The Employee Benefits packet contains material that is presented at orientation to new employees. In most cases, the items discussed in this presentation are in order of the information given. Reference throughout this presentation will refer to handouts and documents provided. If you are viewing this prior to receiving your information, this material will be provided to you at your scheduled orientation date.
The staff members listed here are available to answer questions regarding health, dental, vision and life insurance; flexible spending account; retirement benefits; and disability benefits. The Employee Benefits staff can be reached at 453-6668. The office is located at 1255 Douglas Drive – Miles Hall, Carbondale.

For off-campus employees, a packet of information will be sent to you when the Benefit Office has been notified of your employment. Again, this packet contains all the information that will be discussed during the Benefits section of this orientation and is arranged in the order topics will be presented.

A business card with your Group insurance Representative (GIR) has been included in your packet. The card will provide all necessary contact information you will need to get in touch with your Group Insurance Representative (GIR).
SIU Credit Union offers a full line of checking, savings, investment and loan products, electronic services and credit cards.

Call SIU Credit Union and ask for a Member Service Representative. Just place $5.00 in a Membership Share account and begin taking full advantage of the benefits your employer has arranged for you.
Important Information
Included in your orientation packet, you will find a handout titled “Important Information” which includes information of all the websites and phones numbers for all the benefits programs that are available on campus. This is an excellent reference tool to keep on hand at home or in the office. This same information can also be found on the Human Resources (HR) website which is listed on this slide.

The HR website, along with the Benefits Choice website for State of Illinois employees, are very useful websites to book mark on your computer.
Time Limits
Included in your packet is a document with your enrollment time limits. Please note, not all time limits are the same. Some have longer enrollment periods than others, so please pay close attention to each of the requirements.

If no choice is made within the deadlines, you will be defaulted into the Quality Care Health plan without the option of adding dependents. Also, participation in some programs will be limited until the next Benefits Choice enrollment period (May 1 – May 31 of each year) or medical under writing may be required.
Social Security
When you were hired, you should have signed a “Statement Concerning Your Employment in a Job Not Covered by Social Security”. As employees of SIUC, social security deductions will not be made; however, you will contribute to the State Universities Retirement System of Illinois which will be discussed in more detail next in this presentation.

Social Security benefits are based on either your own work or the work of your spouse or former spouse. Medicare benefits will not be effected. For additional information, please refer to the Social Security publications, “Government Pension Offset” or “Windfall Elimination Provision” or visit the Social Security website, www.ssa.gov, or the local office to see how this could possible affect you.
SURS is the acronym commonly used for the State Universities Retirement System of Illinois. It is a 401(a) (employer sponsored) plan designed for employee’s retirement, disability, death and survivor benefits to eligible SURS participants and annuitants.
Eligible employees contribute 8% of their gross earnings, including overtime and summer sessions. Police officers have a higher contribution rate of 9.5% of gross earnings.

You must choose from three retirement options: Traditional Benefit Package, Portable Benefit Package and the Self-Managed Plan (SMP). Deductions will begin immediately and be put into the SURS Traditional Plan until a selection is made. If choosing the Self Managed Plan (SMP) do so as quickly as possible to get the employer match into your account.

*Tier II members have a limit for FY16 of $111,571.63.
Included in the orientation material are documents outlining the plans and their benefits, including a comparison matrix.

You can call SURS at 800/275-7877 if you have additional questions or need further assistance.
Once certified with SURS, new employees will receive at their home address a welcome letter, a Tier Fact Sheet with information regarding which Tier status you are, and a workbook to help your decision process. SURS will also assign a member ID number that will allow you access to your account information with SURS. Elections may be made by logging into your account with SURS. If electing the Self Management Plan, allocations will be made directly with the providers. Use this access to help plan for your future.
You will receive from SURS a packet of information about the three retirement options. The workbook is titled “The Power of Choice.” If you cannot find your election form, you should contact SURS to request another form or log into your account and print out another election form.
If you do not make an election by the deadline, you will be permanently enrolled into the Traditional Benefit Package without the option to change it.
SOURS offers multiple tools to help you make your election. by webinar, videos, member guides, packet details and by calling and talking to them directly at 1-800-275-7877.


Videos: There are several videos that you may view at http://www.surs.org/videos to help you decide.

Member Guides: Review these guides to further answer questions about the plan.
Retirement Benefits

SURS – How much does my employer contribute?

The State of Illinois shares the cost of providing benefits to Surs participants.

- **Traditional and Portable plans**
  The State contribution averages about 9.1% of the total earnings of all Surs participants in the Traditional and Portable plans.

- If you remain a Surs participant for many years and receive a retirement annuity, the State’s share for your benefits could be more than the 9.1% average of total earnings.

- **Self-Managed plan (SMP)**
  The state contributions toward SMP equal 7.6% of earnings. Approximately 7.1% of those earnings will go directly to the member’s individual SMP account,
Retirement Benefits

SURS

After making your election, you will receive confirmation and a beneficiary designation to complete and return to SURS.
As a SURS participant, you also have disability coverage.

Contact Employee Benefits if you feel you might be out for an extended period of time and may need to submit a claim for disability. There is an application form that will need to be completed by you and your physician. SURS will evaluate the claim and if approved, your disability payments will come directly from SURS.
If you expect to be out more than 60 days, you should complete the application immediately even if unsure.

If you qualify for disability payments, there is a 60-day waiting period before you are eligible to receive a payment from SURS. You must use your accrued sick days during this period. Your vacation can also be used, however, vacation usage is subject to department approval. Any days not covered by accrued sick and/or vacation benefits will be reported as absence without pay.
Please refer to your Voluntary Supplemental Long Term Disability Plan brochure for complete details on the Prudential plan.
Optional Benefit Programs

Prudential LTD

This voluntary LTD plan was designed in consultation with the SURS disability plan and is considered a supplement to your disability coverage with SURS.

SURS provides the greater of (1) 50% of your basic compensation on the day you became disabled or (2) 50% of your average earnings for the 24 months prior to the date you became disabled. It is paid until you have received 50% of your earnings while a participant of SURS.

Keep in mind, with SURS, you are not eligible for disability for an illness until you have been a plan participant for 2 or more years. With the LTD program, you have a 90-day elimination period before coverage will begin provided you have qualified for disability.
Please refer to your LTD booklet to calculate the premium cost, if you have not already received notification from Employee Benefits on what your premiums will be. Premiums are collected after taxes from your check, therefore, your monthly LTD benefit will be tax-free.
The Prudential LTD benefits will pay a maximum of 66.67% of your monthly pre-disability earnings to age 65 (after the elimination period.) If you are eligible to draw disability benefits from SURS, Prudential LTD will only pay a maximum of 16.67% for a combined total of 66.67%.

