

State of Illinois

Rod R. Blagojevich, Governor

Department of Central Management Services

Bureau of Benefits

James P. Sledge, Director



Benefit Choice Options



State of Illinois

Effective January 1, 2009 – June 30, 2009

OPT OUT OPTIONS

- **In accordance with Public Act 92-0600**, full-time employees, retirees, annuitants and survivors may elect to Opt Out of the State Employees Health Insurance Program (this election will terminate health, dental, vision **and** prescription coverage for the member and any dependents) if proof of other major medical insurance can be provided by an entity other than the Department of Central Management Services.

Members who wish to Opt Out must complete Section B on the Benefit Choice Options Period 2 Election form and attach proof of other insurance coverage (such as a copy of an insurance card from another health plan that names you as being insured). The form must be submitted to the Group Insurance Representative no later than November 14, 2008.

Members opting out of the Program continue to be enrolled with Basic Life insurance coverage only and may elect optional life coverage.

Members opting out of the Program are **not eligible** for the:

- Free influenza immunizations offered annually by the Department of Healthcare and Family Services
- COBRA continuation of coverage
- Smoking Cessation Program

Employees opting out of the Program **are eligible** for the:

- Flexible Spending Account (FSA) Program
- Commuter Savings Program (CSP)
- Paid maternity/paternity benefit
- Either of the two separate Employee Assistance Programs
- Long-Term Care Program
- Adoption Benefit Program

- **In accordance with Public Act 94-0109**, non-Medicare members receiving a retirement annuity from the State Employees' Retirement System (SERS) who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the Health Insurance Program (opting out includes health, vision, dental and prescription coverage) and receive a financial incentive of \$150 per month. **Marking 'Opt Out' on the Benefit Choice Options Period 2 Election Form does not entitle you to receive the financial incentive.** Contact the Insurance Section of the SERS at (217) 785-7150 for more information and to obtain a copy of the SERS Opt Out with Financial Incentive Form.
- **Individuals who opt out under either Public Act may re-enroll** in the Program only during Benefit Choice, or within 60 days of experiencing an eligible qualifying change in status. Members who re-enroll, and their dependents, are subject to possible health benefit limitations for pre-existing conditions. A Certificate of Creditable Coverage from the previous insurance carrier must be provided to reduce the pre-existing conditions waiting period.

MEMBER AND DEPENDENT MONTHLY HEALTH, DENTAL AND OPTIONAL LIFE PLAN CONTRIBUTIONS

The monthly dependent contribution is **in addition** to the member health contribution. Dependents must be enrolled in the same plan as the member. **The Medicare dependent contribution applies only if Medicare is PRIMARY for both Parts A and B.** Members with questions regarding Medicare status may contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

Dependent Monthly Health Plan Contributions				
Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
Unicare HMO (Code: CC)	\$ 76	\$107	\$ 71	\$107
HMO Illinois (Code: BY)	\$ 77	\$110	\$ 73	\$110
PersonalCare (Code: AS)	\$ 86	\$124	\$ 82	\$124
OSF HealthPlans (Code: CA)	\$ 86	\$124	\$ 83	\$124
Health Alliance HMO (Code: AH)	\$ 88	\$127	\$ 83	\$127
Health Alliance Illinois (Code: BS)	\$ 97	\$139	\$ 94	\$139
HealthLink OAP (Code: CF)	\$ 99	\$143	\$ 96	\$143
OSF Winnebago (Code: CE)	\$101	\$146	\$ 98	\$146
Quality Care Health Plan (Code: D3)	\$190	\$220	\$136	\$197

Member Monthly Quality Care Dental Plan (QCDP) Contributions	
Employee Only	\$11.00
Employee plus 1 Dependent	\$17.00
Employee plus 2 or more Dependents	\$19.50
Retirees, Annuitants, Survivors and Dependents	\$0

Contribution Calculation Worksheet

Member Monthly Health Contribution: \$ _____
(see chart on page 10)

Dependent Monthly Health Contribution: \$ _____
(if insuring dependents, see chart above)

