State of Illinois
Department of Central Management Services
Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 – June 20, 2011

Local Government Health Plan

Effective July 1, 2011 - June 30, 2012

Plan Administrators

Who to contact for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
PersonalCare HMO	(800) 431-1211	(217) 366-5551	www.personalcare.org
PersonalCare OAP	(800) 431-1211	(217) 366-5551	www.personalcare.org

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	**EyeMed** Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com/stil
Local Care Dental Plan (LCDP) Administrator	**Delta Dental of Illinois** Group Number 20241 P.O. Box 5402 Lisle, IL 60532	(800) 323-1743 (800) 526-0844 (TDD/TTY)	http://soi.deltadentalil.com
Health/Dental Plans, Medicare COB Unit and Smoking Cessation Benefits	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

Plan administrator information continued on inside back cover.

Table of Contents

Important Reminders

Continuity of Care After Health Plan Change: Members who change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, or have dependents that are hospitalized, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Members or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members.

Message to Plan Members

The Benefit Choice Period will be **May 1 through June 20, 2011,** for all members. Members include employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), annuitants, elected officials, survivors and COBRA participants. **Elections will be effective July 1, 2011.**

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form. Members should complete the form **only if changes** are being made. Your unit health plan representative (HPR) will forward the changes indicated on the form to the LGHP for processing.

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

- Change health plans.
- Add or drop dependent coverage.
- Elect to waive coverage. **The election to waive coverage will terminate the health, dental, vision and prescription coverage for the member and any covered dependents.**
- Re-enroll in the Program if previously waived (full-time employees, part-time employees or elected officials).

Benefit Choice Changes for Plan Year 2012

(Enrollment Period May 1 – June 20, 2011)

The information below represents changes to the LGHP benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes.

- **Managed Care Contracts** – From July 1, 2011, through September 28, 2011, members may choose from the following carriers: HealthLink OAP, PersonalCare OAP, HMO Illinois, BlueAdvantage HMO, Health Alliance HMO, Health Alliance Illinois, PersonalCare HMO or the Quality Care Health Plan. Additional information regarding coverage choices that will be offered after September 28, 2011, will be provided as soon as it is available.
- **Dental Plan** - Effective July 1, 2011, Delta Dental of Illinois will become the plan administrator of the dental program. The Dental Schedule of Benefits has not changed. Even though Delta Dental offers two provider networks, the Delta Dental PPO℠ network and the Delta Dental Premier℠ network, you can still utilize any licensed general or specialty dentist, regardless of whether the dentist participates in one of the networks, and receive the benefit shown on the Dental Schedule of Benefits. However, in most cases you can reduce your out-of-pocket expenses by utilizing a network provider. See pages 16 and 17 for more information.

  Questions regarding services rendered prior to July 1, 2011, will continue to be handled by CompBenefits at (800) 999-1669.
- **Dependent Children** – Effective July 1, 2011, any dependent child (under age 26) will be eligible for health, dental and vision coverage regardless of student status, marital status or residency. Exception: In accordance with Public Act 95-0958, adult veteran children must live in Illinois in order to be eligible for coverage in the Adult Veteran category. Also, if the adult veteran child is age 26 or older, they must be unmarried. Use the Benefit Choice Enrollment Form on page 19 to enroll a new dependent.

Other Plan Year 2012 Changes

- **Student, Student Leave of Absence and Student Military Extension** – Effective July 1, 2011, these dependent categories will no longer be available. Dependents enrolled in any of these categories will automatically be reclassified into the "Sponsored Adult Child" category by CMS during the month of August 2011. **Members do not need to take any action regarding this transition.**
- **Civil Union Partners** – Per Public Act 96-1513, the State of Illinois now requires employers to provide coverage for civil union partners and the dependents of civil union partners. June 1, 2011, will begin a 60-day qualifying change in status enrollment period for those members who have a valid Civil Union Partnership Certificate from another state. For members who obtain a Civil Union Partnership Certificate in Illinois, the 60-day qualifying change in status enrollment period will begin upon the issuance of the certificate. Enrollments will be processed in accordance with qualifying change in status rules.