Benefits continue to age 65 if you are unable to perform any gainful occupation.

The Prudential LTD benefits will pay a maximum of 66.67% of your monthly pre-disability earnings to age 65 (after the elimination period.) If you are eligible to draw disability benefits from SURS, Prudential LTD will only pay a maximum of 16.67% for a combined total of 66.67%.

See the example in the brochure and other questions regarding coverage.

You are not required to pay premiums while collecting disability benefits.
Optional Benefit Programs

Prudential LTD

- Certain exclusions apply that are listed in your brochure including pre-existing conditions.

- If you enroll within 60 days of your date-of-hire, there is no medical underwriting.

- Complete and submit the enrollment form and coverage will begin after a 60-day waiting period.

To enroll, complete the SIUC, Voluntary Group Long Term Disability form inside the brochure. Costs may be calculated by using the step-by-step process in the brochure or you may find the costs on the Member Information sheet that is provided with your orientation material from Employee Benefits.
Next in your packet is information regarding tax sheltered annuities. TSA programs (403b) are another way for you to save towards your retirement.
In your packet is a list of Board of Trustee approved companies and their corresponding agents. You may also find this list under the Human Resources, Benefits web page under Supplemental Retirement Plans, Approved Agents or at this link, http://hr.siu.edu/benefits/vendors.html.

There is no employer match.

Call the agent to set up your payroll deduction. The agent will have the paperwork necessary to start your contribution and help you decide what options they have available under their plan.
When registering, the access code for SIUC is 103379.

Optional Benefit Programs

Tax Sheltered Annuities

For TIAA CREF - Enrollment packets are available from SIUC Employee Benefits office.

To Enroll:
- Open an account on the TIAA-CREF web page at https://www.tiaa-cref.org/public/register-enroll or complete an enrollment form
- Complete a Salary Reduction Agreement Form
- Return both forms to Employee Benefits for processing.
Optional Benefit Programs

**Tax Sheltered Annuities**

**Maximum Deferral Amounts**

- If under age 50, $18,000
- If over age 50, $24,000

Enrollment may be done at any time during your employment and is not restricted at any particular time. Enroll when it is convenient for you.

These amount may change at the end of 2015. Employee Benefits will send out an Universal Availability Notice in mid to late November for the next calendar year limits.
State of Illinois program also has a plan for retirement savings.
Information regarding the Deferred Compensation program is available to be viewed on their website. There is no employer match.

You may do this plan along with TSA plans if you wish. Contact the Employee Benefits office for more information.
These amount may change at the end of 2015. Employee Benefits will send out a Universal Availability Notice in mid to late November for the next calendar year limits.
Next item in your packet is Workers’ Compensation.
Workers’ Compensation Program

Administered by TriStar Risk Management

Steps to take if injured on the job:

- For life threatening injuries, seek prompt medical care and then proceed with the reporting process
- Notify Supervisor
- Report the accident to TriStar 1-855-495-1554
- If medical treatment is needed, contact your primary care physician.
- Contact Jeni Batson at 618-453-6690
- Complete the injury packet!

Please refer to handout in your orientation packet for detailed instructions regarding reporting workers’ compensation injuries.

If you require immediate medical attention, please go to the nearest health care facility and seek treatment. Then report your injury to TriStar.

If you require medical treatment and it is not an emergency, contact your primary care physician. It is recommended that you keep in mind the guidelines of your group insurance carrier when receiving medical treatment. If TriStar determines that your claim is not compensable, you can then submit the medical claims to your group insurance provider.
Flexible Spending Accounts (FSA)

Connect Your Care

http://www.connectyourcare.com

1-888-469-3363
Fiscal year runs from July 1 to June 30.

The State of Illinois provides you the opportunity to participate in IRS Tax-favored Flexible Spending Accounts (FSAs) to lower your taxable income by setting aside money for medical expenses and dependent expenses. Contributions are made each pay period.

DCAP contributions are not eligible for the roll over into the next year. Must be used or it will be lost.
Optional Benefit Programs

FSA Types

Medical Care Assistance Plan (MCAP)
- Allows eligible out-of-pocket medical, dental and vision expenses that are not covered by your insurance plans to be paid by tax-free dollars.

Dependent Care Assistance Plan (DCAP)
- Allows eligible child and/or adult day care expenses to be paid with tax-free dollars.

MCAP also allows for some over-the-counter items, co-payments, chiropractic care, orthodontic treatment, transportation for medical care, etc. to be covered under MCAP. These expenses can be incurred by yourself, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year.

DCAP allow for baby-sitting fees, after school care, day-care services, nursery and preschool for children under the age of 12. Eligible dependents include your qualifying child, spouse and/or relative. DCAP can also be used for dependent care for any individual living with you that is physically or mentally unable to care for themselves and is eligible to be claimed as a dependent on your taxes.

For a complete list of eligible charges for each of these programs, see www.connectyourcare.com.
**Optional Benefit Programs**

**FSA Account Information**

**MCAP**
- Minimum deposit is $20 per month or $240 annually
- Maximum deposit is $208.33 per month or $2,499.96 annually

**DCAP**
- Minimum deposit is $20 per month or $240 annually
- Maximum deposit is $416.66 per month or $5,000 annually
- DCAP amount is per family

MCAP deductions for 9 month employees may be up to $555.54 per month.

DCAP – you and your spouse must be employed. If spouse is a full-time student, and earns less than $5,000 a year, the maximum annual deposit is $3,000 a year for one dependent and $5,000 for two or more dependents.

Account balances can be found at www.connectyourcare.com by logging into your account. If it is your first time visiting the site, click on the “Register” button to select your user name and password.

Call the number on the back of your payment card for balance information.
Optional Benefit Programs

FSA – NEW Carryover

- Beginning with FY2016 plan year, MCAP participants who have a balance in their MCAP account after September 30th, will have up to $500 of that account balance automatically carried over to their next plan year MCAP account.

- This carried-over amount will be available for use throughout the next plan year.

Example: MCAP participant enrolls in MCAP for the maximum mount of $2,500. On October 1, 2015, the balance remaining in their MCAP account is $350, and enroll for $2,500 in FY16, they will have a total of $2,850 in their MCAP account. If the participant does not re-enroll in FY16, have and MCAP account balance after the run-out period, will be allowed to use those funds for expenses in the next plan year.

