STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

FY 2025

benefit choice

Local Government Health Plan

Benefit Choice Period

May 1 - May 31, 2024 • Effective July 1, 2024

Table of Contents

How to Elect Benefits

All Benefit Choice changes should be made on the Benefit Choice Election Form available on page 12. Members should complete the form only if changes are being made. Your unit Health Plan Representative (HPR) will forward the form to the Local Government Health Plan (LGHP) for processing.

What You Need to Do

1. Continue reading this brochure to review your benefit options.
2. If you would like to make a change to your benefits this year, elect new benefits by filling out the Benefit Choice Election Form on Page 12 of this Benefit Choice book, or the printable form can be found at MyBenefits.illinois.gov.
3. Give your Benefit Choice Election Form to your HPR before May 31, 2024.
4. Take advantage of your benefits which will become effective July 1, 2024.

Need Help?

AVA, the interactive digital assistant, is available online at

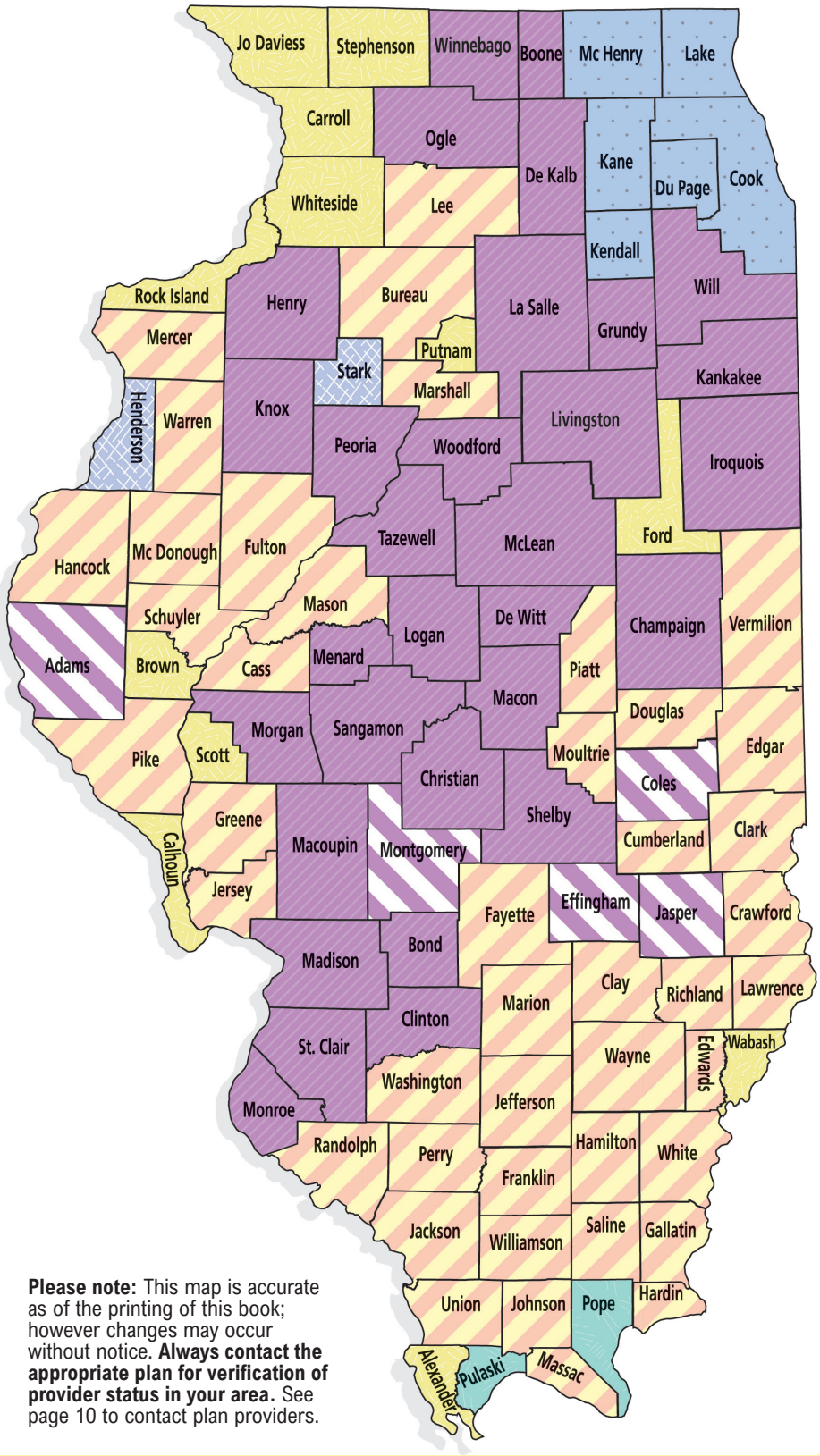
MyBenefits.illinois.gov

Or

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

What is Available in Your Area in FY25

Review the following map and charts to identify plans available in your county. Then, review your monthly contribution and plan benefits to determine which plan is best for you.



Health Alliance HMO
Aetna HMO
HealthLink OAP
Aetna OAP
BCBS OAP
Local Consumer-Driven Health Plan (LCDHP)
Local Care Health Plan (LCHP)

HMO Illinois
Blue Advantage HMO
Health Alliance HMO
Aetna HMO
HealthLink OAP **(except Iroquois - no tier 1)**
Aetna OAP
Blue Cross Blue Shield OAP
Local Consumer-Driven Health Plan (LCDHP)
Local Care Health Plan (LCHP)

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Local Care Health Plan (LCHP)

Aetna HMO
Aetna OAP
BCBS OAP
Health Alliance HMO
Local Consumer-Driven Health Plan (LCDHP)
Local Care Health Plan (LCHP)

Please note: This map is accurate as of the printing of this book; however changes may occur without notice. **Always contact the appropriate plan for verification of provider status in your area.** See page 10 to contact plan providers.

Benefit Choice Period

Elect Your Benefits May 1 - May 31, 2024

What's New

Health Plan Availability