Monthly Dental Contribution: \$ _____
(see chart to left)

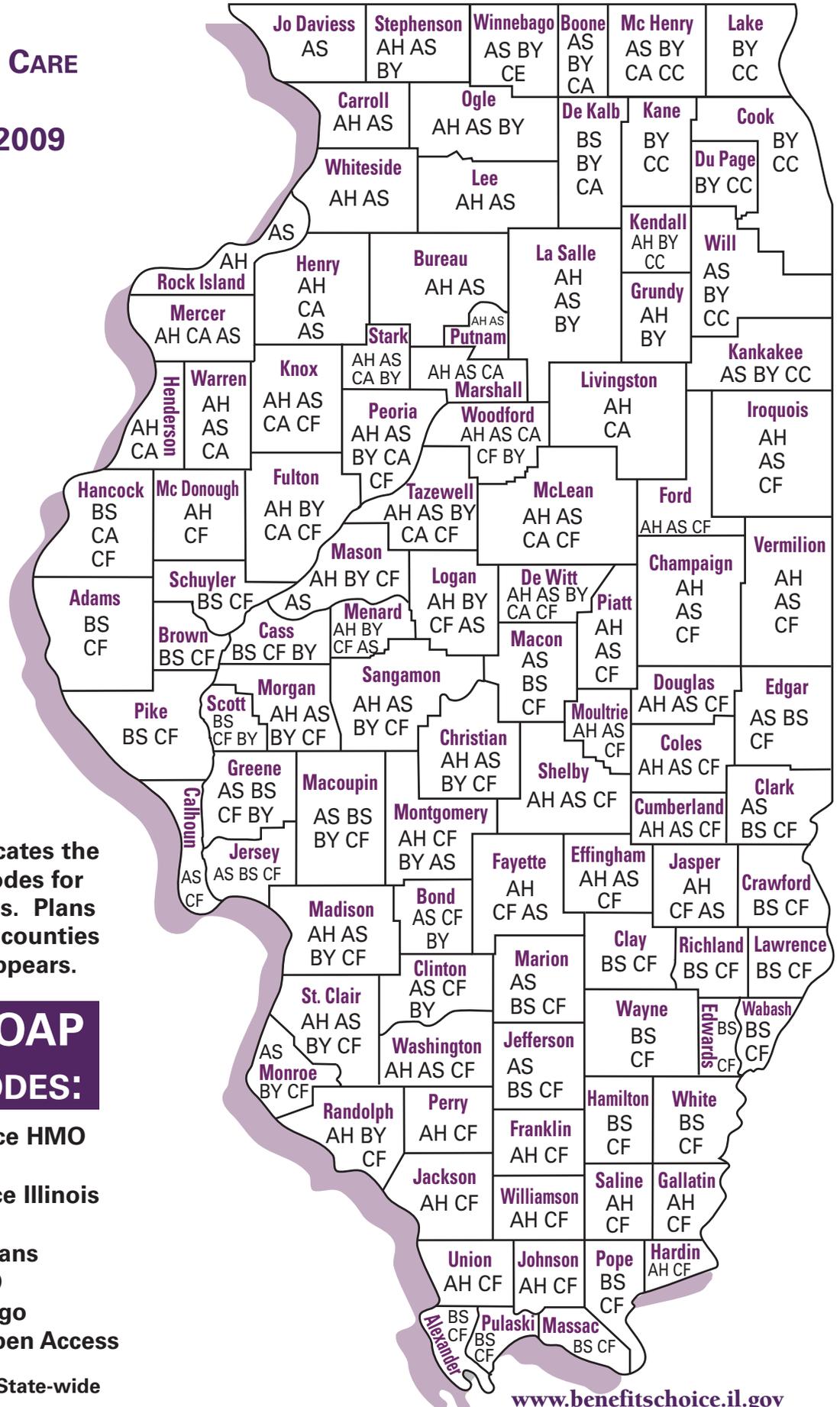
Monthly Optional Term Life Contribution: \$ _____
(see chart on page 10)

My Total Monthly Contribution: \$ _____

Note: An interactive Premium Calculation Worksheet is available for full-time employees online at www.benefitschoice.il.gov.

