State of Illinois
Department of Central Management Services
Bureau of Benefits





Benefit Choice Options

Enrollment Period May 1 – June 15, 2012 | Effective July 1, 2012

Local Government Health Plan

Plan Administrators

Who to contact for information

Managed Care Plan Administrators	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Coventry Health Care HMO (formerly PersonalCare HMO)	(800) 431-1211	(217) 366-5551	chcillinois.coventryhealthcare.com
Coventry Health Care OAP (formerly PersonalCare OAP)	(800) 431-1211	(217) 366-5551	chcillinois.coventryhealthcare.com
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

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 Benefit	**CMS Group Insurance Division** 801 South 7th 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.

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Message to Plan Members

The Benefit Choice Period will be **May 1 through June 15, 2012**, 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, 2012**.

All Benefit Choice changes should be made on the Benefit Choice Election Form available on the Benefits website at **www.benefitschoice.il.gov**. 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 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.

Benefit Choice Changes for Plan Year 2013

(Enrollment Period May 1 – June 15, 2012)

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. **The Benefit Choice Period will be May 1 through June 15, 2012.** All elections will be effective July 1, 2012.

- **Managed Care Contracts** In an effort to ensure that health carriers are in place for the start of the next fiscal year (July 1, 2012), a decision has been made to enter into emergency contracts with Health Alliance HMO, Health Alliance Illinois and Coventry Health Care HMO. These contracts will be for 90 days with an option to extend for an additional period as needed. During the FY 2013 Benefit Choice Period, members may choose from the following carriers: HealthLink OAP, Coventry Health Care OAP, HMO Illinois, BlueAdvantage HMO, Health Alliance HMO, Health Alliance Illinois, Coventry Health Care HMO or the Local Care Health Plan.
- **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.
- **Federal Healthcare Reform** Effective July 1, 2012, the copayment for compound drugs will be at the nonpreferred drug level due to compound drug billing layout changes as a result of federal healthcare reform. Patients who are prescribed compound drugs are encouraged to contact their doctor for less expensive alternatives. Please note, a compound drug is one which requires a prescription from a doctor and is prepared by a pharmacist, who mixes or adjusts drug ingredients to customize a medication to meet a patient's individual needs.

HMO and OAP Changes

- Physician office visit copayment increases to $30
- Specialist office visit copayment increases to $30
- Behavioral health office visit copayment increases to $30
- Prescription copayment for generic drugs increases to $12
- New prescription 'specialty' category added with copayment of $96 (see page 16)

Local Care Health Plan (LCHP) Changes

- Plan year deductible for a plan participant increases to $750
- Plan coinsurance for out-of-network charges decreases to 60%
- Inpatient hospital deductible (in-network) increases to $250
- Inpatient hospital deductible (out-of-network) increases to $500
- In-network, out-of-pocket maximum (family) decreases to $3,000
- Prescription copayments increase to $12.50/$25/$50
- New prescription 'specialty' category added with copayment of $100 (see page 16)

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 the Medicare Coordination of Benefits Unit 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.** The Medicare Unit's address and phone number can be found on the inside front cover.
- **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 dependent changes.**

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

Important Reminders

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 are discharged on or after July 1, 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.

Documentation Requirements: Documentation, including the SSN, is required when adding dependent coverage.

Health Plan

The Local Government Health Plan (LGHP) provides employees, annuitants and survivors 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 various health insurance coverage options:

✦ **Local Care Health Plan (LCHP)**

✦ **Managed Care Plans** (two types)

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide and the doctors and hospitals you can access. See the Benefits Comparison charts on pages 8-13 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 re-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. If you need to have services 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.

Disease Management Programs and Wellness Offerings

Disease Management Programs

Disease Management Programs are utilized by the Local Care Health Plan (LCHP) plan 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 the LCHP plan administrator 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 cover of this book and on the Benefits website.

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Managed care plans have limitations including geographic availability and defined provider networks, whereas the Local Care Health Plan has a nationwide network of providers available to its members.