There are several changes this year. It is **your responsibility** to verify what Health Plans are available in your area (see page 1).

A New Enhanced Delta Dental Benefits Program

The Delta Dental of Illinois' Enhanced Benefits Program integrates medical and dental care – where oral health meets overall health. This program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. For more information on this program please go to www.deltadentalil.com or by calling them at 1-800-323-1743.

Additional Vision Benefits

The Vision Plan administered by EyeMed now offers additional coverage for Progressive Lenses, Premium Anti-Reflective Coating and coverage for Photochromic and Polarized lenses. For additional information, please visit the LGHP Vision Plan page at MyBenefits.illinois.gov.

Adding a Dependent

If you add a dependent for the first time this year, you must provide the required documentation no later than June 10, 2024. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan. Note: Any documentation received after May 31, 2024, may result in a delay of ID cards.

Qualifying Changes in Status

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

You must report a qualifying change in status to your Health Plan Representative (HPR) within 60 days of the event to be eligible to make benefit changes outside of the Benefit Choice Period. The change will be effective the date of the event or request, whichever is later. Also note that it is required to report important events to your HPR, including a change in Medicare status, leave of absence, unpaid time away from work, or to report a financial or medical power of attorney.

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, 2024 and discharged on or after July 1, 2024, 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 who are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, should contact their new plan administrator before July 1, 2024, to coordinate the transition of services for treatment.

HMO Benefits

Health Maintenance Organization (HMO) members are required to stay within the health plan provider network. No out-of-network services are available, other than listed below. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. For a copy of the SPD, contact the plan administrator (see page 10).

