



STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

FY 2022 Benefit Choice

Discover Your Options



**Many
Changes
and NEW Options
INSIDE!**



Benefit Choice Period • May 1-June 1, 2021
State Employees Group Insurance Program

Effective July 1, 2021

Table of Contents

Benefit Choice Period	1
What is Changing	1
What is Available in Your Area	2
Monthly Contributions	3
Adding a Dependent	4
Opt-Out	4
Qualifying Changes in Status	4
Transition of Care after Health Plan Change	4
Health Plans	5
HMO Benefits	5
Open Access Plan (OAP) Benefits	6
Quality Care Health Plan (QCHP) Benefits	7
Consumer Driven Health Plan (CDHP) Benefits	8
Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA)	9
HSA	9
MCAP	10
DCAP	10
Vision	11
Dental	12
Life	13
Medicare Requirements	14
Total Retiree Advantage	
Illinois (TRAIL)	14
Wellness	15
Be Well Illinois	15
Employee Assistance Program (EAP) & Personal Support Program (PSP)	15
Smoking Cessation	15
Weight-Loss	15
Contacts	16
Federally Required Notices	17

ONLINE ENROLLMENT PLATFORM

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

1. Go to MyBenefits.illinois.gov.
2. In the top right corner of the home page, click **Login**.
3. If you are logging in for the first time, click Register in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice materials mailed to your home.
4. Enter your login ID and password. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles.
5. After exploring your benefit options and determining which benefits you would like to elect, click on the Benefit Choice Event, located on the Welcome page.

Need Help?

AVA, the interactive digital assistant, is available online at

MyBenefits.illinois.gov

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 YOU NEED TO DO

1. Go to MyBenefits.illinois.gov to review your benefit options.
2. Choose the benefits you'd like to elect at MyBenefits.illinois.gov between May 1-June 1, 2021.
3. Consider going paperless. Provide, or update your email address at MyBenefits.illinois.gov to receive quick responses and notifications through electronic communications.
4. Take advantage of your new benefits which will become effective July 1, 2021.

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

DISCLAIMER

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

Benefit Choice Period

Elect Your Benefits May 1 - June 1, 2021

TAKE ACTION! Here is a quick view of benefit changes for the coming plan year. Action is **ONLY** required if you intend to enroll or re-enroll in a Flexible Spending (MCAP/DCAP), or Health Savings account. If you wish to keep your current coverage as is, no action is required.

What's New

The following Benefit Changes effective July 1, 2021

Premium Changes

Contribution amounts will vary based on the member's salary and chosen health plan (see page 3).

Dental Only Coverage

Beginning July 1, 2021, employees now have the option to enroll in Dental Only coverage. However, if you enroll in health coverage and choose dental coverage, dependents must mirror the coverage of the member.

Health Plan Availability

New this fiscal year, effective July 1, 2021, members now have the option of choosing from three OAP plans. We are pleased to announce that these Open Access Plans (OAP) will now be offered by Aetna, Healthlink and Blue Cross Blue Shield. Please check the map on Page 2 for coverage availability.

HealthLink Service Area Outside of Illinois

HealthLink members will continue to have network access in Missouri, Arkansas, Indiana, Kentucky, Ohio and Wisconsin. HealthLink members will no longer have access in other areas such as Florida or Texas.

Behavioral Health

For those enrolled in the Quality Care Health Plan (QCHP) and the Consumer Driven Health Plan (CDHP), your behavioral health provider network and claims will now be administered by Aetna. Please make sure to review the Aetna provider directory to ensure your provider is in-network, or contact Aetna (see page 15 for contact information) to discuss transition of care.