  Information and FAQs regarding coverage for civil union partners can be found on the Benefits website. **As the law permitting civil union partner coverage is not effective until June 1, 2011, coverage for civil union partners and their dependents CANNOT be requested during the Benefit Choice Period.**
- **Member Handbook** – A new Local Government Member Handbook will be released on October 1, 2011. This handbook contains vital information for members regarding the various benefits offered by LGHP. The handbook will be available on the Benefits website beginning October 1, 2011.
- **Federal Healthcare** – The following changes are a result of the Patient Protection and Affordable Care Act.
  1. Preexisting condition limitations no longer apply.
  2. Annual and lifetime maximums have been eliminated.
  3. Residency of a dependent child, except for a dependent child enrolled in the Adult Veteran category, is no longer relevant. Dependent children enrolled in the Adult Veteran category must reside in the State of Illinois to be eligible for coverage.
  4. Marital status of a dependent child under the age of 26 is no longer relevant.
  5. Preventive services are paid at 100%.
- **Prescription Drug Step Therapy (PDST)** – Beginning July 1, 2011, members enrolled in the Local Care Health Plan or one of the self-insured managed care plans will be subject to prescription drug step therapy (PDST). PDST is a program designed to encourage members to select lower cost drugs prior to moving to a higher cost therapeutic equivalent. See page 15 for more information.

Member Responsibilities

You must notify the health plan representative (HPR) at your employing unit if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union) must be reported to your HPR 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 may not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You go on a leave of absence or have time away from work.** You should immediately contact your HPR 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 have or gain other coverage.** If you have group coverage provided by a plan other than the LGHP, 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 your HPR when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.**
- **You get married or enter into a civil union partnership; or your marriage or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **The employment status of your spouse, civil union partner or dependent changes.**

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

Health Plan

The Local Government Health Plan provides employees and annuitants of an enrolled local government unit with health, prescription, behavioral health, dental and vision coverage.

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

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)
- Local Care Health Plan (LCHP) – a plan with both in-network and out-of-network benefits

The health insurance plans differ in the benefit levels they provide and the doctors and hospitals you can access. See pages 6-12 for information to help you determine which plan is right for you.

You also have the option of waiving health coverage if you have other comprehensive health coverage. Electing to waive includes the termination of health, dental, vision, behavioral health and prescription coverage.

If you change health plans during the Benefit Choice Period, or elect health coverage after waiving, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. You should expect your new ID cards by the beginning of the plan year, July 1, 2011. If you need to have services provided on or after July 1, 2011, but have not yet received your ID cards, contact your health insurance carrier.

Remember, whatever health plan you elect during the Benefit Choice Period will remain in effect the entire plan year, unless you experience a qualifying change in status that allows you to change plans.

Behavioral Health Services

Local Care Health Plan:
Behavioral health services are now included in a member's annual plan deductible and annual out-of-pocket maximum. Behavioral health services are not subject to separate copayments, limits or other specific provisions. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the Local Care Health Plan (LCHP) benefit schedule on pages 10 and 11 for in-network and out-of-network providers. Magellan Behavioral Health is the plan administrator for behavioral health services under LCHP. Please contact Magellan for specific benefit information.

Managed Care Plans:
Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 8 and 9. Please contact the managed care plan for specific benefit information.

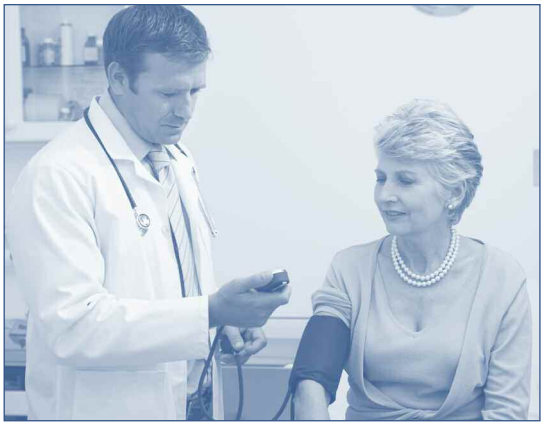
Disease Management Programs and Wellness Offerings

Disease Management Programs:
Disease Management Programs are utilized by CIGNA, the LCHP administrator, and the managed care health plans as a way to improve the health of plan participants. You may be contacted by your health plan to participate in these programs.