HMO Plan Design		
Plan Year Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	
Hospital Services		
	In-Network	**Out-of-Network**
Emergency Room Services	$300 copayment per visit	$300 copayment per visit
Inpatient Hospitalization	$350 copayment per admission	Not covered
Inpatient Alcohol and Substance Abuse	$350 copayment per admission	Not covered
Inpatient Psychiatric Admission	$350 copayment per admission	Not covered
Outpatient Surgery	$300 copayment per visit	Not covered
Skilled Nursing Facility	100% covered	Not covered
Diagnostic Lab and X-ray	100% covered	Not covered
Transplant Services		
Organ and Tissue Transplants	$350 copay, limited to network transplant facilities as determined by the medical plan administrator. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.	
Professional and Other Services		
	In-Network	**Out-of-Network**
Preventive Care/Well-Baby/Immunizations	100% covered	Not covered
Physician Office Visit	$40 copayment per visit	Not covered
Specialist Office Visit	$45 copayment per visit	Not covered
Telemedicine	$10 copayment	Not covered
Outpatient Psychiatric and Substance Abuse	$40 or $45 copayment per visit	Not covered
Durable Medical Equipment	70% covered	Not covered
Home Health Care	$45 copayment per visit	Not covered

Prescription Drugs

Plan Year Pharmacy Deductible – $175 per enrollee Preventive Prescription Drugs – $0

	Reduced Tier I *	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	$4.00	$15.00	$30.00	$60.00	$120.00
Copayments (90-day supply)	$10.00	$37.50	$75.00	$150.00	$350.00

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

Open Access Plan (OAP) Benefits

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

- **Tier I** offers a managed care network which provides enhanced benefits and operates similar to an HMO.
- **Tier II** offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
- **Tier III** covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP. For a copy of the SPD, contact the plan administrator (see page 10).

Benefit	Tier I	Tier II	Tier III (Out-of-Network)**
Plan Year Out-of-Pocket Maximum • Per Individual • Per Family	$7,250 (includes eligible charges from Tiers I & II combined)**** $13,750 (includes eligible charges from Tiers I & II combined)****		Not Applicable
Plan Year Deductible (must be satisfied for all services)	$0	$400 per enrollee*	$600 per enrollee*
Hospital Services *(Percentages listed represent how much is covered by the plan)*			
Emergency Room Services	$300 copayment per visit	$300 copayment per visit	$300 copayment per visit
Inpatient Hospitalization	$350 copayment per admission	80% of network charges after $400 copayment per admission*	50% or allowable charges after $500 copayment per admission*
Inpatient Alcohol and Substance Abuse	$350 copayment per admission	80% of network charges after $400 copayment per admission*	50% of allowable charges after $500 copayment per admission*
Inpatient Psychiatric Admission	$350 copayment per admission	80% of network charges after $400 copayment per admission*	50% of allowable charges after $500 copayment per admission*
Outpatient Surgery	$300 copayment per visit	80% of network charges after $300 copayment*	50% of allowable charges after $300 copayment*
Skilled Nursing Facility	85% of network charges	85% of network charges*	Not covered
Diagnostic Lab and X-ray	100% covered	80% of network charges *	50% of allowable charges*
Transplant Services			
Organ and Tissue Transplants	**Tier I:** 100% covered. **Tier II:** 90% of network charges. **Tier III:** Not covered. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.		
Professional and Other Services			
Preventive Care/Well-Baby /Immunizations	100% covered	100% covered	Not covered
Physician Office Visits	$40 copayment	80% of network charges*	50% of allowable charges*
Specialist Office Visits	$45 copayment	80% of network charges*	50% of allowable charges*
Telemedicine	$10 copayment	Not covered	Not covered
Outpatient Psychiatric and Substance Abuse	$40 or $45 copayment	80% of network charges*	50% of allowable charges*
Durable Medical Equipment	70% of network charges	60% of network charges*	50% of allowable charges*
Home Health Care	$45 copayment	75% of network charges*	Not covered

Prescription Drugs

Plan Year Pharmacy Deductible – $175 per enrollee Preventive Prescription Drugs – $0

	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	$15	$30	$60	$120
Copayments (90-day supply)	$30	$60	$120	–
Maintenance Choice (90-day supply)***	$15	$30	$60	–

* A plan year deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.
** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region.
*** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.
**** For an explanation of Out of Pocket Maximums, please see page 8.

Local Care Health Plan (LCHP) Benefits

Local Care Health Plan (LCHP) members may choose any physician or hospital for medical services; however, when receiving services from a LCHP in-network provider, members receive enhanced benefits, resulting in lower out-of-pocket costs. LCHP has a nationwide network of providers through Aetna PPO. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the LCHP. For a copy of the SPD, contact the plan administrator (see page 10).