Local Care Health Plan (LCHP)

LCHP 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 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.

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.

Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Members must select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will 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 through an HMO. The minimum level of HMO coverage provided by all plans is described on the charts on pages 8-13. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

  If a member is enrolled in an HMO and their PCP leaves the HMO plan's network, the member has three options:

  – Choose another PCP within that plan;

  – Change to a different managed care plan; or

  – Enroll in the Local Care Health Plan.

- **Open Access Plans (OAPs)**

  Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. These plans provide three benefit levels broken into tier groups. Tiers I and II offer two managed care networks which provide enhanced benefits and require 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 to medical services obtained through Tier II and Tier III providers.

  It is important to remember that the tier level at which benefits are provided 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 the charts on pages 8-13.

Behavioral Health Services

Local Care Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under Local Care Health Plan (LCHP). Behavioral health services are included in an enrollee'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 LCHP benefit schedule on pages 8-13 for in-network and out-of-network providers. 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 8-13. Please contact the managed care plan for specific benefit information.

To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Managed Care Plans in Illinois Counties

LGHP Managed Care Health Plans For Plan Year 2013

Effective 2/1/13, some counties health plan options changed. Click here to view new map.

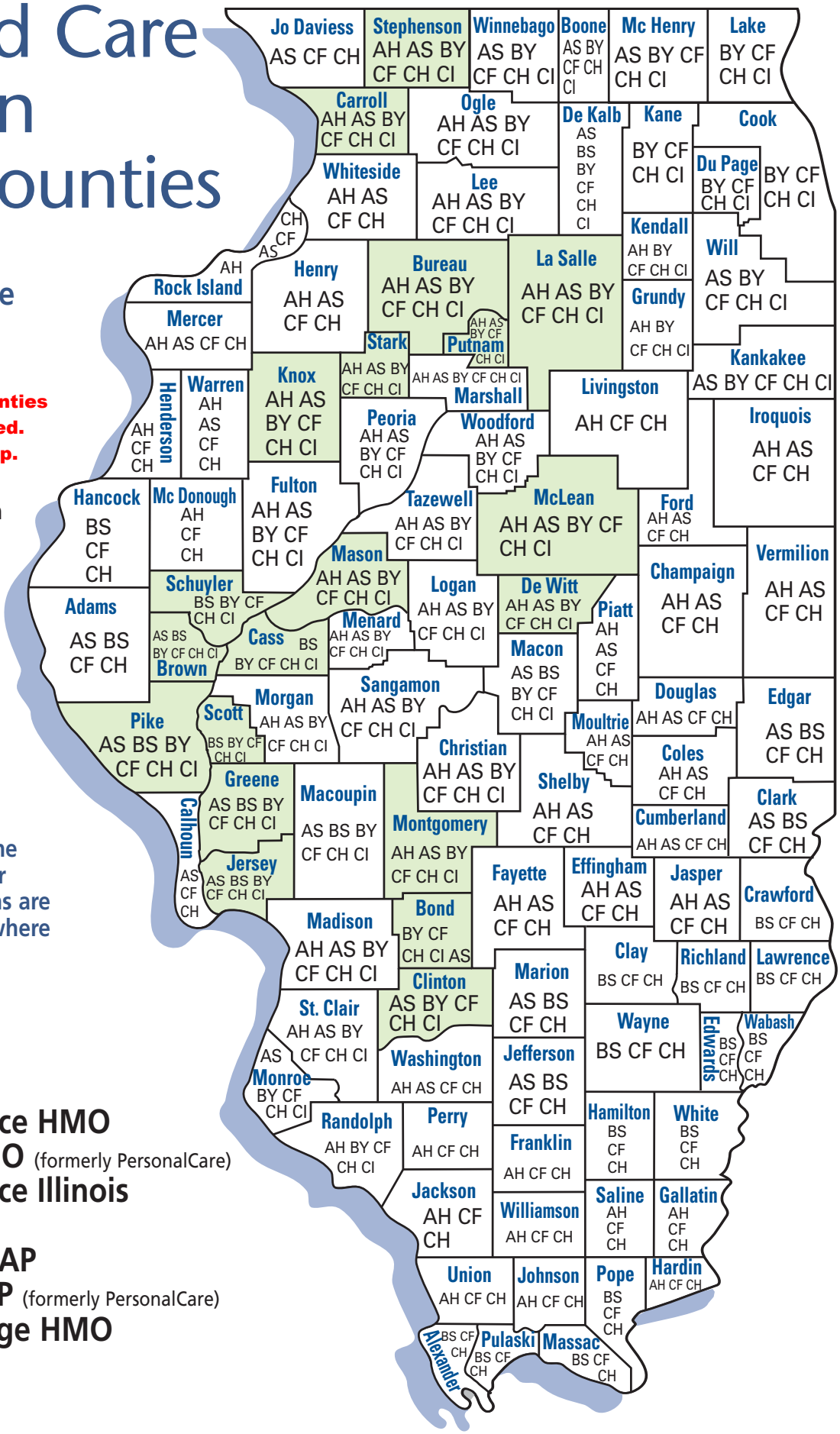
Shaded areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.