Medical Care Assistance Plan (MCAP) & Dependent Care Assistance Plan (DCAP)

For FY2022, the IRS has extended and added to the temporary COVID-19 flexibility for MCAP and DCAP (per the guidance of Notice 2021-15):

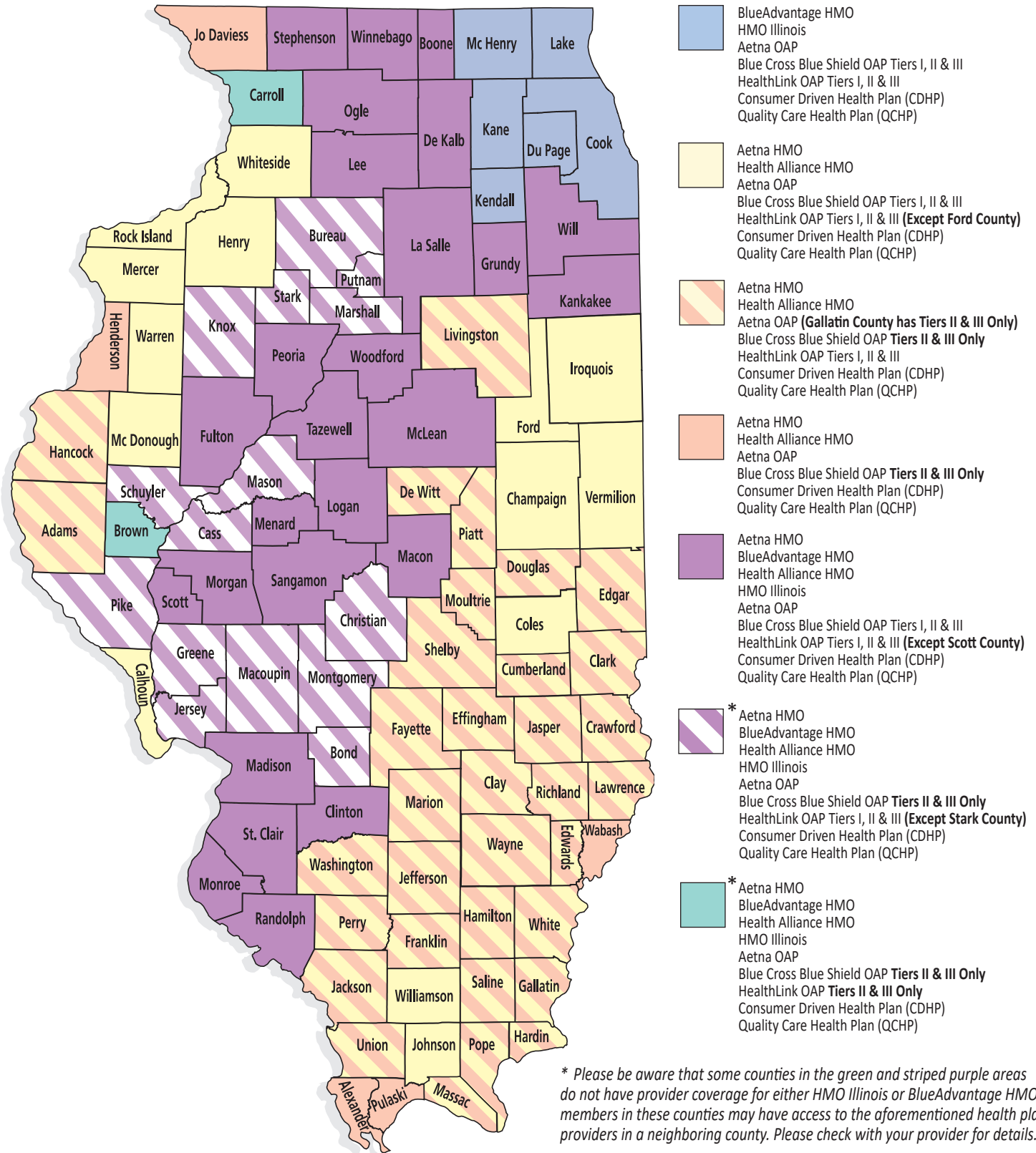
- Any unused funds from your MCAP/DCAP account will be rolled over as long as you re-enroll in that program.
- Additional election flexibility allowed, contact [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

The American Rescue Plan has increased DCAP contributions to \$5,250 for the FY22 plan year.