Does not apply for DCAP accounts.
If you need help in calculating your deductions, we will be able to assist you in filling out the paperwork. The number of deductions depends on the number of pay-periods left in the fiscal year.

**Effective Dates of FSA**

- **New Hires:** Effective the first day of the pay period following the date the enrollment form is signed or on the date of the event, whichever is later.

- **Mid Year Enrollments:** Effective the first day of the pay period following the date the enrollment form is signed or the date of the event, whichever is later.

- **Benefits Choice:** Effective date is 7/1/xx
Optional Benefit Programs

Enrollment & Reenrollment

• FSA booklets are available online.
• Enrollment forms are available at Human Resources or online
• You have 60 days from your date-of-hire to enroll or 60 days from a change in status.
• If you elect to participate in an FSA, reenrollment is not automatic.
• Reenrollment packets will be sent to your home address during the Benefits Choice Period (May 1-31)
• Return the reenrollment forms to the Benefits Office.

Changing your deduction amount may be possible during the plan year if you experience an event that permits change.

Funds of up to $500.00 can be rolled over from one year to the next. If you do not re-enroll in the next enrollment period, up to $500.00 can still be claimed, but must be submitted using paper claims. More on this can be viewed at http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Pages/FlexibleSpendingAccounts.aspx.
Check your account balance online to ensure you have sufficient funds to cover a transaction. If not, the transaction will be denied. You can swipe the card for the amount left in your account and pay the difference with another form of payment.

Familiarize yourself with what expenses are eligible using the list of Eligible Expenses online.

Always save your itemized receipts to verify the charges if needed.
Optional Benefit Programs

Paying Expenses Out-of-Pocket

If you paying for expenses with personal funds and need to requesting reimbursement, this is how.

- Keep your itemized receipt as documentation.
- Log on to your online account to file for reimbursement.
- Print the claim submission form and submit documentation.
- You can receive reimbursement funds via check or direct deposit.

To set up for direct deposit, log into your account and select Direct Deposit under My Profile. Complete the short, secure form and enter your bank account and routing numbers. Choose Direct Deposit as your preferred method of Claim Reimbursement and click the Confirm button.

Fax Reimbursement forms to: 866-892-8063
Mailing address: Claims Department, PO Box 622317, Orlando FL 32862-2317
Upload documents via the ConnectYourCare website or by using the mobile app available on your phone.
Optional Benefit Programs

Mobile Solutions

- ConnectYourCare
  - Secure, interactive mobile application for Android, iOS, and Windows devices.
  - Log into your account at www.connectyourcare.com on your phone. The sensors will detect that you are using a smartphone and will present a version of the site specifically for smartphones.
Optional Benefit Programs

Mobile Solutions

Features Include

- View account balance, account alerts and transaction history
- View all claims, claims requiring action and claims details
- Submit a new claim
- Online Bill-Pay and Click-to-Pay (if applicable)
- Receive important account alerts
- Tap to call customer service
- Upload Claim Documentation

Register by clicking on the Mobile Alerts link in your online account.

Upload claim documentation by taking a photo with your phone’s camera or choose existing image. The image is submitted in seconds so there is no need for faxing or mailing. The image is saved with the claim as a record of submission.
Optional Benefit Programs

Flex Spending while on a Leave

- Contributions while you are on a Leave of Absence may be arranged.

- Contact the Benefits office at 453-6668 for more information.
Prorate
Prorate

- Employees on a 9-month academic appointment may spread their pay over the 12 months.
  - If you do not prorate your check prior to September 1, you will be billed by Central Management System (CMS) for the insurance premiums over the summer months.
  - Payments are made directly to CMS
  - Contact Human Resources, Employee Benefits to request a form or click here to be directed to the form. http://eforms.siu.edu/siuforms/info/hro3024.html
Now we will be getting into information about the insurance plans available.
This agency is administered by the State Employees Group Insurance Program as set forth in the State Employees Group Insurance Act of 1971.

You have the opportunity to review your choices and change your coverage each Plan Year during the annual Benefit Choice Period. If you do not want to change, do nothing and your coverage will remain the same. Some changes may be made within the plan, so be sure to review the Benefits Choice Options Booklet for any changes for the next upcoming year.

After going to www.benefitschoice.il.gov website, select Benefits Website, State Employees Benefits, then Group Insurance Benefits and Programs.
Employee Eligibility

- **Full-time:** Employees who work 100% of a normal work week with at least an 8-month appointment.
- **Part-time:** Employees who work a schedule of 50% or greater and have at least an 8-month appointment.
- **Employees who are 50% to 99%:** These employees pay a portion of the State rate. Contact Human Resources for the appropriate costs.
- **Less than 50%:** Employees less than 50% are not eligible for insurance benefits.

Although your employment status may be classified as full-time, your eligibility for Group Insurance could be part-time based upon hours worked.
Opt Out

- Full time employees may be allowed to “opt out” of the State insurance program. Requirements are:
  - Provide proof of other insurance coverage in another health care plan other than the State of Illinois plan
  - Complete an Opt Out Election Certificate

- Note: Full-time employees may not Opt Out to be a dependent of another member enrolled in a plan administered by the Department of Central Management System.
Waive Insurance Coverage

- Part-time employees are allowed to waive coverage of the State of Illinois insurance program. Requirements are:
- Do not have to show proof of other coverage
- Must have basic life coverage

Note: Part-time employees may not waive coverage to be a dependent of another member enrolled in a plan administered by the Department of Central Management System.
Members of the State of Illinois Group Insurance Program may now view their group insurance benefits information online. The link below will direct members to the Public Authentication Portal screen. If this is the first time you have attempted to view your benefit statement, you will need to create a Public ID by clicking on the “Sign Up” button. You will be asked for an email address when creating your ID, which can be any email address you want to use to receive your ID validation.
Benefit Statements

Getting Access:

- Follow the steps as outlined on the screens, paying special attention to the Public ID and Password requirements.
- Once you’ve created an ID, you will receive an email with a link to validate your new Public ID. When you click on the link to validate, you will see a new screen with a “Continue” button. Click on “Continue” to return to the Public Authentication Portal (Sign in screen).
- You should then enter the Public ID and password you just validated and click the “Sign In” button.
Benefit Statements

- Getting Access Continued:
  - The next screen is a one-time registration that asks for your last name, social security number and birth date. By registering, you will be able to access your online benefit statement, while making sure your information stays protected. You should now be at your personal benefit statement!