Wellness Offerings:
Wellness options and preventive measures are offered and encouraged by CIGNA and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside covers of this book and on the Benefits website.

Managed Care Plans

There are several managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.



Health Maintenance Organizations (HMOs)

Members must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment applies. No annual plan deductibles apply for medical services. The minimum level of HMO coverage provided by all plans is described on page 8. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

Open Access Plans (OAPs)

Open access plans provide three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with copayments and/or coinsurance. Tier III (out-of-network) offers members flexibility in selecting healthcare providers, but requires higher out-of-pocket costs. A deductible applies for medical services under Tier II and Tier III. It is important to remember that the level of benefits is determined by the healthcare provider selected. Members enrolled in an OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 9.

Important Reminders About Managed Care Plans

Primary Care Physician (PCP) Leaves the Network: If a member's PCP leaves the managed care plan's network, the member has three options:

- Choose another PCP within that plan;
- Change managed care plans; or
- Enroll in the Local Care Health Plan.

The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's healthcare providers who are not designated as the PCP.

Provider Network Changes: Managed care plan provider networks are subject to change. Members should always call the respective plan to verify participation of specific providers, even if the information is printed in the plan's directory.

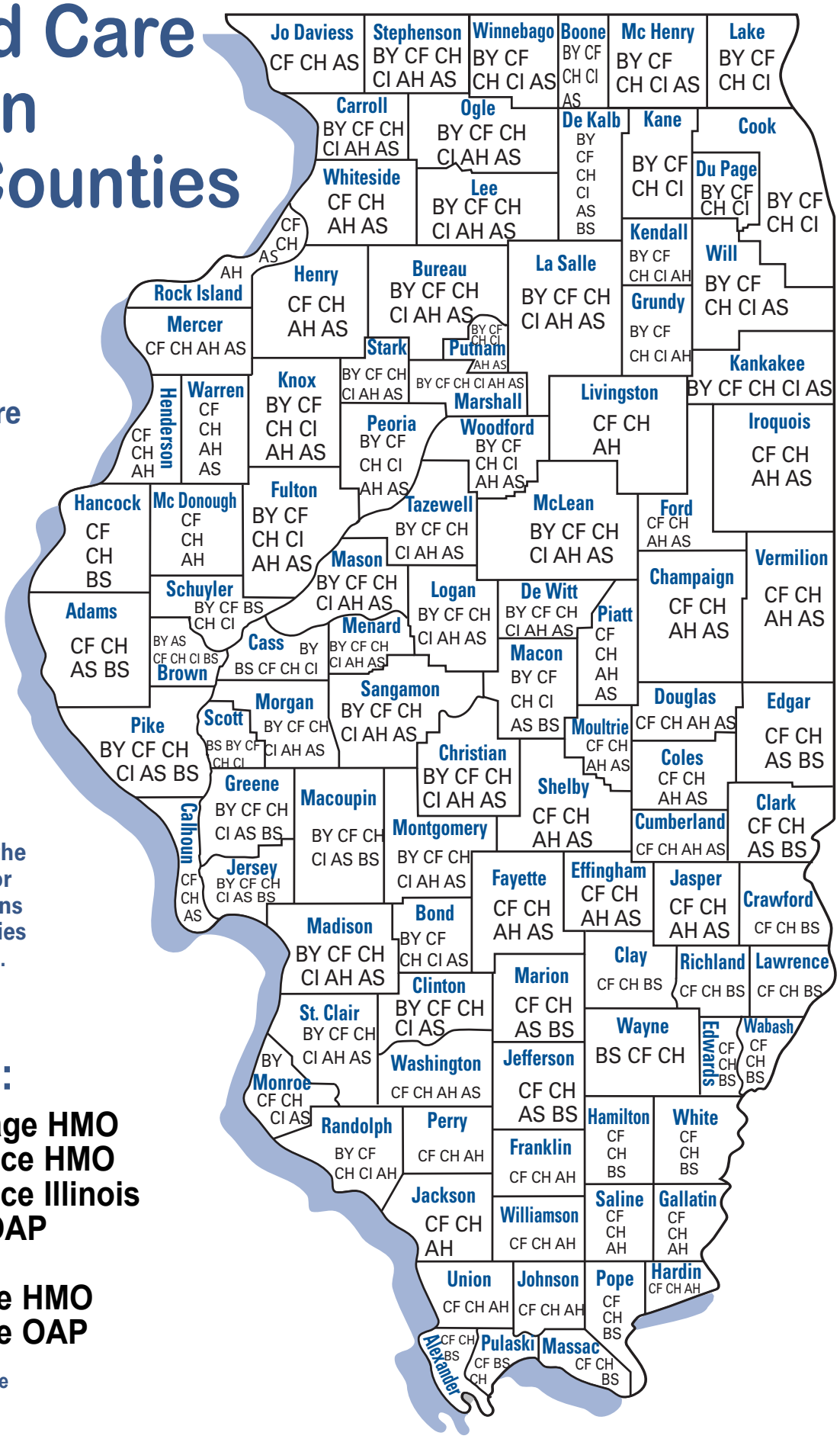
Dependents: Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on this type of coverage.