MANAGED CARE PLANS IN ILLINOIS COUNTIES

STATE MANAGED CARE HEALTH PLANS FOR PLAN YEAR 2009



The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.

HMO AND OAP CARRIER CODES:

- AH – Health Alliance HMO
- AS – PersonalCare
- BS – Health Alliance Illinois
- BY – HMO Illinois
- CA – OSF HealthPlans
- CC – UniCare HMO
- CE – OSF Winnebago
- CF – HealthLink Open Access

Note: QCHP available State-wide

MANAGED CARE PLANS

There are 8 managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.

Health Maintenance Organizations (HMOs)

Members must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a co-payment applies. No annual plan deductibles apply for medical services; however, **beginning January 1, 2009, there will be an annual \$50 prescription deductible applied for each individual.** The minimum level of HMO coverage provided by all plans is described on page 14. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

Open Access Plan (OAP)

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with pre-determined co-payments. Tier III (out-of-network) offers members flexibility in selecting healthcare providers with higher out-of-pocket costs. Tier II and Tier III require a deductible for medical services. **Beginning January 1, 2009, an annual \$50 prescription deductible will be applied to each individual.** It is important to remember that the level of benefits is determined by the healthcare provider selected. Members enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 15.

IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

Primary Care Physician (PCP) Leaving a Network: If a member's PCP leaves the managed care plan's network, the member has three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Quality Care Health Plan. The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

Provider Network Changes: Managed care plan provider networks are subject to change. Members should always call the respective plan to verify participation of specific providers, even if the information is printed in the plan's directory.

Dependents: Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on this type of coverage.

Plan Year Limitations: Managed care plans may impose benefit limitations based on a calendar year schedule. In certain situations, the State's plan year may not coincide with the managed care plan's year.

Behavioral Health Services: Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are available through the member's medical plan.

HMO BENEFITS

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD. A new \$50 prescription deductible applies (see page 18 for details).

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after \$250 co-payment per admission
Alcohol and substance abuse (maximum number of days determined by the plan)	100% after \$250 co-payment per admission
Psychiatric admission (maximum number of days determined by plan)	100% after \$250 co-payment per admission
Outpatient surgery	100% after \$150 co-payment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after \$200 co-payment per visit
Professional and Other Services	
Physician Office visit (including physical exams and immunizations)	100% after \$15 co-payment per visit
Specialist Office visit	100% after \$20 co-payment per visit
Well Baby Care (first year of life)	100%
Psychiatric care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Alcohol and substance abuse care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Prescription drugs (new \$50 deductible applies; formulary is subject to change during plan year)	\$10 co-payment for generic \$22 co-payment for preferred brand \$44 co-payment for non-preferred brand
Durable Medical Equipment	80%
Home Health Care	\$20 co-payment per visit

Some HMOs may have benefit limitations on a calendar year.

OPEN ACCESS PLAN (OAP) BENEFITS

The benefits described below represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact HealthLink for a copy of the SPD. A new \$50 prescription deductible applies (see page 18 for details).