You must enroll or re-enroll in a Flexible Spending Account each plan year. The MCAP benefit is not available if enrolling in an HSA.

What is Available in Your Area in FY22

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



Monthly Contributions

The State shares the cost of health coverage with you. While the State covers the majority of the cost, you must make monthly contributions determined by your annual salary. The following charts outline monthly contribution rates for full-time members. Part-time members are required to pay a percentage of the State's portion of the monthly contribution in addition to their own. Special rules apply for non-IRS dependents (see MyBenefits.illinois.gov for more information).

Employee Annual Salary	Aetna HMO	Blue Advantage HMO	Health Alliance HMO	HMO Illinois	Aetna OAP	BCBSIL* OAP	HealthLink OAP	CDHP*	QCHP*
\$0 to \$30,200	\$107	\$83	\$107	\$87	\$101	\$101	\$114	\$85	\$120
\$30,201 - \$45,600	\$126	\$102	\$126	\$106	\$120	\$120	\$133	\$104	\$139
\$45,601 - \$60,700	\$145	\$121	\$145	\$125	\$139	\$139	\$152	\$123	\$157
\$60,701 - \$75,900	\$163	\$139	\$163	\$143	\$157	\$157	\$170	\$141	\$176
\$75,901 - \$100,000	\$182	\$158	\$182	\$162	\$176	\$176	\$189	\$160	\$195
\$100,001 - \$125,000	\$235	\$211	\$235	\$215	\$229	\$229	\$242	\$213	\$248
\$125,001 & Over	\$268	\$244	\$268	\$248	\$262	\$262	\$275	\$246	\$281

Members who retire, accept a salary reduction, or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary. This applies to members who return to work after having a 10-day or greater break in State service after terminating employment. This does not apply to members who have a break in coverage due to a leave of absence.

Dependent Monthly Health Plan Contributions

In addition to monthly contributions for their own health coverage, members must make additional monthly contributions for dependents they cover. Dependents must be enrolled in the same plan as the member. The Medicare dependent monthly contribution applies only if Medicare is primary for both Parts A and B.

Number of Dependents	Aetna HMO	Blue Advantage HMO	Health Alliance HMO	HMO Illinois	Aetna OAP	BCBSIL* OAP	HealthLink OAP	CDHP*	QCHP*
1 Dependent	\$177	\$141	\$177	\$145	\$168	\$168	\$185	\$153	\$272
2+ Dependents	\$222	\$177	\$223	\$184	\$213	\$213	\$238	\$197	\$310
1 Medicare A & B Primary Dependent	\$154	\$120	\$153	\$124	\$145	\$145	\$161	\$130	\$165
2+ Medicare A & B Primary Dependents	\$196	\$155	\$197	\$161	\$187	\$187	\$208	\$171	\$226

DISCLAIMER

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY22. For future years, the State reserves the right to designate the plan options which constitute the basic program of health benefits and to require additional contributions in accordance with the law for any optional coverage elected by an annuitant, retiree, or survivor.

*BCBSIL OAP = Blue Cross Blue Shield of Illinois

CDHP = Consumer Driven Health Plan

QCHP = Quality Care Health Plan

Adding a Dependent

If you add a dependent for the first time, or re-enroll a dependent during open enrollment, you must provide the required documentation to complete enrollment no later than June 10, 2021. Failure to provide adequate documentation by this deadline, will result in dependents not being added to your plan. Note: Any documentation received after June 1, 2021, may result in a delay of ID cards.

Opt-Out

Full-time employees, retirees, annuitants, and survivors have the option to opt-out of health coverage if they have other comprehensive coverage provided by an entity other than the Department of Central Management Services. Proof of other coverage and appropriate documentation must be submitted by June 10, 2021 for changes effective July 1, 2021. Be advised that if you have previously opted-out, or waived benefits, you can re-enroll during the Benefit Choice Period or if you experience a Qualifying Change in Status.