Plan Year Limitations: Managed care plans may impose benefit limitations based on a calendar year schedule. In certain situations, the LGHP's plan year may not coincide with the managed care plan's plan year.

Behavioral Health Services: Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are available through the member's health plan.

Managed Care Plans in Illinois Counties

LGHP Managed Care Health Plans For Plan Year 2012



The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.

HMO & OAP Carrier Codes:

CI = BlueAdvantage HMO
AH = Health Alliance HMO
BS = Health Alliance Illinois
CF = HealthLink OAP
BY = HMO Illinois
AS = PersonalCare HMO
CH = PersonalCare OAP

Note: LCHP available Statewide

HMO Benefits

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Hospital Services

Inpatient hospitalization	100% after $250 copayment per admission
Alcohol and substance abuse	100% after $250 copayment per admission
Psychiatric admission	100% after $250 copayment per admission
Outpatient surgery	100% after $200 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $200 copayment per visit

Professional and Other Services
(Copayment not required for preventive services)

Physician Office visit	100% after $20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $20 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $20 copayment per visit
Prescription drugs	$10 copayment for generic $24 copayment for preferred brand $48 copayment for nonpreferred brand
Durable Medical Equipment	80%
Home Health Care	$20 copayment per visit

Some HMOs may have benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	 $0 $0	 $1,000 $2,500	 $2,000 $5,000
Annual Plan Deductible (must be satisfied for all services)	$0	$300 per enrollee*	$500 per enrollee*
Hospital Services			
Inpatient	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C after $400 copayment per admission
Inpatient Psychiatric	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C after $400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $250 copayment per admission	90% of network charges after $300 copayment per admission	80% of U&C after $400 copayment per admission
Emergency Room	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Surgery	100% after $200 copayment per visit	90% of network charges after $200 copayment	80% of U&C after $200 copayment
Diagnostic Lab and X-ray	100%	90% of network charges	80% of U&C
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $20 copayment	90% of network charges	80% of U&C
Specialist Office Visits	100% after $20 copayment	90% of network charges	80% of U&C
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 copayment	90% of network charges	80% of U&C
Other Services			
Prescription Drugs – Covered through LGHP administered plan, Medco Generic $10 Preferred Brand $24 Nonpreferred Brand $48			
Durable Medical Equipment	80% of network charges	80% of network charges	80% of U&C
Skilled Nursing Facility	80% of network charges	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $20 copayment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan copayments, deductibles and amounts over usual and customary (U&C) do not count toward the out-of-pocket maximum.

The Local Care Health Plan (LCHP)

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

The LCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the LCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The LCHP is separate from the OAP health plans described on page 9.

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

Plan participants can access plan benefit and participating LCHP network information, explanation of benefits (EOB) statements and other valuable health information online. To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Plan Year Maximums and Deductibles

Plan Year Maximum Lifetime Maximum	Unlimited Unlimited	
Plan Year Deductible	$500 per participant	
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit LCHP hospital admission Non-LCHP hospital admission Transplant deductible	$400 $100 $400 $250

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: In-Network and Out-of-Network. Coinsurance and deductibles apply to one or the other, but not both. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100% of eligible charges for the remainder of the plan year.

