EMPLOYEE BENEFITS STAFF

- Vanessa Sneed
  - Business/Administrative Associate

- Cathy Yeager
  - Benefits Services Supervisor

- Karla Rowell
  - Human Resource Officer

- Paula Buritsch
  - Human Resource Assistant

- Lisa Cardinale-Brown
  - Workers’ Compensation & Disability Coordinator
As an employee of SIUC, you are eligible to join the SIU Credit Union. The partnership between SIU and the Credit Union allows employees to receive:

- Discounts on vehicle loan rates below the basic rate
- Discounts on fixed rate home equity loans below the basic rate
- Increases on certificate of deposits above the basic rate
IMPORTANT INFORMATION
IMPORTANT INFORMATION

- Website
  - SIUC Human Resources: hr.siu.edu
  - Department of Central Management System
    - www.benefitschoice.il.gov
  - My Benefits Marketplace
    - www.mybenefits.illinois.gov
    - Select: SEGIP Member
    - First time users must register

Forms and State Benefit Handbooks are online
TIME LIMITS
IMPORTANT INFORMATION, TIME LIMITS & RESPONSIBILITIES

BENEFIT ENROLLMENT TIME LIMITS

- Health, Dental & Life
  - 30 calendar days from hire date
  - Those who do not make a selection will be defaulted into the Quality Care Health, Quality Care Dental with no dependent coverage and will receive only basic life insurance with no optional life units.

- Flex Spending Accounts
  - 30 days from date-of-hire

- Prudential Voluntary Supplemental Long Term Disability Insurance
  - 60 days from date-of-hire

- VOYA Supplemental Term Life Insurance
  - 30 days from date-of-hire

- State Universities Retirement System (SURS)
  - 6 months from certification
SOCIAL SECURITY
SIUC and its employees are exempt from Social Security participation.

- Social Security will not be deducted from your paycheck.
- Medicare is deducted from your pay (1.45%)
SURS provides retirement, disability, death and survivor benefits.

- 8% of your gross salary is contributed to SURS*
- Deductions begin from hire date

Members must choose from one of three retirement option plans:**

- Traditional
- Portable
- Self Managed Plan (SMP)
Employees have **six months** to make a decision.

- One-time, life-time irrevocable choice
- If enrolled previously, no need to make another selection.
- Default for no election is the Traditional Plan

New members must choose a plan within six months from the date SURS receives certification of your employment from SIUC. Your choice is permanent and cannot be changed. If you were previously certified with SURS, you will not be allowed to change your selection.
RETIREMENT BENEFITS
SURS – PLAN ELECTION

- Welcome letter with deadline dates from SURS
- Tier Fact Sheet indicates whether you are Tier I or Tier II
- SURS ID #: This ID number is unique to SURS. Use it to log into your account to view your contributions and to run estimates of your retirement benefit.
- Workbook to help you make your choice of retirement plan.
RETIREMENT BENEFITS
SURS – PLAN ELECTION

- Election Form: Included in your information from SURS will be an election form.

- Complete and submit this form directly to SURS in the postage paid envelope provided or by logging into your account and making the submission on-line.
If you need help in making your election, here are some things to help you decide.

- **Webinar:** Sign up for a webinar. Visit the SURS website at [http://www.surs.org/seminars-webinars](http://www.surs.org/seminars-webinars) and register on a date that fits your schedule.

- **Videos:** Watch a video. There are several videos that you may view at [http://www.surs.org/videos](http://www.surs.org/videos) to help you decide.

- **Member Guides:** Review these guides to further answer questions about the plan.

- **Call SURS:** Call SURS at 1-800-275-7877 if you need further assistance in picking a plan.
After making your election, you will receive confirmation and a beneficiary designation to complete and return to SURS.

If you elect the Self-Managed Plan, you must select your provider and investment options online at netbenefits.com/surs. If you elect the SMP electronically at www.surs.org, you will automatically be directed to the net benefits website to complete your investment selections. If you do not select your provider(s) or investment options, you will be defaulted into an age appropriate target date fund.
Accessing your account

You may access your SURS account information at anytime by logging into the SURS Member Website.

Those enrolled in Traditional and Portable Plans can view a daily snapshot of their account including account balance, service credit, beneficiaries and more under the My SURS tab.