- Members who do not feel their information is correct should contact Employee Benefits at 618-453-6668 immediately to resolve any potential issues.
Benefit Statements

- Information on these statements list:
  - the cost the employee pays for coverage monthly for themselves and for any dependent
  - life coverage the member pays for and has elected
  - dependents covered under their plan
- Members may also check
  - mailing address
  - Flex Spending
  - Medicare status
  - and access forms if needed.

This statement also give the cost that the state pays for you to have this coverage.

All this information may be printed to keep in your records.
Now we will go over dependents that can be covered under your plan.
Eligible Dependents

- Spouse or Civil Union Partner
- Natural child(ren) up to age 26
- Adopted child(ren) up to age 26
- Step child(ren) or Child of Civil Union Partner up to age 26
- Child with legal guardianship up to age 26
- Disabled Child age 26 and older
- Adult Veteran Child age 26 up to 30
- Other – Organ Transplant recipient
- Adjudicated child

Documentation requirements:
Spouse – marriage certificate/civil union certificate
Natural child(ren) – birth certificate
Adopted child(ren) – court documents
Step child(ren) – marriage certificate and/or civil union certificate and birth certificate of child
Legal Guardianship – court documents
Disabled Child(ren) – birth certificate, letter with diagnosis code, condition etc. from the child’s physician, copy of Medicare card, and eligibility certification statement (CMS-138)
Adult Veteran Child – Birth certificate, proof of Illinois residency, DD-214, Eligibility certification statement (CMS-138) and copy of tax return
Other – birth certificate, proof of organ transplant performed, eligibility certificate statement (CMS-138) and copy of tax return for dependent
Adjudicated child – judicial support order from a judge or copy of DHFS qualified medical support order
Eligible Dependents

- Documentation requirements:
  - **Spouse** – marriage certificate/civil union certificate
  - **Natural child(ren)** – birth certificate
  - **Adopted child(ren)** – court documents
  - **Step child(ren)** – marriage certificate and/or civil union certificate and birth certificate of child
  - **Legal Guardianship** – court documents
Eligible Dependents

- **Disabled Child(ren)** – birth certificate, letter with diagnosis code, condition etc. from the child's physician, copy of Medicare card, and eligibility certification statement (CMS-138)
- **Adult Veteran Child** – Birth certificate, proof of Illinois residency, DD-214, Eligibility certification statement (CMS-138) and copy of tax return
- **Other** – birth certificate, proof of organ transplant performed, eligibility certificate statement (CMS-138) and copy of tax return for dependent
- **Adjudicated child** – judicial support order from a judge or copy of DHFS qualified medical support order
If you become eligible for Medicare while employed, please submit a copy of your card to the Benefits Office as soon as it is received.

Dependents

- A valid Social security number is required to add dependent coverage.

- Employees must provide a copy of their Medicare card for themselves or for any dependents who are enrolled in Medicare.
State of Illinois
Health, Dental, Vision, Mental Health and Life
Insurance Coverage
Vision Coverage
EyeMed
EyeMed
Out-of-Network Claims
PO Box 8504
Mason OH 45040-7111
www.eyemedvisioncare.com/stil
1-866-723-0512
1-800-526-0844 TTD
Vision Coverage

EyeMed

- Vision coverage is provided at **no additional cost** to members enrolled in any of the State-sponsored health plans.

- All members and enrolled dependents have the same vision coverage regardless of the health plan selected.

- Members choosing to “Opt Out” of the health plans are not eligible for the vision program.
Contact lenses are in lieu of standard frames and spectacle lenses.

**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.

Separate cards are issued for this coverage. If you need additional cards, log into your account and print out new cards. Cards are printed with the subscriber's name only. Eligible dependents can use one of the cards for identification purposes.

### Vision Coverage

**EyeMed Summary**

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out-of-Network</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>$25 co-payment</td>
<td>$30 allowance</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>$25 co-payment</td>
<td>$50 allowance for single vision lenses $80 allowance for bifocal and trifocal lenses</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Standard Frames</td>
<td>$25 co-payment (up to $175)</td>
<td>$70 allowance</td>
<td>Once every 24 months</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$120 allowance</td>
<td>$120 allowance</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>
You may choose from private or retailer providers for your service. Locate a provider in or out-of-state by using their website. All local Marion Eye Centers are eligible including the office located on campus in the Student Health Center.

You may also call the provider to make sure they accept the EyeMed Vision care insurance.
If you use an out-of-network provider, complete an Out-of-Network claim form to recoup some of the charges.
Mental Health
Magellan Behavioral Health is the plan administrator for services under the QCHP. Services are included in the annual medical plan year deductible and annual out-of-pocket maximum. For authorization procedures or specific benefit information.
Mental Health

Magellan Behavioral Health

- Access is easy and confidential. Assistance is available 24 hours a day, 7 days a week at no cost to you and your eligible dependents.

- Call to speak with a trained professional on a variety of concerns, including but not limited to:
  - Stress
  - Grief
  - Family or parenting issues
  - Alcohol or drug dependencies
  - Marital or relationship issues
  - Adjusting to change
  - Work/life balance
  - Child and or elder care
  - Anger
  - Pre & Postnatal concerns
Coverage is also available under your health insurance plan. Contact your carrier for coverage and costs.
Managed Care Plans (HMO & OAP)

- Behavioral health services are provided under the managed care plans.
- Covered services are behavioral health must meet the managed care plan administrator’s medical necessity criteria and will be paid accordance with the schedules of benefits.
- Please contact plan providers for specific benefit information.
Mental Health

Employee Assistance Program

- For NON-AFSCME represented employees
- Employee Assistance Program (EAP)
  - Administrator: Magellan Behavioral Health
  - 866-659-3848 (nationwide)
  - 800-456-4006 (TDD/TTY)
  - www.Magellan Health.com

Provides valuable support and information during difficult times for active employees and their dependents. Free, voluntary and provide problem identification, counseling and referral services, regardless of health plan chosen.
Mental Health

Personal Support Program

- For AFSCME represented employees
- AFSCME Council 31
  - Personal Support Program (PSP – AFSCME – EAP)
  - 800-647-8776 (statewide)
  - 800-526-0844 (TDD/TTY)
  - www.afscme31.org

Provides valuable support and information during difficult times for active employees and their dependents. Free, voluntary and provide problem identification, counseling and referral services, regardless of health plan chosen.
Dental coverage is separate from your health insurance plan. Separate cards are issued for dental.

Administered by Quality Care Dental Plan. QCDP is an acronym commonly used for Quality Care Dental Plan.
All members and enrolled dependents have the same dental benefits available regardless of the health plan selected.