Qualifying Changes in Status

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

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

Please note: Members becoming Medicare-eligible will have a separate enrollment opportunity prior to their 65th birthday. Details can be found in the TRAIL section on Page 13.

Transition of Care after Health Plan Change

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



HMO Benefits

Health Maintenance Organization (HMO) members are required to stay within the health plan provider network. No out-of-network services are available, 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 15).

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	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$400 copayment per admission	Not covered
Inpatient Alcohol and Substance Abuse	\$400 copayment per admission	Not covered
Inpatient Psychiatric Admission	\$400 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
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	Not covered

Transplant Services

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

Professional and Other Services

	In-Network	Out-of-Network
Preventive Care/Well-Baby/Immunizations	100% covered	Not covered
Physician Office Visit	\$30 copayment per visit	Not covered
Specialist Office Visit	\$35 copayment per visit	Not covered
Telemedicine	\$10 copayment	Not covered
Outpatient Psychiatric and Substance Abuse	\$30 or \$35 copayment per visit	Not covered
Durable Medical Equipment	80% covered	Not covered
Home Health Care	\$35 copayment per visit	Not covered
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	Not covered

Prescription Drugs

	Plan Year Pharmacy Deductible – \$150 per enrollee		Preventive Prescription Drugs – \$0		
	Reduced Tier I *	Tier I	Tier II	Tier III	
Copayments (30-day supply)	\$4.00	\$13.00	\$31.00	\$55.00	
Copayments (90-day supply)	\$10.00	\$32.50	\$77.50	\$137.50	

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

Open Access Plan (OAP) Benefits

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

- **Tier I** offers a managed care network which provides enhanced benefits and operates similar to an HMO.
- **Tier II** offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
- **Tier III** covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP. For a copy of the SPD, contact the plan administrator (see page 15).

Benefit	Tier I	Tier II	Tier III (Out-of-Network)**
Plan Year Out-of-Pocket Maximum • Per Individual • Per Family	\$3,000 (includes eligible charges from Tier I and Tier II combined) \$6,000 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Plan Year Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*

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

Emergency Room Services	\$275 copayment per visit	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$400 copayment per admission	90% of network charges after \$450 copayment per admission*	60% of allowable charges after \$550 copayment per admission*
Inpatient Alcohol and Substance Abuse	\$400 copayment per admission	90% of network charges after \$450 copayment per admission*	60% of allowable charges after \$550 copayment per admission*
Inpatient Psychiatric Admission	\$400 copayment per admission	90% of network charges after \$450 copayment per admission*	60% of allowable charges after \$550 copayment per admission*
Outpatient Surgery	\$300 copayment per visit	90% of network charges after \$300 copayment*	60% of allowable charges after \$300 copayment*
Skilled Nursing Facility	100% covered	90% of network charges*	Not covered
Diagnostic Lab and X-ray	100% covered	90% of network charges*	60% of allowable charges*
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	90% of network charges*	60% of allowable charges*

Transplant Services

Organ and Tissue Transplants	Tier I: 100% covered. Tier II: 90% of network charges. Tier III: Not covered. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.		
------------------------------	---	--	--

Professional and Other Services

Preventive Care/Well-Baby/Immunizations	100% covered	100% covered	Not covered
Physician Office Visits	\$30 copayment	90% of network charges*	60% of allowable charges*
Specialist Office Visits	\$35 copayment	90% of network charges*	60% of allowable charges*
Telemedicine	\$10 copayment	Not covered	Not covered
Outpatient Psychiatric and Substance Abuse	\$30 or \$35 copayment	90% of network charges*	60% of allowable charges*
Durable Medical Equipment	80% of network charges	80% of network charges*	60% of allowable charges*
Home Health Care	\$35 copayment	90% of network charges*	Not covered

Prescription Drugs

Plan Year Pharmacy Deductible – \$150 per enrollee Preventive Prescription Drugs – \$0

	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$13.00	\$31.00	\$55.00
Copayments (90-day supply)	\$32.50	\$77.50	\$137.50
Maintenance Choice (90-day supply)***	\$16.25	\$38.75	\$68.75

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

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

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

Quality Care Health Plan (QCHP) Benefits

Quality Care Health Plan (QCHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP in-network provider. QCHP has a nationwide network of providers through Aetna PPO. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the QCHP. For a copy of the SPD, contact the plan administrator (see page 15).