Those enrolled in SMP, can view account balance information from both plan providers. These are updated quarterly. Statements will come from the investment service providers.
Tier I: Available to those hired or who have eligible Illinois reciprocal system service.

Tier II: Public Act 96-0889 revised the Traditional and Portable benefit plans for members who begin participation on or after January 1, 2011
## TRADITIONAL CONTRIBUTIONS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee</th>
<th>Employer*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Tier I</td>
<td>8%; 6 ½ % ret annuity; ½ for AAI; and 1% survivor benefit</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Traditional Police</td>
<td>9 ½ %; 8% ret annuity; ½ for AAI; and 1% survivor benefit</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Traditional Tier II</td>
<td>8%; 6 ½ % ret annuity; ½ for AAI; and 1% survivor benefit</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Traditional Tier II Police</td>
<td>9 ½ %; 8% ret annuity; ½ for AAI; and 1% survivor benefit</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Plan</td>
<td>Employee</td>
<td>Employer*</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Portable Tier I</td>
<td>8%</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td></td>
<td>6 ½% ret annuity; ½ for AAI; 1% for enhanced refund benefits</td>
<td></td>
</tr>
<tr>
<td>Portable Tier I</td>
<td>9 ½%</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Police</td>
<td>8½% ret annuity; ½ for AAI; 1% for enhanced refund benefits</td>
<td></td>
</tr>
<tr>
<td>Portable Tier II</td>
<td>8%</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td></td>
<td>6 ½% ret annuity; ½ for AAI; 1% for enhanced refund benefits</td>
<td></td>
</tr>
<tr>
<td>Portable Tier II</td>
<td>9 ½%</td>
<td>*Varies from year to year</td>
</tr>
<tr>
<td>Police</td>
<td>8½% ret annuity; ½ for AAI; 1% for enhanced refund benefits</td>
<td></td>
</tr>
</tbody>
</table>
## SMP CONTRIBUTIONS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMP</td>
<td>8%</td>
<td>7.6% of earnings; 7.3% funds retirement benefits; .3% to fund disability</td>
</tr>
<tr>
<td>SMP Police</td>
<td>8%</td>
<td>7.6% of earnings; 7.3% funds retirement benefits; .3% to fund disability</td>
</tr>
</tbody>
</table>
## CONTRIBUTIONS AND SALARY LIMITS

<table>
<thead>
<tr>
<th>Section 401(a) Limits – <strong>impacts all plan options</strong></th>
<th>SURS employee and employer contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>If member is certified before 7/1/1996</td>
<td>Not subject to this limit</td>
</tr>
<tr>
<td>If member is certified after 7/1/1996</td>
<td>Subject to limit</td>
</tr>
<tr>
<td>If member is certified after 7/1/1996, but has past refund which can be repaid, they may be eligible to be “grand fathered” into the group not subject to this limit</td>
<td>Determined by SURS</td>
</tr>
</tbody>
</table>
## CONTRIBUTIONS AND SALARY LIMITS

<table>
<thead>
<tr>
<th>Section 415(c) Limits</th>
<th>Impacts Self-Managed Plan Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits total annual employee and employer contributions to the SMP is $54,000.00 for</td>
<td></td>
</tr>
<tr>
<td>the calendar year 1/1/17 – 12/31/17.</td>
<td></td>
</tr>
</tbody>
</table>
You may qualify for disability benefits if, after you have at least two years of service credit, you are sick or injured and unable to work for 60 or more days.

If you become disabled due to an accident, there is no minimum service credit required to qualify for a disability benefit.
Elimination Period
- 60 days or through the exhaustion of your sick leave whichever is greater

Disability Benefit Amount
- Payment will be 50% of your basic compensation on the day you became disabled, or 50% of your average earnings for the 24 months prior to the date you became disabled.

Duration of Disability Benefits
- Maximum benefit amount you can draw is 50% of your total earnings while a participant of SURS.
VOLUNTARY SUPPLEMENTAL LONG TERM DISABILITY PLAN (LTD)

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
290 WEST MOUNT PLEASANT AVENUE
LIVINGSTON, NJ 07039
1-800-290-5903
This voluntary LTD plan was designed in consultation with the SURS disability plan and is considered a supplement to your disability coverage with SURS.

SURT 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.
Advantages of participation:

- Economical group rates – typically lower than individual rates
- Convenient payroll deduction
- Benefits are not subject to income tax
- Partial income replacement
- Rates based on age and salary
Monthly LTD benefit will be 66.67% of your monthly pre-disability earnings.