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	Not Applicable	\$600 \$1,200	\$1,500 \$3,500
Annual Plan Deductible (must be satisfied for all services)	\$0	\$200 per enrollee*	\$300 per enrollee*
Hospital Services			
Inpatient	100% after \$250 co-payment per admission	90% of network charges after \$300 co-payment per admission	80% of U&C after \$400 co-payment per admission
Inpatient Psychiatric	100% after \$250 co-payment per admission, up to 30 days per plan year	90% of network charges after \$300 co-payment per admission up to 30 days per plan year	80% of U&C after \$400 co-payment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	100% after \$250 co-payment per admission, up to 10 days rehabilitation per plan year	90% of network charges after \$300 co-payment per admission up to 10 days rehabilitation per plan year	80% of U&C after \$400 co-payment per admission, up to 10 days rehabilitation per plan year
Emergency Room	100% after \$200 co-payment per visit	90% of network charges after \$200 co-payment per visit	80% of U&C after lesser of \$200 co-payment per visit, or 50% of U&C
Outpatient Surgery	100% after \$150 co-payment per visit	90% of network charges after \$150 co-payment	80% of U&C after \$150 co-payment
Outpatient Psychiatric and Substance Abuse	100% after \$15 co-payment, up to 30 visits per plan year	90% of network charges after \$15 co-payment, up to 30 visits per plan year	80% of U&C after \$15 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	100%	90% of network charges	80% of U&C
Physician and Other Professional Services			
Physician Office Visits	100% after \$15 co-payment	90% of network charges	80% of U&C
Specialist Office Visits	100% after \$20 co-payment	90% of network charges	80% of U&C
Preventive Services, including immunizations, allergy testing and treatment	100% after \$15 co-payment	90% of network charges	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	90% of network charges	Covered under Tier I and Tier II only
Other Services			
Prescription Drugs – Covered through State of Illinois administered plan, Medco; new \$50 deductible applies			
	Generic \$10	Preferred Brand \$22	Non-Preferred Brand \$44
Durable Medical Equipment	100%	90% of network charges	80% of U&C
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$20 co-payment	90% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan co-payments and deductibles do not count toward the out-of-pocket maximum.

THE QUALITY CARE HEALTH PLAN (QCHP)

QCHP is the medical plan that offers a comprehensive range of benefits (administered by CIGNA). Under the QCHP, plan participants can choose any physician or hospital for medical services and any pharmacy for prescription drugs. A new \$50 prescription deductible applies (see page 18 for details). Plan participants receive enhanced benefits resulting in lower out-of-pocket amounts when receiving services from a QCHP network provider. The QCHP has a nationwide network that consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail pharmacy network) and behavioral health services (Magellan behavioral health network). Notification to Intracorp, the QCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction.

Plan participants can access plan benefit and participating QCHP network information, Explanation of Benefits (EOB) and other valuable health information online. To access online links to plan administrators, visit the Benefits website at www.benefitschoice.il.gov.

Plan Year Maximums and Deductibles

Plan Year Maximum	Unlimited						
Lifetime Maximum	Unlimited						
Plan Year Deductible	The plan year deductible is based upon each employee's annual salary (see chart below for current plan year information)						
Additional Deductibles* * These are in addition to the plan year deductible.	<table> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>Non-QCHP hospital admission</td> <td>\$200</td> </tr> <tr> <td>Transplant deductible</td> <td>\$100</td> </tr> </table> <p>Note: There is no additional deductible for admission to a QCHP network hospital</p>	Each emergency room visit	\$400	Non-QCHP hospital admission	\$200	Transplant deductible	\$100
Each emergency room visit	\$400						
Non-QCHP hospital admission	\$200						
Transplant deductible	\$100						

Plan Year Deductibles

Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Member Plan Year Deductible	Family Plan Year Deductible Cap
\$59,300 or less	\$300	\$750
\$59,301 - \$74,300	\$400	\$1,000
\$74,301 and above	\$450	\$1,125
Retiree/Annuitant/Survivor	\$300	\$750
Dependents	\$300	NA

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100% of eligible charges for the remainder of the plan year. There are two separate out-of-pocket maximums: a general one and one for non-QCHP hospital charges. Coinsurance and deductibles apply to one or the other, but not both.

General: \$1,200 per individual \$3,000 per family per plan year	Non-QCHP Hospital: \$4,400 per individual \$8,800 per family per plan year
The following do not apply toward out-of-pocket maximums: <ul style="list-style-type: none"> • Prescription Drug benefits, deductibles or co-payments. • Behavioral Health benefits, coinsurance or co-payments. • Notification penalties. • Ineligible charges (amounts over Usual and Customary (U & C) and charges for non-covered services). • The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay. 	