Since there is no other dental plan coverage available to choose from, members may elect to “Opt Out” or elect to enroll in the dental plan. Declining participation in the dental plan does not effect enrollment in the health insurance plans. You may not enroll in the dental plan without enrolling in the health plan.

Enrollment may only be changed at Benefits Choice Period with no exception. There are no mid-year changes that would allow enrollment outside of the Benefits Choice Period.
### Delta Dental - Rates

<table>
<thead>
<tr>
<th>Dental Monthly Rates</th>
<th>FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Only</td>
<td>$11.00</td>
</tr>
<tr>
<td>Member Plus One Dependent</td>
<td>$17.00</td>
</tr>
<tr>
<td>Member Plus Two or More Dependents</td>
<td>$19.50</td>
</tr>
</tbody>
</table>
Members and dependents may see a dentist of their choice in-state or out-of-state.

Dental cards will be provided to members in the mail by the provider. Additional cards may be printed by logging into Delta Dental.
Quality Care Dental Plan

Delta Dental

- QCDP reimburses a predetermined maximum benefit amount for each covered service.

- Benefit schedules are provided on-line on HR web page at http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Documents/FY2016_State_Dental_Schedule.pdf

- Members are responsible for any charges over the scheduled benefit amount

- Cleanings are available twice a year.
Network dentists will automatically file the dental claim for their patients.
Quality Care Dental Plan

Delta Dental – Out of Network

- Participants who use out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claims depending on the payment arrangements the plan participant has with their dentist.

- When using an out-of-network dentist, insurance payments will be sent directly to the member and the member is responsible for paying the dentist.

Dental Claim Form:
http://www.illinois.gov/cms/Employees/benefits/Documents/delta-dental-claimform_IL.pdf

Submit Claims to:
Delta Dental of Illinois
PO Box 5402
Lisle IL 60532

The annual plan year deductible must 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.
A pretreatment estimate is a review by Delta Dental of a dental provider’s proposed treatment, including diagnostic, x-ray and laboratory reports, as well as the expected charges. This treatment plan is sent to Delta Dental for verification of eligible benefits. Obtaining a pretreatment estimate to verify coverage will help you make decisions regarding your dental services and help you avoid unanticipated out-of-pocket costs.
Quality Care Dental Plan

**Delta Dental**

- Delta Dental has a mobile app that you can download on Apple and Android smartphones and tables. Visit the App Store or Google Play to download and install their free app.
  - Can view coverage
  - Cost Estimator
  - Find a dentist
  - Email ID Card
  - Toothbrush Timer
Now on with the health insurance plans!
General Information

- There are several health plans available based on geographic location.
- All plans offer comprehensive benefit coverage.
- Health maintenance organizations (HMOs) have limitations including geographic availability and defined provider networks.
- Open Access Plans (OAPs) and Quality Care Health Plan (QCHP) have nationwide networks of providers available to their members.
Insurance Costs

- While the State covers most of the cost to employee health coverage, employees must also make a monthly salary based contribution.

- Employees who are working less than 100% will pay a portion of the State costs. Please contact the Human Resource Benefits office for premium rates as the following rates will not apply to you.
Contact Human Resources Employee Benefits office at 618-453-6668 if you are less than 100% (full-time) for your rates.

<table>
<thead>
<tr>
<th>Employee Annual Salary</th>
<th>Managed Care Plans</th>
<th>Quality Care Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2016</td>
<td>FY2016</td>
<td></td>
</tr>
<tr>
<td>$30,200 &amp; Under</td>
<td>$68.00</td>
<td>$93.00</td>
</tr>
<tr>
<td>$30,201 - $45,600</td>
<td>$86.00</td>
<td>$111.00</td>
</tr>
<tr>
<td>$45,601 - $60,700</td>
<td>$103.00</td>
<td>$127.00</td>
</tr>
<tr>
<td>$60,701 - $75,900</td>
<td>$119.00</td>
<td>$144.00</td>
</tr>
<tr>
<td>$75,901 - $100,000</td>
<td>$137.00</td>
<td>$162.00</td>
</tr>
<tr>
<td>$100,000 &amp; Above</td>
<td>$186.00</td>
<td>$211.00</td>
</tr>
</tbody>
</table>
### Insurance Costs

#### Dependent Monthly Contributions

<table>
<thead>
<tr>
<th>Health Plan Name &amp; Code</th>
<th>One Dependent FY2016</th>
<th>Two or More Dependents FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care Health Plan (D3)</td>
<td>$249.00</td>
<td>$287.00</td>
</tr>
<tr>
<td>Coventry HMO (AS)</td>
<td>$111.00</td>
<td>$156.00</td>
</tr>
<tr>
<td>Coventry OAP (CH)</td>
<td>$111.00</td>
<td>$156.00</td>
</tr>
<tr>
<td>Health Alliance HMO (AH)</td>
<td>$113.00</td>
<td>$159.00</td>
</tr>
<tr>
<td>HealthLink OAP (CF)</td>
<td>$126.00</td>
<td>$179.00</td>
</tr>
</tbody>
</table>

Contact Human Resources Employee Benefits office at 618-453-6668 if you are less than 100% (full-time) for your rates.
Quality Care Health Plan

CIGNA
QCHP Group #: 3181456
CIGNA Health Care
PO Box 182223
Chattanooga TN 37422-723
1-800-962-0051 (nationwide)
1-800-526-0844 (TDD/TTY)
www.cigna.com/stateofil
Quality Care Health Plan

- Under QCHP (Cigna), plan participants may choose any physician or hospital for medical services; however, plan participants will receive enhanced benefits, resulting in lower out-of-pocket costs when receiving services from a QCHP network provider.
- QCHP has a nationwide network of physicians, hospitals and ancillary providers.
- To search:
  http://cigna.benefitnation.net/cignadol/default.asp?employer=3181456

QCHP is administered by CIGNA. More information can be found on the Employee Handbook
and the Employee Benefits Booklet. Amendment to State of Illinois Handbook 7/1/15:

Also on the Human Resources webpage, we have a link to CVS/Caremark for your pharmacy needs. More information about pharmacy in the prescription slides.
Quality Care Health Plan

- QCHP Notification and Medical Case Management Administrator requires preauthorization for certain medical services. In order to avoid penalties, call 1-800-962-0051. Group number #3181456

- QCHP utilizes Magellan for behavioral health benefits and CVS/caremark for prescription benefits. There is a $125 prescription deductible that applies to each plan participant.