Plan Year Maximums and Deductibles			
In-Network Medical $1,000 per enrollee	In-Network Prescription $175 per enrollee	Out-of-Network Medical $1,000 per enrollee	Out-of-Network Prescription $175 per enrollee

Out-of-Pocket Maximum Limits***			
In-Network Individual $2,000	In-Network Family $4,000	Out-of-Network Individual $6,000	Out-of-Network Family $12,000

Hospital Services *(Percentages listed represent how much is covered by the plan)*		
	In-Network	**Out-of-Network***
Emergency Room Services	$400 per visit; Deductible applies	$400 per visit; Deductible applies
Inpatient Hospitalization	80% covered; Deductible applies after $350 per admission	50% of allowable charges; Deductible applies after $600 per admission
Inpatient Alcohol and Substance Abuse	80% covered; Deductible applies after $350 per admission	50% of allowable charges; Deductible applies after $600 per admission
Inpatient Psychiatric Admission	80% covered; Deductible applies after $350 per admission	50% of allowable charges; Deductible applies after $600 per admission
Outpatient Surgery	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Skilled Nursing Facility	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	80% covered; Deductible applies	50% of allowable charges; Deductible applies

Transplant Services	
Organ and Tissue Transplants	80% after $250 transplant copayment; Deductible applies, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services.

Professional and Other Services		
	In-Network	**Out-of-Network***
Preventive Care/Well-Baby /Immunizations	100% covered	50% of allowable charges; Deductible applies
Physician Office Visit	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Specialist Office Visit	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Telemedicine	80% covered; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Durable Medical Equipment	80% covered; Deductible applies	50% of allowable charges; Deductible applies
Home Health Care	80% covered; Deductible applies	50% of allowable charges; Deductible applies

Prescription Drugs

Plan Year Pharmacy Deductible – $175 per enrollee Preventive Prescription Drugs – $0

	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	$15	$30	$60	$120
Copayments (90-day supply)	$30	$60	$120	$240
Maintenance Choice (90-day supply)**	$15	$30	$60	–

* Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region.
** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.
*** For an explanation of Out of Pocket Maximums, please see page 8.

Local Consumer-Driven Health Plan (LCDHP) Benefits

This is a high-deductible health plan as defined by the IRS. Local Consumer-Driven Health Plan (LCDHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a LCDHP in-network provider. LCDHP has a nationwide network of providers through Aetna PPO. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the LCDHP. For a copy of the SPD, contact the plan administrator (see page 10).

Plan Year Medical Deductibles			
In-Network Individual $2,000	In-Network Family* $4,000	Out-of-Network Individual $4,000	Out-of-Network Family* $8,000
Out-of-Pocket Maximum Limits ****			
In-Network Individual $5,000	In-Network Family $8,000	Out-of-Network Individual $7,000	Out-of-Network Family $14,000

Hospital Services *(Percentages listed represent how much is covered by the plan)*		
	In-Network	**Out-of-Network****
Emergency Room Services	80%; Deductible applies	80%; Deductible applies
Inpatient Hospitalization	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Inpatient Alcohol and Substance Abuse	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Inpatient Psychiatric Admission	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Outpatient Surgery	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Skilled Nursing Facility	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies

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

Professional and Other Services		
	In-Network	**Out-of-Network****
Preventive Care/Well-Baby /Immunizations	100% covered	Not covered
Physician Office Visit	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Specialist Office Visit	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Telemedicine	80% of network charges; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Durable Medical Equipment	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies
Home Health Care	80% of network charges; Deductible applies	50% of allowable charges; Deductible applies

Prescription Drugs

Preventive Prescription Drugs – $0

	Tier I	**Tier II**	**Tier III**
Copayments (30-day supply)	70%; Deductible applies	50%; Deductible applies	50%; Deductible applies
Maintenance Choice (90-day supply)***	85%; Deductible applies	75%; Deductible applies	75%; Deductible applies

* Members with one or more dependents on their coverage must satisfy the family annual plan year deductible before services will be covered at the plan's benefit levels.