QCHP - MEDICAL PLAN COVERAGE

Hospital Services	
QCHP Hospital Network	90% after annual plan deductible. No admission deductible.
Non-QCHP Hospitals	<ul style="list-style-type: none"> • \$200 per admission deductible. • If the member resides in Illinois or within 25 miles of a QCHP hospital and the member chooses to use a non-QCHP hospital and/or voluntarily travels in excess of 25 miles when a QCHP hospital is available within the same travel distance, the plan pays 65% after the annual plan deductible. • If the member resides in Illinois and has no QCHP hospital available within 25 miles and voluntarily chooses to travel further than the nearest QCHP hospital, the plan pays 65% after the annual plan deductible. • If the member does not reside in Illinois or within 25 miles of a QCHP hospital, the plan pays 80% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	90% of U&C after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible.
Licensed Ambulatory Surgical Treatment Centers	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Professional and Other Services	
QCHP Physician Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in the QCHP Network	70% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services – medical necessity required (limit of 30 visits per plan year)	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after \$100 transplant deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.

Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.

OPTIONAL PROGRAMS FOR QCHP PLAN PARTICIPANTS ONLY

Disease Management Program

Well Aware for Better Health® available through CIGNA by Healthways

QCHP members and dependents with certain risk factors indicating **diabetes or cardiac health conditions** may receive an invitation to voluntarily participate in one or both of these disease management programs. These **highly confidential** programs are based upon certain medical criteria and provide:

- Personal healthcare support **7 days a week, 24 hours a day** with access to a team of **registered nurses (RNs) and other clinicians**
- **Wellness tools**, such as reminders of regular health screenings
- **Educational materials** regarding your health condition, including identification of anticipated symptoms and ways to better manage these conditions

Hospital Bill Audit Program

The Hospital Bill Audit Program applies to hospital charges. Under the Program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill, is eligible for 50% of the resulting savings. There is no cap on the savings amount. Note: Related non-hospital charges, such as radiologists and surgeons, are not eligible charges under the program. The program only applies when QCHP is primary payer. See page 58 of the Benefits Handbook for details.

PRESCRIPTION DRUG BENEFIT

Plan participants enrolled in any State health plan have prescription drug coverage available. All prescription medications are compiled on a preferred drug list (“formulary list”) maintained by each health plan's Prescription Benefit Manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount.

PRESCRIPTION DRUG CO-PAYS		
\$50 Deductible Applies to All Plans	PRESCRIPTION PLAN	
	QCHP	All Other Plans
Generic	\$11	\$10
Preferred (Formulary) Brand	\$24	\$22
Non-Preferred Brand	\$48	\$44

NEW: Effective January 1, 2009 – Prescription Deductible

Beginning with prescriptions filled on or after January 1, 2009, all plan participants will be responsible for a \$50 prescription deductible. Annual prescription deductibles must be satisfied before the prescription co-payments apply. However, if the cost of the drug is less than the plan's co-payment, the plan participant will pay the cost of the drug. See below for examples.

Example 1 – Generic Drug Cost – Less than \$50

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Co-payment	Total Payment
QCHP First Fill	\$37	\$37	\$13	\$0	\$37
QCHP Next Fill	\$37	\$13	\$0	\$11	\$24
Managed Care First Fill	\$37	\$37	\$13	\$0	\$37
Managed Care Next Fill	\$37	\$13	\$0	\$10	\$23

Example 2 – Generic Drug Cost – More than \$50

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Co-payment	Total Payment
QCHP First Fill	\$100	\$50	\$0	\$11	\$61
QCHP Next Fill	\$100	\$0	\$0	\$11	\$11
Managed Care First Fill	\$100	\$50	\$0	\$10	\$60
Managed Care Next Fill	\$100	\$0	\$0	\$10	\$10

Coverage for specific drugs may vary depending upon the health plan. It is important to note that formulary lists are subject to change any time during the plan year. To compare formulary lists (preferred drug lists), cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. Plan participants should consult with their physician to determine if a change in prescription is appropriate.

Plan participants who have additional prescription drug coverage, including Medicare, should contact the managed care plan or Medco for Coordination of Benefits (COB) information.