Plan Year Maximums and Deductibles

Employee's Annual Salary (based on each employee's annual salary as of March 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
\$60,700 or less	\$425	\$1,000
\$60,701 - \$75,900	\$525	\$1,250
\$75,901 and more	\$575	\$1,375
Retiree/Annuitant/Survivor	\$425	\$1,000
Dependents	\$425	N/A

Out-of-Pocket Maximum Limits

In-Network Individual	In-Network Family	Out-of-Network Individual	Out-of-Network Family
\$1,750	\$4,375	\$7,000	\$13,500

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

	In-Network	Out-of-Network*
Emergency Room Services	\$450 per visit; Deductible applies	\$450 per visit; Deductible applies
Inpatient Hospitalization	85% of network charges; Deductible applies after \$200 per admission	60% of allowable charges; Deductible applies after \$700 per admission
Inpatient Alcohol and Substance Abuse	85% of network charges; Deductible applies after \$200 per admission	60% of allowable charges; Deductible applies after \$700 per admission
Inpatient Psychiatric Admission	85% of network charges; Deductible applies after \$200 per admission	60% of allowable charges; Deductible applies after \$700 per admission
Outpatient Surgery	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Skilled Nursing Facility	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies

Transplant Services

Organ and Tissue Transplants	85% after \$200 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services.
------------------------------	--

Professional and Other Services

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

Prescription Drugs

	Plan Year Pharmacy Deductible – \$175 per enrollee			Preventive Prescription Drugs – \$0		
	Tier I	Tier II	Tier III	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$15.00	\$35.00	\$60.00			
Copayments (90-day supply)	\$37.50	\$87.50	\$150.00			
Maintenance Choice (90-day supply)***	\$18.75	\$43.75	\$75.00			

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

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

Consumer Driven Health Plan (CDHP) Benefits

This is a high-deductible health plan as defined by the IRS. Consumer Driven Health Plan (CDHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a CDHP in-network provider. CDHP has a nationwide network of providers through Aetna PPO. CDHP is available for active employees only, under the State Employees' Group Insurance Program. This plan is not available to retirees. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the CDHP. For a copy of the SPD, contact the plan administrator (see page 15).

Plan Year Medical Deductibles

In-Network Individual \$1,500	In-Network Family \$3,000	Out-of-Network Individual \$1,500	Out-of-Network Family \$3,000
----------------------------------	------------------------------	--------------------------------------	----------------------------------

Out-of-Pocket Maximum Limits

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

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

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

Transplant Services

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

Professional and Other Services

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

Prescription Drugs

Preventive Prescription Drugs – \$0 Preventive Prescription Drugs (IRS-allowed) ** - 90% covered; No Deductible

	Tier I	Tier II	Tier III
Copayments (30-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Copayments (90-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Maintenance Choice (90-day supply)***	95%; Deductible Applies	95%; Deductible Applies	95%; Deductible Applies

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

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

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

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

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

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

The State will contribute a third of the deductible to an active State employee's HSA. Maximum HSA contributions (Employer + Employee) for FY22 will be:

Under Age 55			Age 55 and older		
	Individual	Family		Individual	Family
Employer Contribution =	\$500	\$1,000	Employer Contribution =	\$500	\$1,000
Employee Contribution =	\$3,100	\$6,200	Employee Contribution =	\$ 4,100	\$7,200
Max IRS Allowed Contribution =	\$3,600	\$7,200	Max IRS Allowed Contribution =	\$4,600	\$8,200