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

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

**** For an explanation of Out of Pocket Maximums, please see page 8.

Health Plan Comparison

Benefit	LCHP		LCDHP		HMO	OAP Tier I (in-network)	OAP Tier II (in-network)	OAP Tier III (in-network)
Patient Responsibilities								
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**				
Per Enrollee	$2,000	$6,000	$5,000	$7,000	$3,000	$7,250 (Tier I and Tier II combined		Not applicable
Per Family	$4,000	$12,000	$8,000	$14,000	$6,000	$13,750 (Tier I and Tier II combined		Not applicable
Plan Year Deductible*								
Per Enrollee	$1,000 per enrollee		$2,000	$4,000	Not applicable	Not applicable	$400 per enrollee	$600 per enrollee
Per Family	$1,000 per enrollee		$4,000	$8,000			$400 per enrollee	$600 per enrollee
Plan Benefit Levels Comparison								
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****				
Emergency Room	$400 per visit; Deductible applies	$400 per visit; Deductible applies	80%; Deductible applies	80%; Deductible applies	$300	$300	$300	$300
Preventive Services including immunizations	100%	50% of allowable charges*	100%	No coverage	100%	100%	100%	Covered under Tier I and Tier II only
Inpatient	80% of network charges after $350 per visit*	50% of allowable charges after $600 per visit*	80% of network charges*	50% of allowable charges*	$350 copayment	$350 copayment	80% of network charges* after $400 copayment	50% of allowable charges* after $500 copayment
Outpatient Surgery	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	$300 copayment	$300 copayment	80% of network charges* after $300 copayment	50% of allowable charges* after $300 copayment
Diagnostic Lab and X-ray	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	100%	100%	80% of network charges*	50% of allowable charges*
Durable Medical Equipment	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	70% of network charges	70% of network charges	60% of network charges*	50% of allowable charges*
Physician Office Visit	80% of network charges*	50% of allowable charges*	80% of network charges*	50% of allowable charges*	$40 copayment	$40 copayment	80% of network charges*	50% of allowable charges*

Special note: Members enrolled in the LCDHP plan with one or more dependents on their coverage must satisfy the family annual plan year deductible before services will be covered at the plan's benefit level.

* The plan year deductible must be met before benefit levels will be applied.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your plan year out-of-pocket maximum; this varies by plan and geographic region. Members who use out-of-network providers should contact their health plan administrator for information regarding out-of-network charges before obtaining services.

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

In accordance with the Affordable Care Act (ACA), prescription coinsurance and copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **Local Care Health Plan:***
  - Medical plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - LCHP additional medical deductibles
- **Local Consumer-Driven Health Plan:***
  - Medical plan year deductible
  - Medical and prescription coinsurance

* Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

- **HMO Plans:**
  - Medical and prescription copayments
  - Medical coinsurance
- **OAP Plans (only applies to Tier I and Tier II providers):**
  - Medical plan year deductible (Tier II)
  - Medical and prescription copayments
  - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

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 that do not count toward the out-of-pocket maximum include:

- The dispense as written (DAW) penalty (i.e., the cost difference between a brand name medication and a generic, plus the brand copayment when a generic is available);
- Amounts over allowable charges (MRC, MAC, U+C**) for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM

PLAN	Out-of-Pocket Maximum Limits	Plan Year Deductible	Additional Deductibles (LCHP)/ Copayments	Medical Coinsurance	Pharma Coinsurance/ Copayments/ Deductible	Amounts over Allowable Charges (LCHP and LCDHP out-of-network providers and OAP Tier III providers)
LCHP	**In-Network** Individual $2,000 Family $4,000	X	X	X	X	**Amounts over the plan's allowable charges (MRC, MAC, U+C**) are the member's responsibility and do not go toward the out-of-pocket maximum.**
	Out-of-Network Individual $6,000 Family $12,000	X	X	X	X	
LCDHP	**In-Network** Individual $5,000 Family $8,000	X	N/A	X	X	
	Out-of-Network Individual $7,000 Family $14,000	X	N/A	X	X	
HMO	Individual $3,000 Family $6,000	N/A	X	X	X	
OAP Tier I & OAP Tier II	Individual $7,250 Family $13,750	X	X	X	X	
		X	X	X	X	
OAP Tier III	N/A	N/A	N/A	N/A	N/A	

Note: Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles, as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum.