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:

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

Note: LCHP available Statewide



Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	LCHP		HMO
	In-Network	Out-of-Network	In-Network
Covered Services			
Health Plan Year Deductible Per enrollee Note: The annual health plan deductible must be met before plan benefits apply	$750		Not applicable
Out-of-Pocket Maximum* Individual Family	$1,500 $3,000	$4,500 $9,000	$3,000 $6,000
Physicians' Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Physician or Specialist Office Visits • Treatment of illness or injury • Behavioral health	90% after the annual plan deductible	60% of U&C after the annual plan deductible	100% after $30 copayment per visit
Physician or Specialist Office Visits • Wellness care/Preventive healthcare (including womens' healthcare) are not subject to the health plan year deductible	100%	60% of U&C after the annual plan deductible	100%
Outpatient Surgery • When billed as an office visit	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $30 copayment per visit
Allergy Tests, Injections and Serum	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $30 copayment per visit
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Inpatient services	90% after annual plan deductible and a $250 hospital admission deductible per admission	60% of U&C after the annual plan deductible and a $500 hospital admission deductible per admission	100% after $250 copayment per admission
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization Note: Contact plan administrator regarding prior authorization	90% after the annual plan deductible and a $250 hospital admission deductible per admission	60% of U&C after the annual plan deductible and a $500 hospital admission deductible per admission	100% after $250 copayment per admission

* For an explanation of out-of-pocket maximums see pages 12 and 13.
Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	**Tier II – 90% Benefit**	**Tier III – 80% Benefit**
Covered Services			
Health Plan Year Deductible Per enrollee Note: The annual health plan deductible must be met before plan benefits apply	Not applicable	$300	$500
Out-of-Pocket Maximum* Individual Family	Not applicable	$1,000 $2,500	$2,000 $5,000
Physicians' Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Physician or Specialist Office Visits • Treatment of illness or injury • Behavioral health	100% after $30 copayment per visit	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Physician or Specialist Office Visits • Wellness care/Preventive healthcare (including womens' healthcare) are not subject to the health plan year deductible	100%	100%	Covered under Tier I and Tier II only
Outpatient Surgery • When billed as an office visit	100% after $30 copayment per visit	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Allergy Tests, Injections and Serum	100% after $30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Inpatient services	100% after $250 copayment per admission	90% of network charges after the annual plan deductible and a $300 copayment per admission	80% of U&C after the annual plan deductible and a $400 copayment per admission
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization Note: Contact plan administrator regarding prior authorization	100% after $250 copayment per admission	90% of network charges after the annual plan deductible and a $300 copayment per admission	80% of U&C after the annual plan deductible and a $400 copayment per admission