If eligible to draw 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.
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.
Other benefits include:
- Catastrophic Disability Benefit
- Critical Illness Benefit
- Survivor Benefit
TAX SHELTERED ANNUITIES (TSA)

403(B) PLANS
Supplemental retirement investment choices, which also reduces your taxable income

- Defer a dollar amount or a percentage of income
- Enroll or change at any time
- Contributions are conveniently payroll deducted
- Enroll, change or cancel at any time
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.org/public/index.html](https://www.tiaa.org/public/index.html)
    - Register; Access Code: 103379
  - Complete a Salary Reduction Agreement Form
  - Return Salary Reduction Agreement Form to Employee Benefits for processing.
  - Can enroll at any time.
OPTIONAL BENEFIT PROGRAMS
TAX SHELTERED ANNUITIES

Maximum Deferral Amounts

- If under age 50, $19,000
- If over age 50, $25,000

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.
DEFERRED COMPENSATION PROGRAM

801 SOUTH 7TH STREET
PO BOX 19208
SPRINGFIELD IL  62794
1-800-442-1300
Pre-tax Deferred Compensation – supplemental tax-deferred retirement plan for state employees. Distributed monies are fully taxable for federal tax purposes. The funds are never taxed by the State of Illinois.

After-tax Roth – deductions made with after-tax contributions. Allows earnings to be withdrawn tax-free when taking a qualified distribution.
Benefits of a Pre-Tax Supplemental retirement investment plan:

- Lowers your current taxable income
- Contributions are made with before-tax dollars
- Any earnings grow tax-deferred

Withdrawal Info:

- Your contributions and any associated earning are taxed upon distribution.
Benefits of an After-Tax Supplemental retirement investment plan:

- Contributions are made with after-tax dollars
- Does not lower your current taxable income
- Any earnings grow tax-deferred

Withdrawal Info:

- Your contributions and any associated earning are tax-free if you take a qualified distribution.
OPTIONAL BENEFIT PROGRAMS
DEFERRED COMPENSATION PLAN

- Maximum Deferral Amounts
  - If under age 50, $19,000
  - If over age 50, $25,000

- 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; Deferred Compensation does require a completed enrollment form a month prior to the first deduction.
WORKERS’ COMPENSATION

TRISTAR RISK MANAGEMENT
PO BOX 2803
CLINTON IA 52733-2803
1-855-495-1554
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 Lisa Cardinale-Brown at 618-453-6690
  - Complete the injury packet!
FLEXIBLE SPENDING ACCOUNTS (FSA)

CONNECT YOUR CARE

HTTP://WWW.CONNECTYOURCARE.COM

1-888-469-3363
OPTIONAL BENEFIT PROGRAMS
WHAT IS AN FSA?

- An account that you set up and contribute a predetermined amount of money thru payroll deductions.
- Deductions begin the first of the following month following your enrollment and ends at the fiscal year on 6/30/xx.
- This lowers your taxable income which saves in federal income taxes.
- Separate accounts are set up for medical expenses and/or dependent care expenses.
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.
OPTIONAL BENEFIT PROGRAMS
FSA ACCOUNT INFORMATION

MCAP
- Minimum deposit is $20 per month or $240 annually
- Maximum deposit $2,600 annually
- Up to $500 roll over if re-enroll, no roll-over if you don’t re-enroll

DCAP
- Minimum deposit is $20 per month or $240 annually
- Maximum deposit is $5,000 annually
- DCAP amount is per family
Beginning with FY2020 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. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover benefit.

This carried-over amount will be available for use throughout the next plan year.
OPTIONAL BENEFIT PROGRAMS
EFFECTIVE DATES OF FSA

- **New Hires**: Effective on the hire date along with the other benefits enrollment online.

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

- **Benefits Choice**: Enrollment is during May with an effective date of 7/1/xx.
Enrollment and Reenrollment must be done online at [www.mybenefits.illinois.gov](http://www.mybenefits.illinois.gov)

- You have 30 days from your date-of-hire
- 60 days from a qualifying event.
- Re-enrollment is not automatic and must be completed during Benefits Choice in the month of May using the [www.mybenefits.illinois.gov](http://www.mybenefits.illinois.gov) website.
Every participant who enrolls in MCAP will receive in the mail a payment card to pay for qualified expenses.