MANAGED CARE PLAN PRESCRIPTION DRUG BENEFIT

Health Alliance HMO, HMO Illinois, OSF HealthPlans, PersonalCare and UniCare HMO all administer prescription drug benefits through the respective health plan. Members who elect one of these plans must utilize a pharmacy participating in the health 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. It should be noted that most plans do not cover over-the-counter drugs, even if purchased with a prescription. **Members should direct prescription benefit questions to the respective health plan administrator.**

MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT

The following information provides a brief overview of Medco benefits. See the Benefits Handbook or the Benefits website for more information.

Health Alliance Illinois, HealthLink OAP, OSF Winnebago and the Quality Care Health Plan (QCHP) have prescription benefits administered through the Prescription Benefit Manager (PBM), Medco. Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or out-of-pocket maximums; however, **a separate prescription deductible of \$50 applies to each plan participant each plan year.** In order to receive the best value, plan participants enrolled in one of the Medco-administered health plans should carefully review the various prescription networks outlined below. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Participants receiving a drug costing less than the co-payment will only be charged the cost of the drug. If a plan participant elects 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 co-payment.

Non-Maintenance Medication

In-Network Pharmacy - Retail pharmacies that contract with Medco and accept the co-payment amount for **non-maintenance medications** are referred to as in-network pharmacies. The maximum supply allowed at one fill is 60 days, although two co-payments will be charged for any prescription that exceeds a 30-day supply. Plan participants who use an in-network pharmacy must present their Medco ID card/number or will be required to pay the full retail cost. If, for any reason, the pharmacy is not able to verify eligibility (submit claim electronically), the plan participant must submit a paper claim to Medco. A list of in-network pharmacies, as well as claim forms, is available at www.benefitschoice.il.gov or by calling Medco at (800) 899-2587.

Out-of-Network Pharmacy - Pharmacies that do not contract with Medco are referred to as out-of-network pharmacies. In most cases, prescription drug costs will be higher when an out-of-network pharmacy is used. If a medication is purchased at an out-of-network pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges must be obtained by submitting a paper claim and the original prescription receipt to Medco. Reimbursement will be at the applicable brand or generic in-network price minus the appropriate in-network co-payment. Claim forms are available on the Benefits website at www.benefitschoice.il.gov or by calling Medco at (800) 899-2587.

MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT (CONT)

Maintenance Medication

Maintenance medication is taken on a regular basis for conditions such as high blood pressure and high cholesterol. The Maintenance Medication Program (MMP) was developed to provide an enhanced benefit to plan participants who use **maintenance medications**. To determine whether a medication is considered a maintenance medication, contact a Maintenance Network pharmacist or contact Medco directly at (800) 899-2587. A list of pharmacies participating in the Maintenance Network is available at www.benefitschoice.il.gov. When plan participants use **either** the Maintenance Network or the Mail Order Pharmacy for maintenance medications, they will receive a 61-90 day supply of medication (equivalent to 3 fills) for only two co-payments.

The Maintenance Network is a network of retail pharmacies that contract with Medco to accept the co-payment amount for maintenance medication. Pharmacies in this network may also be an in-network retail pharmacy as described under the Non-Maintenance Medication section (page 19). If a plan participant uses a retail network pharmacy, only the first two 30-day fills will be covered at the regular co-payment amount. Subsequent fills will be charged double the co-payment rate.

The Mail Order Pharmacy provides participants the opportunity to receive medications directly from Medco. **Both maintenance and non-maintenance medications may be obtained through the mail order process.**

To utilize the Mail Order Pharmacy, plan participants must submit an original prescription from the attending physician. The prescription should be written for a 61-90-day supply, and include up to three (3) 90-day refills, totaling one-year of medication. The original prescription must be attached to a completed Medco Mail Order form and sent to the address indicated on the form. Order forms and refills can be obtained by contacting Medco at (800) 899-2587, or by accessing the Medco website at www.medco.com. Order forms are also available on the Benefits website.