* For an explanation of out-of-pocket maximums see pages 12 and 13.
Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	LCHP		HMO
	In-Network	Out-of-Network	In-Network
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $200 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	90% after the annual plan deductible and a $400 emergency room deductible per visit	90% of U&C after the annual plan deductible and $400 emergency room deductible per visit	100% after $200 copayment per visit
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
• Imaging • Diagnostic Tests	90% after annual plan deductible	60% of U&C after the annual plan deductible	100%
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Ambulance Service for Emergency Care	90% after annual plan deductible	90% of U&C after the annual plan deductible	100%
Home Health Care Services Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100% after $30 copayment per visit
Skilled Nursing Facility Services Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Hospice Care Note: Prior approval required	90% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	90% after annual plan deductible	60% of U&C after the annual plan deductible	80% of network charges
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	90% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $30 copayment per visit
Chiropractic Services Note: Chiropractic care for maintenance is not covered	90% after annual plan deductible, maximum 30 visits per plan year	60% of U&C after the annual plan deductible, maximum 30 visits per plan year	100% after $30 copayment per visit

Note: See page 13 for an explanation of usual and customary (U&C) charges.
* See page 6 of the LCHP Summary Document on the Benefits website for benefit limitations.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	**Tier II – 90% Benefit**	**Tier III – 80% Benefit**
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	100% after $200 copayment	90% of network charges after the annual plan deductible and a $200 copayment	80% of U&C after the annual plan deductible and a $200 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	100% after $200 copayment per visit	100% after the annual plan deductible and a $200 copayment per visit	100% after the annual plan deductible and a $200 copayment per visit
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
• Imaging • Diagnostic Tests	100%	90% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Ambulance Service for Emergency Care	100%	100%	100%
Home Health Care Services Note: Prior approval required	100% after $30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Skilled Nursing Facility Services Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospice Care Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	80% of network charges	80% of network charges after the annual plan deductible	80% of U&C after the annual plan deductible
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	100% after $30 copayment per visit	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Chiropractic Services Note: Chiropractic care for maintenance is not covered	100% after $30 copayment per visit, maximum 25 visits per plan year	90% of network charges after the annual plan deductible, maximum 25 visits per plan year	Covered under Tier I and Tier II only

Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	LCHP		HMO
	In-Network	Out-of-Network	In-Network
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Transplant Services Note: Prior approval required	90% after the annual plan deductible and a $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator.	Covered in-network only	100%
Pharmacy			
Copayments (30-day supply)			
Generic	$12.50		$12
Preferred Brand	$25		$24
Nonpreferred Brand	$50		$48
Specialty	$100		$96

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100% of covered expenses for the remainder of the plan year. It is important to note that certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges ineligible for payment by the plan include amounts over U&C, charges for noncovered services, prescription copayments, charges for services deemed to be not medically necessary and penalties for failing to precertify/provide notification. For the LCHP, $50 of the Medicare Part A deductible is also the member's responsibility.

The types of charges that are applied toward the out-of-pocket maximum for each type of plan varies and are outlined below:

- **Local Care Health Plan:** The types of charges that apply toward the out-of-pocket maximum for LCHP include the annual plan deductible, additional deductibles and coinsurance.
- **HMO Plans:** HMO plans apply copayments toward the out-of-pocket maximum.
- **OAP Plans:** OAP plans do not have an out-of-pocket maximum for Tier I; however, for Tiers II and III, only coinsurance is applied toward the out-of-pocket maximum. Also for Tiers II and III, the out-of-pocket maximum amount must be met for each tier and are cumulative between tiers. For example, once the 'individual' out-of-pocket maximum for Tier II has been met (i.e., $1,000), coinsurance for Tier II providers is no longer required. However, if the same plan participant then goes to a Tier III provider (out-of-network), they will need to satisfy an additional $1,000 to meet the out-of-pocket maximum for Tier III charges (i.e., $2,000).