In-Network: $1,500 per individual $3,750 per family per plan year	Out-of-Network: $4,500 per individual $9,000 per family per plan year

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits or copayments.
- Notification penalties.
- Ineligible charges (amounts over usual and customary (U & C), charges for noncovered services and charges for services deemed not to be medically necessary).
- The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.

LCHP - Plan Benefits

Hospital Services	
LCHP Hospital Network	• $100 deductible per hospital admission. • 90% after annual plan deductible.
Non-LCHP Hospitals	• $400 deductible per hospital admission. • 70% of U&C after annual plan deductible.
Outpatient Services	
Preventive Services, including immunizations	100%
Diagnostic Lab/X-ray	90% in-network, 70% of U&C out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	
Professional and Other Services	
Services included in the LCHP Network	90% after the annual plan deductible.
Services not included in the LCHP Network	70% of U&C after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	90% in-network, 70% of U&C out-of-network, after annual plan deductible.
Transplant Services	
Organ and Tissue Transplants	90% after $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.

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

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

Health Plan Comparison

Benefit	LCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Patient Responsibilities					
Annual Out-of-Pocket Maximum	**In-Network:** $1,500 per enrollee $3,750 per family/plan year **Out-of-Network:** $4,500 per enrollee $9,000 per family/plan year	$3,000 per enrollee $6,000 per family/plan year Not applicable	Not applicable Not applicable	$1,000 per enrollee $2,500 per family/plan year Not applicable	Not applicable $2,000 per enrollee $5,000 per family/plan year
Annual Plan Deductible Must be satisfied for all services	$500 per enrollee	$0	$0	$300 per enrollee	$500 per enrollee
Other Deductibles/Copayments:					
• **Emergency Room**	$400	$200	$200	$200	$200
• **LCHP Network Hospital Admission**	$100	Not applicable	Not applicable	Not applicable	Not applicable
• **Out-of-Network Hospital Admission**	$400	No coverage	See Tier III for benefit level	See Tier III for benefit level	80% of U&C* after $400 copayment
Plan Benefit Levels Comparison					
Physician Office Visit	90% LCHP network 70% of U&C* Out-of-Network	$20 copayment	$20 copayment	90% of network charges**	80% of U&C*
Preventive Services including immunizations	100%	100%	100%	100%	Covered under Tier I and Tier II only
Inpatient	90% LCHP network 70% of U&C* Out-of-Network	$250 copayment	$250 copayment	90% of network charges** after $300 copayment	80% of U&C* after $400 copayment
Outpatient Surgery	90% LCHP network 70% of U&C* Out-of-Network	$200 copayment	$200 copayment	90% of network charges** after $200 copayment	80% of U&C* after $200 copayment
Diagnostic Lab and X-ray	90% LCHP network 70% of U&C* Out-of-Network	100%	100%	90% of network charges**	80% of U&C*
Durable Medical Equipment	90% LCHP network 70% of U&C* Out-of-Network	80% of network charges**	80% of network charges**	80% of network charges**	80% of U&C*

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

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

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

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

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is a premium-free program for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for members who are retired or who have lost "current employment status" and are eligible for Medicare.
- **Medicare Part C*** (also known as Medicare Advantage): Part C is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll into a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Medicare Part D*** (Prescription Drug Insurance): Medicare Part D coverage requires a monthly premium, unless the participant qualifies for extra-help assistance.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

* The Local Government Health Plan **does not require** plan participants to choose a Medicare Part C Plan (over the original Medicare Part A and B option) or to enroll in a Medicare Part D prescription drug plan.

Local Government Health Plan Medicare Requirements

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

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the Medicare COB Unit to avoid a financial penalty. Plan participants who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA are not required to enroll into Medicare Parts A or B.