- Use it as a credit card, with funds deducted directly from the Flexible Spending Account.
- Save your receipts. Documentation may be required for some paid services. Notification will be sent to your if substantiation is needed. Failure to substantiate a claim may result in the use of your payment card being suspended.
ONLINE AND MOBILE CLAIMS SUBMISSION

- Download the App on your smart phone, CYC Mobile to review your account or upload receipts.
  - Use it to see your claims, pay claims, view your balances and more.
Reimbursement of MCAP or DCAP funds must be requested before the end of the run-out period each year, which is September 30. Only expenses incurred on or before June 30th will be eligible for reimbursement. Request for reimbursement of eligible funds by:

- Faxing the claim form to 443-681-4602
- Mailing the form to: ConnectYourCare, Claims Department, PO Box 622317, Orlando FL 32862-2317
- Uploading documents via the ConnectYourCare website or mobile app.
Employees may continue to contribute while on a Leave of Absence.

Go online to www.mybenefits.Illinois.gov or call customer service at 844-251-1777
PRORATE
PRORATE

- Employees on a 9-month academic appointment may spread their pay over 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 Prorate form: [http://eforms.siu.edu/siuforms/info/hro3024.php](http://eforms.siu.edu/siuforms/info/hro3024.php)
INSURANCE BENEFITS
STATE OF ILLINOIS EMPLOYEE BENEFITS

- Administered by Illinois Department of Central Management Services (CMS) Bureau of Benefits
- Plan Year: July 1, 20xx to June 30, 20xx
- My Benefits Web Portal www.mybenefits.illinois.gov
The State of Illinois now offers a web-based online platform entitled MyBenefits. All plans administered by the State of Illinois, including the State Employees Group Insurance Program (SEGIP).

The site is designed specifically for you to access your benefit options into a one-stop shop for your insurance needs. This includes learning more about your current insurance benefits, making enrollment decisions, changing your current coverage and finding contact information for all your plan administrators.
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.
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

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.
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 Insurance Program may view their group insurance benefits information online.


Other programs offered through the University that are not administered by CMS will not be reflected on this statement. Please contact the Employee Benefits department if you have questions.
DEPENDENT COVERAGE
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
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
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 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.
# Vision Coverage

## Eymed 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</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$80 allowance for bifocal and trifocal lenses</td>
<td></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>
VISION COVERAGE
EYEMED

- Providers:
  - Private, independent providers
  - Optical retailers available include:
    - JC Penney Optical

Use the Eyemed website to locate a provider near you!
VISION COVERAGE USING EYEMED

- Schedule an appointment with an in-network provider and tell them you are a State of Illinois Plan Participant.
  - Provide your ID# or other identifying information needed
  - Pay co-pay(s) at the time of the visit
  - The provider and EyeMed will take care of the rest.
MENTAL HEALTH
Behavioral Health Administrator:

Magellan Behavioral Health

- QCHP Group #3181456
  - PO Box 2216, Maryland Heights MO 63043
  - 800-513-2611 (nation wide)
  - 800-526-0844 (TTD)

- www.MagellanHealth.com
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
Referrals and authorization is required for seeing a counselor face-to-face.

www.magellanhealth.com
- Online screening tools
- Self-assessments
- Personalized improvement plans

Financial and legal help offered at a discount. Call Magellan for more information.
• Behavioral health services are provided under the managed care plans.

• Covered services for behavioral health must meet the managed care plan administrator’s medical necessity criteria and will be paid 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
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
QUALITY CARE DENTAL PLAN

DELTA DENTAL OF ILLINOIS
GROUP #: 20240
PO BOX 5402
LISLE IL 60532
800-323-1743
800-526-0844 (TDD/TTY)
HTTP://SOI.DELTADENTALIL.COM/
Enrollment into the dental plan is optional.

- Members are eligible to “Opt Out”. The election to enroll or not enroll will remain in effect the entire plan year, without exception. The next time to change coverage will not be available until the next Benefit Choice Period.
- All members and enrolled dependents have the same dental benefits available regardless of the health plan selected.
Plan participants who are enrolled may choose any dental provider for services, but may pay less out-of-pocket when using a network provider.

Plan year runs from July 1, 20xx to June 30, 20xx.

Members must enroll in the health plan to be eligible to enroll in the dental plan.