** MRC = Maximum Reimbursable Charge, MAC = Maximum Allowable Charge, U+C = Usual and Customary

Dental

The Local Care Dental Plan (LCDP) offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits at MyBenefits.illinois.gov.

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

Deductible and Plan Year Maximum	
Plan year deductible for preventive services	N/A
Plan year deductible for all other covered services	$100
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
In-network plan year maximum benefit	$2,000

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

Child Orthodontia Benefit

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

Vision

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

Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	$25 copayment	$30 allowance	Once every 12 months
Standard Frames	$25 copayment (up to $175 retail frame cost; member responsible for balance over $175)	$70 allowance	Once every 24 months
Vision Lenses* (single, bifocal and trifocal)	$25 copayment	$50 allowance for single vision lenses $80 allowance for bifocal and trifocal lenses	Once every 12 months
Contact Lenses (All contact lenses are in lieu of vision lenses)	$120 allowance	$120 allowance	Once every 12 months

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

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

Local Government Health Plan

Medicare Requirements

Each member and dependent must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that the member is eligible for Medicare Part A at a premium-free rate, the member is required by the LGHP to enroll in Medicare Part A. Once enrolled in Medicare, the member and/or dependent is required to send a front-side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a member is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the member must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty.

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

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits Service Center (MBSC) 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	mybenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285656) Aetna OAP (Group Number 285652) Local Consumer-Driven Health Plan (LCDHP) - Aetna Local (Group Number 285661) Local Care Health Plan (LCHP) - Aetna PPO (Group Number 285661) Address for all Aetna Plans: PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06801) HMO Illinois (Group Number H06801) Blue Cross Blue Shield OAP (Group Number 269094) Address for all Blue Cross Plans: PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY) 855-810-6537	bcbsil.com/stateofillinois
	Health Alliance Medical Plans HMO (Group Number 1000040) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY	healthalliance.org/stateofillinois
	HealthLink OAP (Group Number 160001) PO Box 419104, St. Louis, MO 63141-9104	877-379-5802 877-232-8388 (TDD/TTY)	healthlink.com/soi/learn-more
Prescription Drug Plan	CVS Caremark® (for LCHP, LCDHP or OAP Plans) Group Numbers: (LCHP 1401LD3) (LCDHP 1401LD9) (Aetna OAP 1401LCH) (BCBSIL OAP 1401LCJ) (HealthLink OAP 1401LCF) **Paper Claims:** CVS Caremark® PO Box 52136, Phoenix, AZ 85072-2136 **Mail Order Rx:** CVS Caremark® PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims (Group Number 9784851) PO Box 8504, Mason, OH 45040-7111	866-723-0512 TTY users, call 711	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20241) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com

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 – MEMBER INFORMATION

Complete all fields.

SECTION B – HEALTH PLAN ELECTION

If you wish to **change your health** plan you must check the Local Care Health Plan (LCHP), the Local Consumer-Driven Health Plan (LCDHP), the OAP or the HMO box. If **electing/changing to either an HMO or OAP plan,** you must specify the plan's full name. If you are electing an HMO, you must also enter the National Provider Identifier (NPI) associated with your Primary Care Physician (PCP)*. NPI's are located in the HMO plan's online directory (available on the plan administrator's website) and are 10 digits in length. If you elect HMO Illinois or BlueAdvantage HMO you will also need to enter the 3-digit medical group number.