Members with Current Employment Status (and their applicable Dependents)

Members who are actively working and become eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65) must accept the premium-free Medicare Part A coverage, but may delay the purchase of Medicare Part B coverage. The Local Government Health Plan (LGHP) will remain the primary insurance for plan participants eligible for Medicare due to age or disability until the date the member retires or loses "current employment status" (such as no longer working due to a disability-related leave of absence). Upon such an event, Medicare Part B is required by LGHP.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his or her Medicare card to his or her health plan representative (HPR).

Plan Participants (Members and Dependents) Eligible for Medicare (cont.)

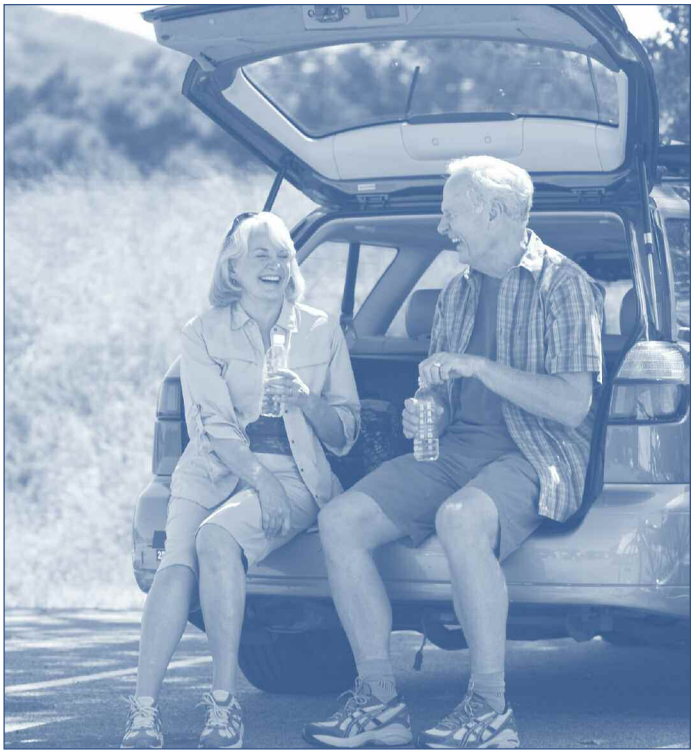
Annuitants and Members without Current Employment Status (and their applicable Dependents)

Members who are retired or who have lost current employment status (such as no longer working due to a disability related leave of absence) and **are eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65)** must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the Local Government Health Plan. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the Local Government Health Plan and will result in additional out-of-pocket expenditures for health-related claims.**

Survivors (and their applicable Dependents)

Survivors (or their dependents) who become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the Local Government Health Plan. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the Local Government Health Plan and will result in additional out-of-pocket expenditures for health-related claims.**

If you are a survivor enrolled in Medicare Part A only, it is imperative that you contact the Medicare COB Unit to discuss the Medicare requirement.



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

Plan participants who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

To ensure that benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, plan participants must notify the State of Illinois Medicare COB Unit when they become eligible for Medicare. The Medicare COB Unit can be reached by calling (800) 442-1300 or (217) 782-7007.

Prescription Drug Benefit

Plan participants enrolled in any LGHP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level has a different copayment amount. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for coordination of benefits (COB) information. LCHP plan participants can receive a 90-day supply of maintenance medication through the mail order program for two copayments.

PRESCRIPTION DRUG COPAYS FOR A 30-DAY SUPPLY

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

Coverage for specific prescription drugs may vary depending upon the health plan. It is important to note that formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan they are considering. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Prescription Drug Step Therapy

Effective July 1, 2011, members who have their prescription drug benefits administered through LCHP or one of the self-insured managed care plans whose prescription benefit manager (PBM) is Medco, will be subject to a coverage tool called prescription drug step therapy (PDST) for specific drugs. PDST requires the member to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still treat the member's condition effectively.

Members who are taking a medication that requires step therapy will receive a letter explaining that the plan will not cover that particular medication unless the alternative medication is tried first. The letter will also have directions on how a member's physician may request a coverage review if the physician believes they should take the original medication without trying the alternative medication first.

Medco: (800) 899-2587
Website: www.medco.com

Dental Options

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected.

