximum benefit decreases to \$2,000
- Out-of-network lifetime maximum benefit decreases to \$1,500

Vision Changes

- Vision eye exams, lenses and standard frame copayments increase to \$20

What You Should Know for Plan Year 2014

- **Federal Healthcare Reform** As a result of the Patient Protection and Affordable Care Act, additional preventive services for women, including well-woman visits, contraception and breastfeeding support, will be paid at 100% beginning July 1, 2013. For a full list of preventive services that are paid at 100%, see the Benefits website or contact your plan administrator.
- **HMO Illinois and BlueAdvantage HMO Medical Group Code** Members and/or dependents enrolling in HMO Illinois or BlueAdvantage HMO must enter a 3-digit medical group code on the Benefit Choice Election Form. Medical group codes can be found on the provider directory page of the plan administrator's website. Members may call HMO Illinois or BlueAdvantage HMO for assistance.
- **Dependent Eligibility Verification Audit** In an effort to control costs and ensure enrollment files are accurate, the State of Illinois will be conducting a dependent eligibility verification audit during FY2014.

Members are reminded that dependents can be dropped from coverage without proof of a qualifying change in status and without penalty during the Benefit Choice Period. If, during the dependent eligibility verification audit, a member is found to be covering an ineligible dependent, they may be subject to a financial penalty, including but not limited to, repayment of all premiums the State made on behalf of the employee and/or the dependent, as well as expenses incurred by the Program.

Answers to common questions about the audit, as well as a list of documents required during the audit, will be available on the Benefits website once the audit begins.

- **Express Scripts/Medco Pharmacy Benefit Managers Merge** Express Scripts and Medco merged into one company in April 2012. The combined company is in the process of changing the name on all its communications to Express Scripts. Until the renaming process is complete, you will sometimes see the Medco name in pharmacy communications and on websites.

Please continue to refill your prescriptions as you normally would by using your current prescription drug ID card, refill order forms or the toll-free member services telephone number on your ID card. Medco is now a part of the Express Scripts family of pharmacies. Members with questions may call Express Scripts at (800) 899-2587.

- **Change in Flexible Spending Accounts (FSA) system for plan year 2014** Effective July 1, 2013, the State of Illinois will begin using a new FSA system. There will be several changes of which participants need to be aware for the conversion from the current system to the new system and website. Please see page 28 of the Benefit Choice Options booklet for details.
- **Medicare Primary Retirees, Annuitants and Survivors** Effective January 1, 2014, Medicare primary retirees, annuitants and survivors (including those who have Medicare primary dependents on their health insurance coverage) will be required to enroll in a State-sponsored Medicare plan. Impacted members will receive a letter in the coming months outlining this change and their health plan choices.
- **QCHP Coordination of Benefits Change** Effective July 1, 2013, the State of Illinois will no longer pay 100% of the claim balance of medical claims after Medicare pays their portion for plan participants enrolled in QCHP. Medicare primary participants will be subject to standard benefit coinsurance for in-network and out-of-network services after Medicare pays. Furthermore, plan exclusions for the QCHP will apply regardless of other health insurance coverage. See pages 51 of the Retiree, Annuitant and Survivor Handbook for more information on the Benefits website.
- **Monthly Health Plan Contributions for Retirees, Annuitants and Survivors** All retirees, annuitants and survivors will be charged a percentage of their combined annuity value to cover the costs of the basic program of group health benefits. See the next page for details.

Member and Dependent Monthly Contributions

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. 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	Full-time Employee Monthly Health Plan Contributions	
\$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

Monthly Health Plan Contribution for Retirees, Annuitants and Survivors

All retirees, annuitants and survivors will be charged a percentage of their annuity to cover the costs of the basic program of group health benefits as follows:

- Medicare eligible – 1% of the value of your annual annuity from all five State retirement systems
- Non-Medicare eligible – 2% of the value of your annual annuity from all five State retirement systems

In addition to the percentage of annuity charged to all retirees, annuitants and survivors, the following charges apply to annuitants and survivors with less than 20 years of service:

20 years or more of creditable service	\$0.00
Less than 20 years of creditable service and, <ul style="list-style-type: none"> • SERS/SURS annuitant/survivor on or after 1/1/98, or • TRS annuitant/survivor on or after 7/1/99 	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 Optional Term Life Plan Contributions

Member by Age	Monthly Rate Per \$1,000
Under 30	\$0.06
Ages 30 - 34	0.08
Ages 35 - 44	0.10
Ages 45 - 49	0.16
Ages 50 - 54	0.24
Ages 55 - 59	0.44
Ages 60 - 64	0.66
Ages 65 - 69	1.28
Ages 70 - 74	2.06
Ages 75 - 79	2.06
Ages 80 - 84	2.06
Ages 85 - 89	2.06
Ages 90 and above	2.06

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

Member and Dependent Monthly 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.

Dependent Monthly Health Plan Contributions*

Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
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

* 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.

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.