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

Qualifying for an HSA

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

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

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

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

Save on eligible health, dental and vision expenses by setting aside pre-tax contributions per pay period for you and your eligible dependents. Expenses include doctor, dentist, glasses/contacts, or prescription drug copays, coinsurance, or other eligible out-of-pocket expenses. All active employees are eligible to enroll in MCAP during the Benefit Choice Period. MCAP is not available to retirees, annuitants, or anyone enrolled in an HSA. Participants will be provided a debit card at no cost. Documentation may be required to substantiate certain expenses paid with the debit card. The MCAP maximum contribution limit remains at \$2,750 for the FY22 plan year period. Due to COVID-19 the IRS has approved the rollover of all unused FY21 funds into FY22 MCAP accounts, but the rollover of unused FY22 funds will again be capped at \$550.00. Participants who do not re-enroll for the new plan year will forfeit any amount eligible for rollover.

Dependent Care (Day Care) Assistance Program (DCAP)

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

The American Rescue Plan has increased DCAP contributions to \$5,250 for the FY22 plan year.

You must re-enroll every year to continue participating. Remember that your FSA elections do not carry over from year-to-year. Re-enroll by logging on to [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) and completing the enrollment process by June 1, 2021.

You have until September 30 to submit claims for services incurred from July 1 through June 30; otherwise, any money left in your account will be forfeited. Due to COVID-19 the IRS has approved the rollover of all unused FY21 DCAP funds into FY22 DCAP accounts, however, unused FY22 DCAP funds will once again not be allowed to rollover; all remaining funds at the end of the plan year will be forfeited.

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



Vision

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

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

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

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





Dental

Beginning July 1, 2021, employees now have the option to enroll in Dental Only coverage. However, if you enroll in health coverage and choose dental coverage, dependents must mirror the coverage of the member.

The State's Quality Care Dental Plan (QCDP) offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

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

Deductible and Plan Year Maximum

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

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

Child Orthodontia Benefit

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

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

Member Only	Member + 1 Dependent	Member + 2 or More Dependents
\$13	\$21	\$23.50

* Orthodontia Treatments must start prior to age 19.

** Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) for more information).

Life Insurance

Basic Life Insurance coverage is provided by MetLife at no cost to all active employees, retirees and annuitants through the State Employees Group Insurance Program.

- Active employees, retirees and annuitants under the age of 60, receive a benefit amount equal to their annual salary.
- Retirees and annuitants, age 60 or older, receive a \$5,000 benefit.

Member Optional Life coverage is provided at a cost to all active employees, retirees and annuitants.

- For active employees, and retirees and annuitants under age 60 – coverage is available up to 8 times their Basic Life amount.
- For retirees and annuitants age 60 or older – coverage is available up to 4 times their Basic Life amount.

The maximum benefit allowed for Member Optional Life plus Basic Life is \$3,000,000. Rate changes due to age will be effective the first pay-period following the member’s birthday.

Optional Term Life Rate	
Member Age	Monthly Rate Per \$1,000
Under 30	\$0.03
30-39	\$0.05
40-44	\$0.09
45-49	\$0.12
50-54	\$0.19
55-59	\$0.36
60-64	\$0.56
65-69	\$1.26
70 and Over	\$2.06

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

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

Spouse life coverage is available in a lump sum amount of \$10,000 for:

- The spouse of an active employee.
- The spouse, under age 60, of a retiree or an annuitant.

A spouse, age 60 and older, of a retiree or an annuitant, will have coverage available in the amount of \$5,000. Rate changes due to age will be effective the first day of the pay period following the **spouse’s** birthday.

Spouse Life Monthly Rates	
Spouse Life \$10,000 Coverage (Members, retirees and annuitants under age 60)	\$6.00
Spouse Life \$5,000 Coverage (Retirees and annuitants age 60 and older)	\$3.00

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

Child Life Monthly Rate	
Child Life \$10,000 Coverage	\$0.60

Underwriting

An EOI (Evidence of Insurability) is required for members to add/increase optional life or to add Spouse Life (unless you are a new hire, or this is a newly acquired spouse/civil union partner). An EOI is not needed to add Child Life coverage or AD&D.