More about CVS/caremark in the pharmacy slides.
After the out-of-pocket maximum has been satisfied, the plan will pay 100% of covered expenses up to the allowable charge 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.

The types of charges that apply toward the out-of-pocket maximum for QCHP include the annual plan year deductible, additional deductible and coinsurance.

Charges ineligible for payment by the plan include prescription deductibles, and copayments, amounts over allowable charges for the plan, non covered services, charges for services deemed to be not medically necessary and penalties for failing to pre-certify or provide notification.

### Quality Care Health Plan (QCHP)

#### Annual Deductibles

<table>
<thead>
<tr>
<th>FY2016 Annual Deductibles</th>
<th>Individual</th>
<th>Family Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee $60,700 or less</td>
<td>$375</td>
<td>$937</td>
</tr>
<tr>
<td>$60,701 - $75,900</td>
<td>$475</td>
<td>$1,187</td>
</tr>
<tr>
<td>$75,901 and above</td>
<td>$525</td>
<td>$1,312</td>
</tr>
<tr>
<td>Retiree/Annuitant/Survivor</td>
<td>$375</td>
<td>$937</td>
</tr>
<tr>
<td>Dependents</td>
<td>$375</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Quality Care Health Plan (QCHP)

#### Deductibles

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitalization (In-Network)</td>
<td>$100 deductible per admission</td>
</tr>
<tr>
<td></td>
<td>85% after annual plan deductible</td>
</tr>
<tr>
<td>Inpatient Hospitalization (Out-of-Network)</td>
<td>$500 deductible per admission</td>
</tr>
<tr>
<td></td>
<td>60% of allowable charges after annual plan deductible</td>
</tr>
<tr>
<td>Emergency Care – Hospital</td>
<td>$450 deductible</td>
</tr>
</tbody>
</table>
Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

<table>
<thead>
<tr>
<th>Out of Pocket Maximums</th>
<th>FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year and Lifetime Maximum</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Individual (In Network)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Individual (Out-of-Network)</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family (In Network)</td>
<td>$3,750</td>
</tr>
<tr>
<td>Family (Out-of-Network)</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

Amounts over the plan’s allowable charges are the member’s responsibility and do not go toward the out-of-pocket maximum.
Quality Care Health Plan (QCHP)

Out of Pocket Maximums

- Effective July 1, 2015, in accordance with the Affordable Care Act (ACA), prescription deductibles 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.

- These types of charges that apply to the out-of-pocket maximum by QCHP are:
  - Annual medical plan year deductible
  - Annual prescription plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - QCHP additional medical deductibles

- Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.
**Quality Care Health Plan (QCHP)**

## Benefit Levels

<table>
<thead>
<tr>
<th>Services</th>
<th>FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>After all applicable deductibles met (In-Network)</td>
<td>$85%</td>
</tr>
<tr>
<td>After all applicable deductibles met (Out-of-Network)</td>
<td>60%</td>
</tr>
<tr>
<td>After Out-of-Pocket met</td>
<td>100%</td>
</tr>
</tbody>
</table>
FY2016 Managed Care Plans

The HMO managed care plans available in our area are:

- Health Alliance HMO (AH)
  - 800-851-3379
  - www.healthalliance.org/stateofillinois

- Coventry HMO (AS)
  - 800-431-1211
  - www.chcillinois.com
Managed Care HMO Plans

**Health Maintenance Organizations (HMO)**

- Members must select a primary care physician (PCP) from a network of participating providers.
- The PCP directs healthcare services and makes referrals for specialists and hospitalizations.
- A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. To change your PCP, call your HMO directly.
- When care and services are coordinated through the PCP, only a copayment will apply.
- There are no annual plan deductibles.
Managed Care HMO Plans

**Health Maintenance Organizations (HMO)**

- Prescription deductible of $100 applies to each plan participant.
- HMO plans have their own separate prescription benefit plan.
- Prescription benefits will be reviewed later in the presentation.
Managed Care HMO Plans

**Health Maintenance Organization**

<table>
<thead>
<tr>
<th>Services</th>
<th>Co-pay FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit (Primary Care Physician)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Office Visit (Specialist)</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Home Health Visit</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$350 per visit</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$250 per visit</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$250 per visit</td>
</tr>
</tbody>
</table>

Some HMOs may have benefit limitations based on a calendar year.

Per admission
## HMO
### Out-of-Pocket Maximums

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximums</th>
<th>FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
</tbody>
</table>
Open Access Plans
OAP Plans
Managed Care OAP Plans

**FY2016 Managed Care Plans**

The managed care OAP plans available in our area are:

- Coventry OAP (CH)
  - 800-431-1211
  - www.chcillinois.com

- HealthLink OAP (CF)
  - 800-624-2356
  - www.healthlink.com/illinois_index.asp
Managed Care OAP Plans

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.
- Members who elect an OAP will have three tiers of providers from which to choose to obtain services.
- The benefit level is determined by the tier in which the healthcare provider is contracted.
- Members enrolled in an OAP can mix and match providers and tiers.
- No referrals are needed!

Each plan has their own physician list.

It is important to remember that the level of benefits is determined by the healthcare provider selected. Members enrolled in an OAP can mix and match providers.
Managed Care OAP Plans

Open Access Plans (OAPs)

- Tier I offers a managed care network which provides enhanced benefits. Tier I benefits require copayments.
- Tier II offers another managed care network, in addition to Tier I, but requires copayments, coinsurance and is subject to an annual plan year deductible.
- Tier III covers all providers which are not in Tier I or II but can offer members flexibility in selecting health care providers, but requires higher out-of-pocket costs. Some services such as preventive/wellness care are not covered when obtained under Tier III.

It is your responsibility to know what Tier level a provider (doctor, hospital, lab) is on to know your out-of-pocket expense.
Managed Care OAP Plans

Open Access Plans (OAPs)

- Prescription deductible of $100 applies to each plan participant.
- OAP plans have their pharmacy through CVS/caremark.
- Prescription benefits will be reviewed later in the presentation.
These programs offered by Coventry OAP and HealthLink OAP allow those family members who live in another area/state to receive care as if they were in network. Call the appropriate plan to get your dependent enrolled.