Benefits Comparison: LCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	**Tier II – 90% Benefit**	**Tier III – 80% Benefit**
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Transplant Services Note: Prior approval required	100%	90% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Pharmacy			
Copayments (30-day supply)			
Generic	$12		
Preferred Brand	$24		
Nonpreferred Brand	$48		
Specialty	$96		

Out-of-Pocket Maximums Chart

		CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM			
PLAN	**Out-of-Pocket Maximum Limits**	**Annual Plan Year Deductible**	**Additional Deductibles/ Copayments**	**Coinsurance**	**Amounts over U&C*** (LCHP out-of-network providers and OAP Tier III providers)
LCHP	**In-Network** Individual $1,500 Family $3,000 **Out-of-Network** Individual $4,500 Family $9,000	X	X	X	Amounts over U&C are the member's responsibility and do not go toward the out of-pocket maximum.
HMO	Individual $3,000 Family $6,000		X		
OAP Tier II	Individual $1,000 Family $2,500			X	
OAP Tier III	Individual $2,000 Family $5,000			X	

* Usual and customary (U&C) is applied to charges accrued when utilizing an out-of-network provider. For example, if an out-of-network provider charges $1,000 for a procedure, but the U&C cost for the procedure is $800, the percentage of coinsurance that the plan will pay is based on the $800. The $200 difference between the charges for the procedure and the U&C cost ($1,000-$800) is always the member's responsibility.

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 State of Illinois 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.

Plan Participants Eligible for Medicare (cont.)

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.

Civil union partner dependents who are eligible for premium-free Medicare Part A upon turning the age of 65 are required by the Local Government Health Plan to enroll in Medicare Part B. Once enrolled, Medicare will be the primary payer for the partner's coverage regardless of the member's current employment status.

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).

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 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.

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.

The maximum fill that LCHP plan participants can obtain at one fill at a retail pharmacy is 60 days worth of medication; however, plan participants can obtain a 90-day supply of maintenance medication through the Mail Order Program. A 90-day supply through the LCHP Mail Order Program will cost two copayments instead of three. See pages 12 and 13 for copayment amounts.

New Specialty Drug Category

A new specialty drug category has been added for plan year 2013. A specialty drug is a medication that typically costs $500 or more per dose or $6,000 or more per year and has one or more of the following characteristics:

- Is a complex therapy for a complex disease;
- Is used for specialized patient training and coordination of care (services, supplies or devices) and is required prior to therapy initiation and/or during therapy;
- Has unique patient compliance and safety monitoring requirements;
- Has unique requirements for handling, shipping and storage;
- Has a potential for significant waste due to the high cost of the drug.

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

Dental Plan

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

Dental Benefit

The Local Care Dental Plan (LCDP) is a dental plan that offers a comprehensive range of benefits administered by Delta Dental of Illinois. 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.

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.

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

- **The Delta Dental PPO℠ Network** If you go to a PPO-level dentist you can maximize your dental benefits and minimize your out-of-pocket expenses because these providers accept a lower negotiated PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.
- **The Delta Dental Premier℠ Network** If you go to a Premier-level dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier-level fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for 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 benefits as provided by the Schedule of Benefits. You will likely 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.

Plan participants can access LCDP network information, explanation of benefits (EOB) statements and other valuable information online by registering with Delta Dental of Illinois Subscriber Connection.

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

Dental Plan (cont.)

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.

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 maximum 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 based on the length of treatment (see 'Length of Orthodontia Treatment' chart below). This lifetime maximum applies to each plan participant regardless of the number of courses of treatment. **Note:** The annual plan year deductible will need to be satisfied each plan year that the plan participant is receiving orthodontia treatment unless it was previously satisfied for other dental services incurred during the plan year.

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 LCDP.
- 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.

Plan Administrators

Who to contact 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) www.cigna.com/stateofil
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $400 applies	**Cigna**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY)
Prescription Drug Plan Administrator LCHP (1401LD3) Coventry 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, program requirements 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.

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