The dental plan has an annual plan deductible. Once the deductible has been met, each member is subject to a maximum dental benefit, including orthodontia, for both in-network and out-of-network providers.
<table>
<thead>
<tr>
<th>Dental Monthly Rates</th>
<th>FY2020</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>
QUALITY CARE DENTAL PLAN
DELTA DENTAL

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

- Benefit schedules are provided on-line at https://www2.illinois.gov/cms/benefits/StateEmployee/Documents/FY2020%20BC/2018StateDental.pdf

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

- Cleanings are available twice a year.
Provider Networks

- Delta Dental PPO network
- Delta Dental Premier network

If using a network dentist, you will not have to pay the dentist at the time of service. Go to http://soi.deltadentalil.com/ to do a provider search.

What you do need to pay for are deductibles, non-covered services and charges over the amount listed in the Schedule of Benefits and/or amounts over the annual maximum benefit.
Participants who use out-of-network dentist will 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.
# QUALITY CARE DENTAL PLAN
DELTA DENTAL – DEDUCTIBLE AND PLAN YEAR MAXIMUMS

<table>
<thead>
<tr>
<th>Service*</th>
<th>FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible for Preventive Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Deductible for All Other Covered Services</td>
<td>$175</td>
</tr>
<tr>
<td>Annual Maximum (In-Network)</td>
<td>$2,500</td>
</tr>
<tr>
<td>Annual Maximum (Out-of-Network)</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ortho Length of Treatment</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 36 Months</td>
<td>In-network $2,000</td>
</tr>
<tr>
<td>0 – 18 Months</td>
<td>In-network $1,820</td>
</tr>
<tr>
<td>0 – 12 Months</td>
<td>In-network $1,040</td>
</tr>
</tbody>
</table>
It is strongly recommended that plan participants obtain a pretreatment estimate for any service over $200, regardless of whether that service is to be received from an in-network or an out-of-network provider.

Failure to do so may result in unanticipated out-of-pocket costs.

Questions regarding a pretreatment estimate can be addressed by Delta Dental.
Delta Dental has a mobile app that you can download on Apple and Android smartphones and tablets. 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
HEALTH PLANS

QUALITY CARE HEALTH PLAN – AETNA PPO (D3)
HEALTH ALLIANCE HMO (AH)
HEALTHLINK OAP (CH)
AENTA HMO (AS)
AENTA OAP (CH)
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.
## INSURANCE COSTS
### EMPLOYEE MONTHLY CONTRIBUTIONS

<table>
<thead>
<tr>
<th>Employee Annual Salary</th>
<th>Managed Care Plans FY2020</th>
<th>Quality Care Health Plan FY2020</th>
</tr>
</thead>
<tbody>
<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>$100,001 &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 FY2020</th>
<th>Two or More Dependents FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care Health Plan - Aetna PPO (D3)</td>
<td>$249.00</td>
<td>$287.00</td>
</tr>
<tr>
<td>Aetna HMO (AS)</td>
<td>$111.00</td>
<td>$156.00</td>
</tr>
<tr>
<td>Aetna 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>
QUALITY CARE HEALTH PLAN

AETNA PPO
QCHP GROUP #: 285658
1-855-339-9731 (NATIONWIDE)
1-800-628-3323 (TDD/TTY)
WWW.AETNASTATEOFIL.COM
Under QCHP (Administered by Aetna), 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: https://www2.illinois.gov/cms/personnel/benefits/pages/healthplanproviderdirectories.aspx
QCHP Notification and Medical Case Management Administrator requires preauthorization for certain medical services. In order to avoid penalties, call the number on the back of your insurance card.

QCHP utilizes Magellan for behavioral health benefits and CVS/caremark for prescription benefits.