Health Plans by Illinois County

July 1, 2013 through June 30, 2014

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

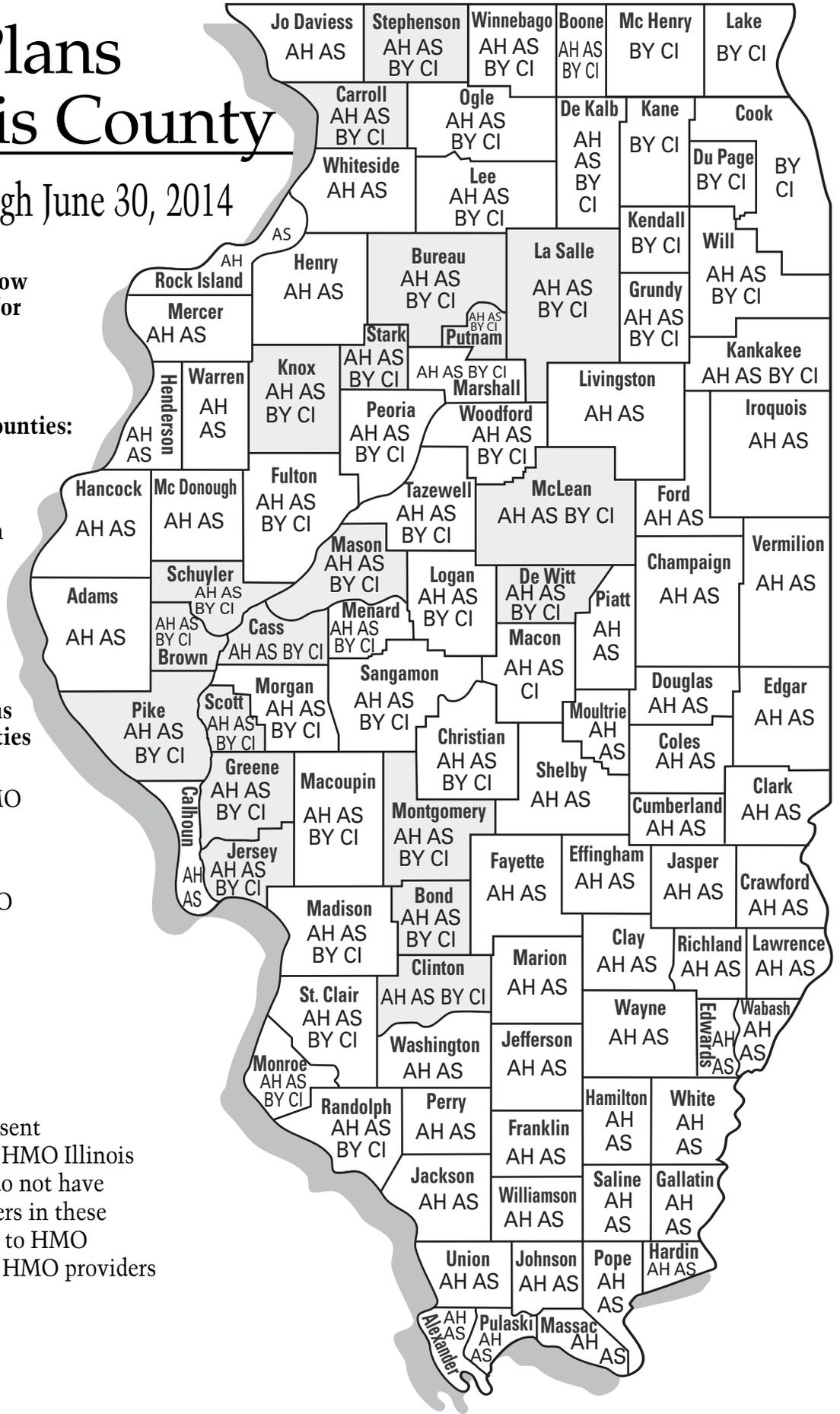
The following plans are available in all Illinois counties:

- CH - Coventry OAP
- CF - HealthLink OAP
- D3 - Quality Care Health Plan (QCHP)

The following HMO plans are available in the counties indicated on the map:

- AH - Health Alliance HMO
- AS - Coventry HMO
- BY - HMO Illinois
- CI - BlueAdvantage HMO

 Shaded 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

Notice of Creditable Coverage

Prescription Drug Information for State of Illinois Medicare Eligible Plan Participants

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 new regulation is designed to help you better understand and evaluate your health insurance choices.

The new 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 has been updated on the Benefits website effective April 1, 2013. 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.

Changes that are effective April 1, 2013, include, but are not limited to, the following:

- References to the Department of Healthcare and Family Services (HFS) were replaced with Department of Central Management Services
- Contact information for the two self-insured open access plans (OAPs) were added
- The pharmacy benefit manager name was changed from Medco to Express Scripts
- Legal requirements were clarified
- Restrictions were updated
- 'Notice of changes' was updated