BENEFICIARY ELECTIONS

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



State Employees Group Insurance Program

Medicare Requirements

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

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

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug (MAPD) Program

The State of Illinois offers retirees, annuitants and their covered dependents comprehensive medical and prescription drug coverage through State-sponsored Medicare Advantage Prescription Drug plans.

Retirees, annuitants and survivors who are **eligible** to enroll in Medicare Parts A and B **are required to enroll** in a TRAIL MAPD plan, if:

- you do not insure dependents, OR
- you cover a dependent(s) also enrolled in Medicare Parts A and B

If you meet the requirement listed above, you will have 60 days to complete your enrollment.

Refer to the **Medicare Checklist available at <https://www2.illinois.gov/cms/benefits/trail/Documents/2021/MedicareChecklist%20SEGIP.CIP21.2.8.pdf>** for information on when to apply for Medicare benefits, how to provide the required information and how to enroll in a TRAIL MAPD plan in a timely manner. **If you are deemed eligible, failure to elect a TRAIL MAPD plan by end of the enrollment opportunity WILL result in loss of your State insurance coverage.**

For more information regarding the Medicare Advantage Prescription Drug 'TRAIL' Program, go to [MyBenefits.illinois.gov](https://www2.illinois.gov/cms/benefits/trail/MyBenefits.illinois.gov), or contact:

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

Wellness

Be Well Illinois

Welcome to **Be Well Illinois**, the State of Illinois' new comprehensive wellness program designed to help you **be well, live well and stay well**.

As a wellness program member, you have direct access to resources to support your overall health and wellbeing on your terms and at your pace. **Be Well Illinois** was developed to help you create and maintain an active lifestyle, provide access to mental health awareness materials and treatment, financial services, nutritional information and group and individual exercise programs. These benefits, in addition to preventive care visits, health screenings and immunizations like the flu shot, are offered at **no-cost to you**.

Engaging with Be Well Illinois is quick and easy. Visit www.Illinois.gov/BeWell to access wellness webinars, the latest information from health plan partners, monthly health awareness education and much more.

Follow us on Facebook at <https://www.facebook.com/BeWellIllinois> to join special wellness challenges, motivational messages and to engage with a community of your peers who are striving to live healthier in 2021 and beyond.

Or email us at BeWell@illinois.gov.

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

The Employee Assistance Program (EAP) is a free, voluntary, and confidential service for all active State members, not represented by the collective bargaining agreement between the State and AFSCME Council 31, and their dependents experiencing hardship in managing relationships, finances, work, education, or other life issues. Counselors are available to provide problem identification, counseling, and referral services, regardless of the medical plan chosen. For EAP services, contact your plan administrator.

The Personal Support Program (PSP), administered by AFSCME, is similar and parallel to the EAP program, however, PSP is for members who are represented by the collective bargaining agreement between the State and AFSCME Council 31 (see page 15 for contact information).

Smoking Cessation

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

Weight-Loss

Members who utilize weight-loss programs may be eligible for up to a \$200 rebate, once every three plan years. Visit MyBenefits.illinois.gov for additional information.

In 2021, CMS announced the unveiling of the new comprehensive wellness brand Be Well Illinois. This wellness brand, designed to improve our workplace wellbeing, focuses not just on the physical health of our members, but the mental, financial, and social health as well.