QCHP utilizes CVS Caremark for pharmacy needs. There is a $125 prescription deductible that applies to each plan participant for prescription benefits. More on this in the pharmacy slides.
### QUALITY CARE HEALTH PLAN (QCHP) (AETNA PPO) ANNUAL DEDUCTIBLES

<table>
<thead>
<tr>
<th>FY2020 Annual Deductibles</th>
<th>Individual Plan Year Deductible</th>
<th>Family Plan Year Deductible 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) (AETNA PPO) DEDUCTIBLES

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitalization (In-Network)</td>
<td>$100 deductible per admission 15% coinsurance</td>
</tr>
<tr>
<td>Inpatient Hospitalization (Out-of-Network)</td>
<td>$500 deductible per admission 40% coinsurance</td>
</tr>
<tr>
<td>Emergency Care – Hospital</td>
<td>$450 deductible 15% coinsurance</td>
</tr>
</tbody>
</table>
## QUALITY CARE HEALTH PLAN (QCHP) (AETNA PPO) 
### OUT OF POCKET MAXIMUMS

<table>
<thead>
<tr>
<th>Out of Pocket Maximums</th>
<th>FY2020</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.
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.
MANAGED CARE PLANS

HMO PLANS
The HMO managed care plans available in our area are:

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

- Aetna HMO (AS) Group #285654
  - 855-339-9731
  - [www.aetnastateofillinois.com](http://www.aetnastateofillinois.com)
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.
- 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 Services**

<table>
<thead>
<tr>
<th>Services</th>
<th>Co-pay FY20</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.
<table>
<thead>
<tr>
<th></th>
<th>FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Maximums</td>
<td></td>
</tr>
<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
The managed care OAP plans available in our area are:

- Aetna OAP (CH) Group #285650
  - 855-339-9731
  - www.aetnastateofillinois.com

- HealthLink OAP (CF)
  - 800-624-2356
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!
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.
- 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 two insurance carriers are going Nationwide

- Aetna OAP - Passport Program
  - Contact Aetna to enroll

- HealthLink OAP - Guest Program effective 7/1/13
  - Contact HealthLink after 7/1/13 to enroll
<table>
<thead>
<tr>
<th>Services FY20</th>
<th>Co-Pay Tier I</th>
<th>Deductibles Tier II</th>
<th>Deductibles Tier III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit</td>
<td>$20 per visit</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$30 per visit</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Home Health Visit</td>
<td>$30 per visit</td>
<td>90%</td>
<td>Covered in Tier I &amp; II</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$350 per visit</td>
<td>90% after $400 co-pay</td>
<td>60% after $500 co-pay</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$250 per visit</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$250 per visit</td>
<td>$250 per visit</td>
<td>$250 per visit</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100%</td>
<td>90% of network charge</td>
<td>60% of allowable charges</td>
</tr>
<tr>
<td>Well Baby Care (first year of life)</td>
<td>100%</td>
<td>100%</td>
<td>Covered in Tier I &amp; II</td>
</tr>
</tbody>
</table>
### OUT OF POCKET MAXIMUMS

<table>
<thead>
<tr>
<th>OAP Tier I &amp; II</th>
<th>Out-of-Pocket Maximums FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></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 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.
PRESCRIPTION DRUG BENEFITS
Members and their enrolled dependents in any of the health plans have a prescription benefit included in the coverage.

Generic, Formulary, Non-Formulary Lists

Prescription deductible and copayments apply to each member and covered dependents

To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, visit the website of each health plan.
## Prescription Drug Benefit Prescriptions

<table>
<thead>
<tr>
<th>FY2020</th>
<th>QCHP</th>
<th>All Other Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-pay</td>
<td>$125</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 Day Supply</td>
<td>90 Day Supply</td>
</tr>
<tr>
<td></td>
<td>QCHP</td>
<td>All other plans</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$8</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30</td>
<td>$26</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$60</td>
<td>$50</td>
</tr>
</tbody>
</table>
Fully-insured managed care plans

- Health Alliance HMO
- Aetna Health Care HMO
  - use a separate prescription benefit manager.

Members who elect one of these plans must utilize a pharmacy participating in the plan’s pharmacy network or the full retail cost of the medication will be charged. Partial reimbursement may be provided if the plan participant files a paper claim with the health plan.
- **Fully-insured managed care plans**
  - Health Alliance HMO
  - Aetna 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.
■ **Self-insured managed care plans**
  - HealthLink OAP
  - Aetna Health Care OAP
  - Quality Care Health Plan (Aetna) (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.
- **Self-insured managed care plans**
  - HealthLink OAP
  - Aetna Health Care OAP
  - Quality Care Health Plan (Aetna) (QCHP)

- Most drugs purchased with a prescription from a physician or a dentist are covered; over the counter drugs are not covered, even if purchased with a prescription.
- **Non-maintenance Medication**

  In-Network Pharmacies are retail pharmacies that contract with CVS/caremark and accept the copayment for medications.