Managed Care OAP Plans

Open Access Plans (OAPs)

- These two insurance carriers are going Nationwide

- Coventry OAP - Pass Port Program
  - Contact Coventry to enroll

- HealthLink OAP - Guest Program effective 7/1/13
  - Contact HealthLink after 7/1/13 to enroll
These levels are the same as the HMO plans, Coventry HMO and HealthAlliance HMO.
## Managed Care OAP Plans

### Open Access Plans (OAPs) Tier II

<table>
<thead>
<tr>
<th>Services</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Plan Deductible</td>
<td>$250 per enrollee</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>90% after $400 co-pay</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>90% after $250 co-pay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>100% after $250 co-pay</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100%</td>
</tr>
<tr>
<td>Well Baby Care (first year of life)</td>
<td>100%</td>
</tr>
</tbody>
</table>
*An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.
OAP
Out of Pocket Maximums

<table>
<thead>
<tr>
<th></th>
<th>Out-of-Pocket Maximums FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>OAP Tier I</td>
<td>Individual $6,600</td>
</tr>
<tr>
<td></td>
<td>Family $13,200</td>
</tr>
<tr>
<td></td>
<td>Tier I and Tier II charges combined</td>
</tr>
<tr>
<td>OAP Tier II</td>
<td>NA</td>
</tr>
<tr>
<td>OAP Tier III</td>
<td>NA</td>
</tr>
</tbody>
</table>

Amounts over the plan's allowable charges are the member’s responsibility and do not go toward the out-of-pocket maximums.
HealthLink OAP 800-624-2356

- Beginning 7/1/2015, members with HealthLink OAP have additional precertification requirement for Radiology and Cardiology Imaging services. These reviews will be performed through AIM Specialty Health. 866-745-3266
- Telemedicine Program: 855-717-6800
- Mental Health/Substance Abuse: 877-284-0102
- Wellness Support Programs: 866-647-6113
- Preadmission/Certification: 877-284-0102
Prescription Drug Benefits
All medications are compiled on a preferred formulary list maintained by each health plan’s prescription benefit manager. (PBM) They may change any time during the plan year.

Use this link to get to the formulary list for each of the plans.
http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Pages/state-admindir.aspx
## Prescription Drug Benefit

### Prescriptions

<table>
<thead>
<tr>
<th>FY2016</th>
<th>30 Day Supply</th>
<th>90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QCHP</td>
<td>All other plans</td>
</tr>
<tr>
<td>Co-pay</td>
<td>$125</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand</td>
<td>$30</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand</td>
<td>$60</td>
</tr>
</tbody>
</table>
If a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the generic copayment.
Prescription benefit questions should be directed to the respective health plan administrator.

**Prescription Drug Benefit**

**Prescription Manager**

- **Fully-insured managed care plans**
  - Health Alliance HMO
  - Coventry Health Care HMO

- Most plans do not cover over-the-counter drugs or drugs prescribed by medical professionals (including dentists) other than the plans participant’s primary care physician (PCP).
- Drugs prescribed by a specialist would be covered provided that the member was referred to the specialist.
Prescription Drug Benefit

Prescription Manager

- **Self-insured managed care plans**
  - HealthLink OAP
  - Coventry Health Care OAP
  - Quality Care Health Plan (QCHP)
  - have prescription benefits administered through CVS/caremark.

- Customer care number for CVS/caremark is 877-232-8128. Service is available 24 hours a day, 7 days a week.
If a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the generic copayment.
Reimbursement will be provided at the applicable brand or generic in-network price minus the appropriate in-network copayment.

Claim forms are available at:
Maintenance medication is medication that is taken on a regular basis for conditions such as high blood pressure and high cholesterol.

Plan participants will be charged a penalty in an amount equal to double the prescription copayment if the script is filled at a non-maintenance network pharmacy or if the script is written for a 30-day supply instead of a 90-day supply. The penalty will be forgiven only for the first two 30-day fills (or first 60-day), but will apply thereafter.
Self-insured Plans

QCHP, HealthLink OAP & Coventry OAP

Mail Order Pharmacy

- Provides participants the opportunity to receive medications directly at their home.
- Both maintenance and non-maintenance medications may be obtained through the mail order process.
- Original prescription must be attached to a completed mail order form and mailed to CVS.
- Order forms are available here:
- Refills can be obtained by contacting CVS by phone or online at www.caremark.com.
State Life Insurance
Minnesota Life
536 Bruns Lane, Unit 3
Springfield IL  62702
1-888-202-5525
www.lifebenefits.com/illinois
Approval for optional life coverage becomes effective the first day of the pay period following the Statement of Health approval date.
Life Coverage

- **Accidental Death & Dismemberment** provides a benefit for your accidental death or dismemberment which occurs as a result of an accident.

Coverage is available in:
- An amount equal to your basic salary; or
- The combined amount of your Basic and Member Optional Life amount (up to 5 times salary or $3 million).

The injury must occur while your coverage under the supplement is in force.
Life Coverage

- **Accelerated Benefits** provides accelerated payment of a partial amount of your death benefit. If you have a terminal condition, you may request an accelerated payment of your death benefit.

- Requirements Include:
  - Life expectancy is 24 months or less; and
  - Certified by a physician
Enrollment at your initial hire for dependent life coverage is automatically available. If you delay enrollment and want to enroll them at a later date, a Statement of Health is required unless the spouse, civil union partner or child is newly acquired.

Life Coverage

- **Spouse/Civil Union Partnership Life**
  - Term coverage of $10,000. Cost is $6.00 per month

- **Child Life:**
  - Term coverage of $10,000 per child. All dependent children age 25 and under are eligible for child life coverage. Cost is $0.70 for one or more children.
Minneapolis Life

Life Coverage

Conversion of Basic Life
If you terminate employment, you can continue your basic life coverage by taking out an individual life insurance policy. Rates are determined on your age at the time of conversion.

Portability of Optional Term Life
If you terminate employment, you can continue your optional life insurance coverage. Premiums will be higher than those paid by active employees.

Premiums are paid directly to Minnesota Life.

Under the Portability Options, premiums will increase with age and are subject to change.
Rate changes due to age go into effect the first pay period following the member’s birthday.

Statement of Health must be completed when adding/increasing member optional life, spouse and/or child life. Prior approval by Minnesota Life Insurance Company must be made before coverage is effective if added after the initial enrollment period.
Life Coverage

- Beneficiary Designation Form
  - May be changed or updated at any time.
  - Forms may be sent directly to Minnesota Life or sent to Human Resources to keep a copy in your Benefits’ file. HR will then send the original to Minnesota Life.
VOYA Term Life Insurance
ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis MN 55401-1900
Voluntary Term Life Insurance

- VOYA provides a term life insurance coverage for you and your dependents.
- New employees have the option of enrolling in the following without medical underwriting (guarantee issue):
  - Portable Life and AD & D coverage up to $35,000 for the employee
  - Portable Life and AD & D coverage up to $5,000 for the spouse
  - Portable Life up to $10,000 for dependent child(ren)
Voluntary Term Life Insurance

- **Employee Coverage**
  - May elect coverage up to 5 times basic annual earning or up to $200,000.
  - May elect Accidental Death & Dismemberment

- **Spouse Coverage**
  - May elect coverage up to 5 times basic annual earning or up to $200,000.
  - May elect Accidental Death & Dismemberment
  - Spouse may apply for Portable Life coverage even if the Employee does not.