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

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

WHAT YOU CAN DO

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

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment	MyBenefits – 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 285654) Aetna OAP (Group Number 285650) Consumer Driven Health Plan (CDHP) - Aetna PPO (Group Number 285658) Quality Care Health Plan (QCHP) - Aetna PPO (Group Number 285658) Address for all Aetna Plans: PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06800) HMO Illinois (Group Number H06800) Blue Cross Blue Shield OAP (Group Number 263995) 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 000010) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/stateofillinois
	HealthLink OAP (Group Number 160000) PO Box 411580, St. Louis, MO 63134	800-624-2356 877-232-8388 (TDD/TTY)	healthlink.com/soi/learn-more
Prescription Drug Plan	CVS Caremark® (for QCHP, CDHP, or OAP Plans) Group Numbers: (QCHP 1400SD3) (CDHP 1400SD9) (Aetna OAP 1400SCH) (BCBSIL OAP 1400SCJ) (HealthLink OAP 1400SCF) Paper Claims: CVS Caremark® PO Box 52136, Phoenix, AZ 85072-2136 Mail Order Rx: CVS Caremark® PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 TTY users, call 711	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20240) PO Box 5402, Lisle, IL 60532m	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Life Insurance	MetLife Insurance Company, Group Life Claims PO Box 6100, Scranton, PA 18505	800-880-6394 TTY users, call 711	metlife.com/stateofillinois
Flexible Spending Accounts (FSA)	ConnectYourCare PO Box 622317, Orlando, FL 32862-2317	888-469-3363 800-526-0844 (TDD/TTY) 443-681-4602 (fax)	connectyourcare.com
Health Savings Accounts (HSA)	PayFlex Systems USA, Inc. 10802 Farnam Drive, Suite 100 Omaha, NE 68154	888-678-8242	payflex.com
Commuter Savings Program (CSP)	Commuter Check Direct Claims Administrator 320 Nevada Street, Newton, MA 02460	888-235-9223 844-878-0594 (TDD/TTY)	commutercheckdirect.com
Employee Assistance Program (EAP)	ComPsych Corporation 455 N. Cityfront Plaza Drive, Chicago, IL 60611	833-955-3400 800-697-0353 (TDD/TTY)	compsych.com
Personal Support Program (PSP – AFSCME EAP)	AFSCME Council 31	800-647-8776 (statewide) 800-526-0844 (TDD/TTY)	afscme31.org
T. Rowe Price Retirement Plan Services, Inc.	4515 Painters Mill Road Mail Code; OM 6350 Owings Mills, MD 21117	(888) 457-5770	rps.troweprice.com
State Employees' Retirement System	2101 South Veterans Parkway PO Box 19255, Springfield, IL 62794-9255	217-785-7444 866-321-7625 (TDD/TTY)	srs.illinois.gov
State Universities Retirement System	1901 Fox Drive, Champaign, IL 61820	800-275-7877 800-526-0844 (TDD/TTY)	surs.org
Teachers' Retirement System (TRS)	2815 West Washington Street PO Box 19253, Springfield, IL 62794-9253	877-927-5877 (877-9-ASK-TRS) 866-326-0087 (TDD/TTY)	trsil.org
CMS Bureau of Benefits Group Insurance	PO Box 19208, Springfield, IL 62794-9208	800-442-1300 800-526-0844 (TDD/TTY)	benefitschoice.il.gov

Federally Required Notices

Notice of Creditable Coverage

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

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

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

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

Summary of Benefits and Coverage (SBC) and Glossary

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

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

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

Notice of Privacy Practices

The Notice of Privacy Practices will be updated at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov), effective July 1, 2021. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).



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

PRSR STD
U.S. POSTAGE
PAID
SPRINGFIELD, IL
PERMIT NO. 489

Benefit Choice Fairs

The CMS-sponsored Benefit Choice Open Enrollment fairs are currently scheduled for online webinar presentations throughout the month of May. Dates, times and links to the scheduled events are listed below and are open to all active and retired members not enrolled in a Medicare Advantage Prescription Drug (MAPD) Plan. CMS representatives, as well as benefit vendors, available in your area, will be present during the webinars to answer questions. The Benefit Choice online fair sessions for the State Employees Group Insurance Program (SEGIP) are scheduled for the following dates and times:

[Session 1](#)

Monday, May 3, 2021
10:00 AM CT

[Session 2](#)

Thursday, May 6, 2021
10:00 AM CT

[Session 3](#)

Thursday, May 13, 2021
10:00 AM CT

[Session 4](#)

Thursday, May 20, 2021
10:00 AM CT

To login to any of the above sessions, go to <https://tinyurl.com/FY22BCFairs>