- **Out-of-Network Pharmacies** are pharmacies that do not contract with CVS/caremark. Drug cost will be higher and you will pay the full retail cost at the time of dispensing. Reimbursement of eligible charges may be obtained by submitting a paper claim and original prescription receipts to CVS/caremark.
Maintenance Medication Program (MMP) was developed to provide an enhanced benefit to members who used maintenance medications.

Participating pharmacies can be found at: https://www2.illinois.gov/cms/benefits/stateemployee/pages/stateprescription.aspx

Plan participant’s prescription must be written for a 3 months supply.
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: https://www2.illinois.gov/cms/benefits/stateemployee/documents/english%20mail%20service%20order%20form.pdf
- Refills can be obtained by contacting CVS by phone or online at https://www.caremark.com/wps/portal
For employee, there are two types of term coverage available:

- **Basic Life insurance**: is provided automatically at no cost to eligible employees for an amount equal to their annual salary.

- **Optional Life insurance**: is optional life insurance coverage that may be purchased at the employee’s expense.
  - Optional units are in increments of your annual salary
  - New employees are eligible to elect 4 times annual salary without medical underwriting
  - Medical underwriting is necessary for units 5 - 8
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).
**MINNESOTA LIFE 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
MINNESOTA LIFE
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 $.70 for one or more children.
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 term life insurance coverage.
<table>
<thead>
<tr>
<th>Member by Age</th>
<th>Monthly Rate Per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>.06</td>
</tr>
<tr>
<td>Ages 30 – 34</td>
<td>.08</td>
</tr>
<tr>
<td>Ages 35 – 44</td>
<td>.10</td>
</tr>
<tr>
<td>Ages 45 – 49</td>
<td>.16</td>
</tr>
<tr>
<td>Ages 50 – 54</td>
<td>.24</td>
</tr>
<tr>
<td>Ages 55 – 59</td>
<td>.44</td>
</tr>
<tr>
<td>Ages 60 – 64</td>
<td>.66</td>
</tr>
<tr>
<td>Ages 65 – 69</td>
<td>1.28</td>
</tr>
<tr>
<td>Ages 70 and above</td>
<td>2.06</td>
</tr>
</tbody>
</table>
Beneficiary Designation Form:

- Must be completed. Locate form here:
- 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
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)
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.
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
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 staff.
- Premiums for guarantee issue amounts will be deducted immediately.
- Premiums for amounts over the guarantee issue will be deducted once approval has been received.
VOYA

VOLUNTARY TERM LIFE INSURANCE

- **Benefit Description:**

- **Beneficiary Designation:**

- **Employee Enrollment:**
- **Spouse Enrollment:**

- **Proof of Good Health (Statement of Health):**
BENEFIT CHANGE PERIODS

ANNUAL CHANGES
MID-YEAR CHANGES
• Every year during the month of May, employees have the option of making changes to their plans.

• If you are happy with the coverages that you have, you do not have to do anything to continue with your current coverage.

• If you have enrolled in a plan and decide that plan is not for you, you will have an opportunity to change. This needs to be submitted during the month of May and becomes effective on 7/1/xx.
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; Evidence of Insurability is required if increasing
- Add/Remove dependent(s)
- Enroll/re-enroll in Flex Spending Account
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 election change online at [www.mybenefits.Illinois.gov](http://www.mybenefits.Illinois.gov). Failure to make the change within the 60 days time limit will void your change of status and you will have to wait until the next Benefits Choice to make your change.
EXAMPLES
QUALIFYING CHANGE OF 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
HOW TO MAKE CHANGES

- Benefit Choice Changes (May 1 – May 31)
  - Select Benefits Choice as reason
- Mid year changes
  - Select reason for change
LEAVE OF ABSENCE
There are several leaves that you will be responsible to pay insurance premiums while away from work.

- Disability Leave
- Medical or FMLA
- Family Leave, non-medical
- Military Leave
- Education/Sabbatical Leave
- Seasonal Leave
- Dock/Suspension
- Personal Leave
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)
ENROLLMENT
ENROLLING OR OPTING OUT

- Enrollment/opting out must be done at:
  - www.mybenefits.Illinois.gov
  - Upload any documentation needed

- Return to Employee Benefits any Optional Plan Enrollment Forms, if enrolling into:
  - Prudential LTD
    - or
  - VOYA Term Life
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.