Plan participants can access Local Care Dental Plan (LCDP) network information, explanation of benefits (EOB) statements and other valuable information online.

Dental Benefit

The LCDP is a dental plan that offers a comprehensive range of benefits. Effective July 1, 2011, the LCDP will be administered by Delta Dental of Illinois. **The Dental Schedule of Benefits is not changing for FY 2012.** The LCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive'. The annual plan deductible is $100 per participant per plan year. Once the deductible has been met, the plan participant has a maximum annual dental benefit of $2,000 for all dental services.

Deductible and Plan Year Maximum

Annual Deductible for Preventive Services	N/A
Annual Deductible for All Other Covered Services	$100
Plan Year Maximum Benefit*	$2,000

* Orthodontics + all other covered services

Plan participants enrolled in the dental plan can choose any dental provider for services; however, plan participants may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a plan participant may utilize for dental services in addition to out-of-network providers: the Delta Dental PPO℠ network and the Delta Dental Premier℠ network.

- **The Delta Dental PPO Network:** If you go to a PPO dentist, your out-of-pocket expenses will often be less because these providers accept a reduced PPO fee (less any deductible). If the PPO fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.

- **The Delta Dental Premier Network:** If you go to a Premier dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier fee (less any deductible). If the allowed fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.

- **Out-of-Network:** If you go to a dentist who does not participate in either the PPO or Premier network, you will receive the same benefits that you currently receive; however, you may have to pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist. **When using an out-of-network dentist, insurance payments will be sent directly to the member and the member is responsible for paying the dentist.**

Dental Options (cont.)

Example of PPO, Premier and Out-of-Network Dentist Payments *(this is a hypothetical example only and assumes all deductibles have been met).*

Delta Dental PPO Dentist*		Delta Dental Premier Dentist*		Out-of-Network Dentist	
Dentist submitted fee	$1,000	Dentist submitted fee	$1,000	Dentist submitted fee	$1,000
PPO allowed fee	$790	Premier maximum allowed fee	$900	No negotiated fee	n/a
Schedule of Benefits amount	$781	Schedule of Benefits amount	$781	Schedule of Benefits amount	$781
Your Out-of-Pocket Cost	**$9**	**Your Out-of-Pocket Cost**	**$119**	**Your Out-of-Pocket Cost**	**$219**

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is $1,500. This lifetime maximum is subject to course of treatment limitations (see 'Length of Orthodontia Treatment' chart below).

Members who have children who are currently undergoing orthodontia treatment which began prior to July 1, 2011, should contact their orthodontist's office and request that they submit the original orthodontia treatment plan to Delta Dental for reimbursement purposes. Members who use an out-of-network provider may be required to pay for services up front. Delta Dental will reimburse the member (not the provider) for the insurance portion of the services.

Orthodontia Services

Annual Deductible*	$100
Maximum Lifetime Orthodontia Benefit	$1,500

* The annual plan year deductible will need to be satisfied unless it was previously satisfied for other dental services incurred during the plan year.

Length of Orthodontia Treatment

The lifetime maximum benefit for child orthodontics is based on the length of treatment. This lifetime maximum applies to each plan participant regardless of the number of courses of treatment.

Length of Treatment	Maximum Benefit
0 - 36 Months	$1,500
0 - 18 Months	$1,364
0 - 12 Months	$780

Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by this plan.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

Delta Dental: (800) 323-1743
TDD/TTY: (800) 526-0844
Website: http://soi.deltadentalil.com

Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the LGHP health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. All vision benefits are available once every 24 months from the last date used. Copayments are required.

Service	Network Provider Benefit	Out-of-Network Provider Benefit**
Eye Exam	$10 copayment	$20 allowance
Spectacle Lenses* (single, bifocal and trifocal)	$10 copayment	$20 allowance for single vision lenses $30 allowance for bifocal and trifocal lenses
Standard Frames	$10 copayment (up to $90 retail frame cost; member responsible for balance over $90)	$20 allowance
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	$20 copayment for medically necessary $50 copayment for elective contact lenses $70 allowance for all other lenses not mentioned above	$70 allowance

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

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

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

Optional Programs

Smoking Cessation Program

Benefit applies to all Members

Members and dependents are eligible to receive a rebate up to $50 for completing an approved smoking cessation program, limited to one rebate per participant, per plan year. One-time procedures are not considered an approved program.