VISION PLAN

All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Co-payments are required. For more information regarding the vision plan, see pages 97-98 of the Benefits Handbook or contact the plan administrator, EyeMed Vision Care at (866) 723-0512, (800) 526-0844 (TTD/TTY) or by visiting their website and logging in as a member at www.eyemedvisioncare.com/stil.

Service	Network Provider Benefit	Out-of-Network*** Provider Benefit	Benefit Frequency
Eye Exam	\$10 co-payment	\$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	\$10 co-payment	\$40 allowance for single vision lenses \$60 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	\$10 co-payment (up to \$130 retail frame cost; member responsible for balance over \$130)	\$50 allowance	Once every 24 months
Contact Lenses** (All contact lenses are in lieu of standard frames and spectacle lenses)	\$100 allowance	\$100 allowance	Once every 24 months

- * 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.
- ** Contact Lenses: The contact lens allowance applies toward the costs of the contact lenses as well as the professional fees for fitting and evaluation services.
- *** Out-of-network claims must be filed within one year from the date of service.

FY09 DENTAL OPTIONS AND SCHEDULE OF BENEFITS

All members and dependents have the same dental benefits available regardless of the health plan selected. During the Benefit Choice Period, members have the option to elect not to participate in the Quality Care Dental Plan (QCDP). This election will remain in effect the entire plan year, without exception. The Benefit Choice Period is also the only time members may enroll or re-enroll in the dental plan if they previously elected not to participate.

Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as diagnostic or preventive. **Effective January 1, 2009, the annual plan deductible will increase to \$125 per participant per plan year (prior to January 1, 2009, the deductible was \$100).** If a plan participant had met the \$100 deductible between July and December 2008, they are still responsible for the additional \$25 deductible for services incurred from January 1, 2009, through June 30, 2009.

Once the deductible has been met, the plan participant has a maximum annual dental benefit of \$2,000 for all dental services. The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations. For more information, see pages 91-95 of the Benefits Handbook or contact the Dental Plan Administrator, CompBenefits, at (800) 999-1669 or (312) 829-1298 (TDD/TTY).

The QCDP reimburses only those services listed on the Dental Schedule of Benefits. Listed services are reimbursed at a pre-determined maximum scheduled amount. Members are responsible for all charges over the scheduled amount and/or the annual maximum benefit.

DIAGNOSTIC SERVICES	Maximum Benefit	Code
Periodic Oral Examination	\$ 35	D0120
Limited Oral Evaluation (specific oral health problem)	\$ 57	D0140
Oral Examination for Patient Under 3 Years of Age and Counseling with Primary Care Giver	\$ 64	D0145
Comprehensive Oral Examination- new or established patient	\$ 64	D0150
Radiographs/Diagnostic Imaging		
Intraoral Complete Series (once in a period of three plan years, including bitewings)	\$ 99	D0210
Intraoral - Periapical First Film	\$ 21	D0220
Intraoral - Periapical Each Additional Film	\$ 15	D0230
Bitewing Single Film	\$ 24	D0270
Bitewing Two Films	\$ 32	D0272
Bitewing Three Films	\$ 48	D0273
Bitewing Four Films	\$ 48	D0274
Panoramic Film, (once in a period of three plan years)	\$ 89	D0330
PREVENTIVE SERVICES		
Prophylaxis Adult - Twice each plan year	\$ 70	D1110
Prophylaxis Child - Twice each plan year	\$ 52	D1120
Topical Application of Fluoride - Child (including prophylaxis) (once each plan year, covered through age 18 only)	\$ 70	D1201
Topical Application of Fluoride - Child (not including prophylaxis) (once each plan year, covered through age 18 only)	\$ 30	D1203
Topical Flouride Varnish;Therapeutic Application for Moderate to High Caries Risk Patients	\$ 30	D1206
Sealant - per tooth	\$ 40	D1351
Space Maintainers (Passive Appliances)		
Fixed Unilateral	\$275	D1510
Fixed Bilateral	\$350	D1515
Removable Unilateral	\$307	D1520
Removable Bilateral	\$425	D1525
RESTORATIVE SERVICES		
Amalgam Restorations		
Amalgam One Surface, Primary or Permanent	\$ 95	D2140
Amalgam Two Surfaces, Primary or Permanent	\$119	D2150
Amalgam Three Surfaces, Primary or Permanent	\$143	D2160
Amalgam Four or More Surfaces, Primary or Permanent	\$176	D2161