Proof of good Health is required for coverage amounts greater than the guaranteed issue amount or for late entrants. Rates for the employee and spouse is based on the employee’s current age.

Employees actively working may continue coverage until retirement. Coverage will terminate at age 70.

Rates are provided in the orientation packet and a link on a slide coming up.
Voluntary Term Life Insurance

- Child Coverage
  - Coverage of $2,500, $5,000, $7,500 or $10,000 is available.
  - One premium covers all eligible children.
  - Cost: .40 cents per $2,500
  - Coverage continues to age 23 if unmarried and a full-time student

Children from age 14 days to 6 months are covered for $100.00.

Forms for enrolling are linked on a slide coming up.
Voluntary Term Life Insurance

How to apply:
- Determine the amount of insurance you and your family need.
- Employees complete the Employee Life Insurance Enrollment Form. Spouses complete the Spouse Life Insurance Enrollment Form.
- Give completed form to Employee Benefits
- Premiums for guarantee issue amounts will be deducted immediately
- Premiums for amounts over the guarantee issue will be deducted once approval has been received.

If applying for coverage amounts over the guaranteed issue limits ($35,000 for employee and $5,000 for spouse) or if you are applying during a time outside of the designated enrollment period, a completed Portable Proof of Good Health Form is required for the person applying.
Voluntary Term Life Insurance

- **Benefit Description**

- **Beneficiary Designation**

- **Employee Enrollment:**
Voluntary Term Life Insurance

- **Spouse Enrollment:**
- **Proof of Good Health (Statement of Health):**

All completed forms to elect coverage or to update beneficiary designation forms needs to be sent to the Human Resources Employee Benefits office for processing.
Benefit Change Periods

Annual Changes
Mid-Year Changes
Benefits Choice Period

Annual Benefit Change Period

- Every year during the month of May, employees have the option of making changes to their plans.
- If you enroll in a plan and decide that plan is not for you, you will have an opportunity to change plans. This needs to be submitted during the month of May and becomes effective on 7/1/xx.
- There are no pre-existing conditions when changing between plans. But if you are in the middle of treatment, you need to contact the plan that you are changing to, to make sure they will complete the services.

If you are happy with your plan, you do not have to do anything. Your coverage will continue with the plan you are in.

At Benefits Choice time, CMS will send notifications to members at their home addresses regarding the upcoming changes for the next plan year.
Benefits Choice Period

Annual Benefit Change Period

- During the Benefit Choice Enrollment Period, you may:
  - Change your health plans, “Opt Out” or “Opt In.”
  - Elect to participate or not to participate in the dental plan
  - Increase/decrease optional life; Statement of Health is required if increasing
  - Add/Remove dependent(s)
  - Enroll/re-enroll in Flex Spending Account
Mid-Year Change

If during the year, you experience a change of status, you may change your benefits according to the status change.

- See pages 11 and 12 of the State of Illinois Benefit Handbook for status changes.
- See pages 13 & 14 for documentation requirements.
- You have 60 days after a qualifying event to submit your benefit change. If you do not contact the Benefits Office within this time period, you may have to wait until the next Benefits Choice to make your change.

If you are uncertain if you have experienced a change in status, contact Employee Benefits at 618-453-6668 to speak to someone who can be of assistance.

Benefits Handbook:

Amendment to State of Illinois Handbook 7/1/15:
http://hr.siue.edu/_common/documents/benefits/fy16-handbook-amend.pdf
Examples

Qualifying Changes in Status

- Newborn/newly acquired dependent
- Marriage
- Divorce
- Death of spouse or dependent
- Change in your spouse’s or dependent’s employment status
- Dependent who no longer meets eligibility criteria
- Change in Public Aid recipient status or Medicare status
- Court order resulting in gaining or losing custody
- Going on or off a Leave of Absence

Complete a change form
http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Documents/Enrollment_Form.pdf along with documentation to Human Resources to make the appropriate changes.

Contact Human Resources if you have a change that could allow you to make changes.
Leave of Absence
Leave of Absences

- There are several leaves that you will be responsible to pay insurance premiums while away from work.
  - Disability Leave
  - Medical or FMLA
  - Family Leave, nonmedical
  - Military Leave
  - Education/Sabbatical Leave
  - Seasonal Leave
  - Dock/Suspension
  - Personal Leave

There are many other leaves, but these are the most common.

Seasonal leaves are leaves during the summer months when you are not teaching or working during the summer months.

Contact Employee Benefits office prior to your leave to inquire about your options about keeping or dropping coverage.
Leave of Absence

- If you are going to be off payroll for any reason, during your leave, you will be billed for your insurance from Central Management Services.
- You may make changes to reduce your premiums, but be sure to contact Employee Benefits Office to discuss your options before going on a leave.
- If you do not pay while you are on a LOA, CMS Special Payment Programs Unit will collect payment through involuntary withholding. Contact CMS to make payment arrangements at 1-800-442-1300.
Member Responsibilities
Member Responsibilities

- It is each Member’s responsibility to know their benefits and review the information in the State of Illinois Benefits Handbook.
- Notify your Group Insurance Representative when any life changes occur
  - Life changing event
  - Address Change
  - Loss of Eligibility
  - Leave of Absence
  - Other events (page 11 – 14 in the Benefits Handbook)

State of Illinois Handbook:

Amendment to State of Illinois Handbook 7/1/15:
Enrollment Forms
To Enroll:
Complete Enrollment Form and sign:
http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Documents/Enrollment_Form.pdf
Please include any marriage or birth certificates for any dependents enrolling. Must have social security numbers and birthdates.

If opting out:
Complete the Opt Out Form:
Complete an Enrollment form and sign. Employees opting out may still have life insurance coverage.
Include other coverage information (cards)

If waiving (for part-time employees).
Complete the waiver form:

Complete a Minnesota Life Beneficiary Designation Form for all enrollments:
http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Documents/Beneficiary-Form.pdf
Questions?

- This concludes our presentation.

- Employee Benefits can be reached at 618-453-6668 or call the Benefits presenter with the information provided to you at orientation.