Hospital Bill Audit Program

Program applies to only LCHP Members

The Hospital Bill Audit Program applies to both LCHP and non-LCHP hospital charges. Under the program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill, is eligible for 50% of the resulting savings up to a maximum of $1,000 per admission. **Note:** Related nonhospital charges, such as radiologists and surgeons, are not eligible charges under the program. The program only applies when LCHP is the primary payer.

LOCAL GOVERNMENT HEALTH PLAN (LGHP)

BENEFIT CHOICE ELECTION FORM

(Instruction Sheet on Back)

Enrollment Period May 1, 2011 - June 20, 2011

Complete This Form Only If Changing Your Benefits

SECTION A: EMPLOYEE INFORMATION (required)

SSN: — —

Last Name	First Name	Phone Numbers	
		Home:	Work:

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

Health Plan Election *	If you selected an HMO or OAP plan, you must complete the following:
Elect One:	Carrier Code _____ (2 characters – see map)
Local Care Health Plan (LCHP) ☐	Carrier/Plan Name _____
~ Or ~	**If you elected an HMO, also complete the field below** (to find the PCP/Provider Identifier, go to the health plan's website):
Managed Care Plan (HMO or OAP) ☐	PCP/Provider Identifier _____ (6 - 10 characters)

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

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

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

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

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

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your unit's HPR.

CMS-450 IL401-1631 (06/17/11)

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

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

SECTION A – EMPLOYEE INFORMATION
Complete all fields.

SECTION B – HEALTH PLAN ELECTION
If you wish to change your **health** plan you must check either the Local Care Health Plan (LCHP) or the Managed Care box. If **electing/changing managed care plans**, you must enter the HMO or OAP plan's carrier code (see map for carrier codes) and the plan's name. If you are electing an HMO, you must also complete the PCP/Provider Identifier field. The provider identifier is associated with a specific physician and is referenced as either the PCP code (at least 6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see inside front cover of the Benefit Choice booklet for website addresses).

Do not complete this section if you only want to change your primary care physician (PCP) – you must contact your managed care plan directly in order to make this change.

SECTION C – DEPENDENT INFORMATION
Complete this section if you are (1) changing your health plan to an HMO, or (2) adding or dropping dependent health coverage. If your dependents are already enrolled in health and you are only changing your health plan to LCHP or one of the OAP plans you do not need to complete this section. If you are adding dependent health coverage, you must also provide the appropriate documentation as indicated below:

Spouse	Marriage certificate
Natural Child through age 25	Birth certificate
Stepchild through age 25	Birth certificate indicating your spouse is the child's parent and a marriage certificate indicating the child's parent is the member's spouse.
Adopted Child through age 25	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardianship through age 25	Court documentation signed by a judge.
Adult Veteran Child through age 29	Birth certificate, Eligibility Certification Statement (CMS-138)* and documentation as indicated on the 'Documentation Requirements' page of the Eligibility Certification Statement.
Disabled	
Other (organ transplant recipient)	
* The Eligibility Certification Statement (CMS-138) is available on the Benefits website at **www.benefitschoice.il.gov**.	

SIGNATURE
You must sign and date the Benefit Choice Election Form and give to your HPR by June 20, 2011, in order for your elections to be effective July 1, 2011.

Dependent documentation must be submitted to your HPR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**

Plan Administrators

Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	**CIGNA** Group Number 2457474 **CIGNA HealthCare** P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $400 applies	**Intracorp, Inc.**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator LCHP (1401LD3) PersonalCare OAP (1401LCH) HealthLink OAP (1401LCF) Health Alliance Illinois (1401LBS)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Medco** Group Number: 1401LD3, 1401LCH, 1401LCF, 1401LBS **Paper Claims:** Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
LCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	**Magellan Behavioral Health** Group Number 2457474 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

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

Printed by the authority of the State of Illinois
(CMS-BEN2002-02-1,000-05/11)
Printed on recycled paper