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 dependent(s) are already enrolled and you are only changing your health plan to LCHP, LCDHP 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 or Civil Union Partner	Marriage certificate or civil union partnership certificate
Natural Child through age 25	Birth certificate
Stepchild or civil union partner's child through age 25	Birth certificate indicating your spouse/civil union partner is the child's parent and a marriage/civil union partnership certificate indicating the child's parent is your spouse/civil union partner
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 (IRS/non-IRS) through age 29	Birth certificate (if not already on file), proof of Illinois residency and Veterans' Affairs release form DD-214 (or equivalent)
Disabled age 26 or older	Birth certificate (if not already on file), statement from the Social Security Administration with the Social Security disability determination or a court order adjudicating the disability, and a copy of the Medicare card (if applicable)
Other (organ transplant recipient)	Birth certificate (if not already on file), proof of organ transplant performed after June 30, 2000

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

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR no later than **May 31, 2024,** in order for your elections to be effective July 1, 2024.

*A Primary Care Physician (PCP) is a family practice, general practice, internal medicine, pediatrician (children) or an OB/GYN (women) physician.

LOCAL GOVERNMENT HEALTH PLAN (LGHP)

BENEFIT CHOICE ELECTION FORM

Enrollment Period May 1 through May 31, 2024

Complete This Form Only If Changing Your Benefits

SECTION A: MEMBER INFORMATION

Last Name:	First Name:
Primary Phone #:	Alternate Phone #:
Email Address:	SSN:

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

Health Plan Election*

Elect One:

- ☐ Local Care Health Plan (LCHP)
- ☐ Local Consumer-Driven Health Plan (LCDHP)
- ☐ Health Maintenance Organization (HMO)
  - ☐ Aetna HMO
  - ☐ BlueAdvantage HMO
  - ☐ Health Alliance HMO
  - ☐ HMO Illinois
- ☐ Open Access Plan (OAP)
  - ☐ Aetna OAP
  - ☐ Blue Cross Blue Shield OAP
  - ☐ HealthLink OAP

If you selected an HMO or an OAP, you must complete the following:

Carrier Name: _____

If you elected an HMO, also complete the field below:

Nation Provider Identifier (NPI) (10 digits required):

_____

(NPI's can be found on the health plan's website)

If you elected HMO Illinois or BlueAdvantage HMO, you must complete the following:

Medical Group # (3 digits): _____

* If you have another health insurance plan, including Medicare, you must send a copy of your 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) C (Change)			Name	SSN (REQUIRED)	Birth Date	Relationship[2]	Sex (M/F)	National Provider Identifier (HMOs only) If HMO IL or BlueAdvantage HMO add 3-digit Medical Group # °	Medical Group Number
A	D	C							

Note: [1]Documentation required to add dependents – see specific documentation requirements on the instruction sheet.

[2]Relationship categories are on the instruction sheet

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: _____

Send completed form to your unit's HPR no later than May 31, 2024.

Federally Required Notices

Notice of Creditable Coverage

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

This Notice confirms that the Local Government Health Plan (LGHP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through LGHP is, on average, as good as, or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan.

Because your existing coverage is Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your coverage through LGHP and experience a continuous period of 63 days or longer without Creditable Coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your LGHP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your LGHP coverage ends.

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

Summary of Benefits and Coverage (SBC) and Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The summary is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in coverage, or if you request a copy from your issuer or group health plan. You may also request a paper copy of the SBCs and glossary of terms from your health insurance company or group health plan. All LGHP health plan SBCs are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated at MyBenefits.illinois.gov**,** effective July 1, 2024. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at MyBenefits.illinois.gov.

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

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be well ILLINOIS

The State of Illinois' ongoing comprehensive approach to wellness.

The State of Illinois cares about you and your health.

Be Well Illinois is designed to not only focus on supporting your physical health but also your mental, financial, and social wellbeing. As a wellness plan member, you can use this site to access health plan information and educational resources including wellness webinars, monthly health awareness causes, financial wellness, healthy eating, and exercise.

While the decision to make healthy lifestyle changes is your choice and not a job requirement, the hope is that by creating an environment where these choices are supported by the work culture makes it easier and supports your success.

Engaging with Be Well Illinois is easy, connect with us in one of the following ways.

Visit us at www.Illinois.gov/BeWell
Follow us on Facebook at https://www.facebook.com/BeWellIllinois
Or email us at BeWell@illinois.gov