FY09 DENTAL SCHEDULE OF BENEFITS CONTINUED

RESTORATIVE SERVICES CONTINUED	Maximum Benefit	Code
Resin-Based Composite Restorations		
One Surface, Anterior	\$114	D2330
Two Surfaces, Anterior	\$143	D2331
Three Surfaces, Anterior	\$172	D2332
Four or More Surfaces or involving incisal angle (anterior)	\$193	D2335
One Surface Posterior	\$135	D2391
Two Surface Posterior	\$180	D2392
Three Surface Posterior	\$200	D2393
Four or More Surfaces, Posterior	\$249	D2394
Inlay/Onlay Restorations		
Inlay - metallic - one surface.....	\$321	D2510
Inlay - metallic - two surfaces.....	\$364	D2520
Inlay - metallic - three or more surfaces.....	\$420	D2530
Onlay - metallic - three surfaces.....	\$431	D2543
Onlay - metallic - four or more surfaces.....	\$448	D2544
Inlay - porcelain/ceramic - one surface	\$378	D2610
Inlay - porcelain/ceramic - two surfaces	\$399	D2620
Inlay - porcelain/ceramic - three or more surfaces	\$425	D2630
Onlay - porcelain/ceramic - two surfaces.....	\$413	D2642
Onlay - porcelain/ceramic - three surfaces	\$445	D2643
Onlay - porcelain/ceramic - four or more surfaces	\$472	D2644
Inlay - resin-based composite - one surface.....	\$248	D2650
Inlay - resin-based composite - two surfaces.....	\$296	D2651
Inlay - resin-based composite - three or more surfaces	\$311	D2652
Onlay - resin-based composite - two surfaces.....	\$270	D2662
Onlay - resin-based composite - three surfaces	\$317	D2663
Onlay - resin-based composite - four or more surfaces	\$340	D2664
Crowns/Single Restorations Only		
Crown-Resin (indirect)	\$306	D2710
Crown-Resin with high noble metal	\$755	D2720
Crown-Resin predominantly base metal	\$708	D2721
Crown-Resin with noble metal	\$723	D2722
Crown-Porcelain/Ceramic Substrate	\$714	D2740
Crown-Porcelain fused to high noble metal	\$708	D2750
Crown-Porcelain fused to predominantly base metal	\$662	D2751
Crown-Porcelain fused to noble metal	\$719	D2752
Crown-3/4 cast predominately base metal	\$688	D2781
Crown-Full cast high noble metal	\$676	D2790
Crown-Full cast predominantly base metal	\$660	D2791
Crown-Full cast noble metal	\$712	D2792
Other Restorative Services		
Recement Inlay	\$ 75	D2910
Recement Crown	\$ 77	D2920
Prefabricated stainless steel Crown (primary tooth)	\$350	D2930
Prefabricated stainless steel Crown (permanent tooth)	\$450	D2931
Prefabricated Resin Crown	\$295	D2932
Recement Implant/Abutment Supported Crown	\$ 77	D6092
Recement Implant/Abutment Supported Fixed Partial Denture	\$ 58	D6093
ENDODONTICS		
Pulp Capping		
Pulp Cap - Direct (excluding final restoration)	\$ 51	D3110
Pulp Cap - Indirect (excluding final restoration)	\$ 40	D3120
Pulpotomy - Therapeutic (excluding final restoration)	\$140	D3220
Root Canal Therapy (include intra-operative radiographs)		
Anterior (excludes final restoration)	\$645	D3310
Bicuspid (excludes final restoration)	\$775	D3320
Molar (excludes final restoration)	\$947	D3330
Retreatment of Previous Root Canal Therapy		
Anterior	\$750	D3346
Bicuspid	\$989	D3347
Molar	\$970	D3348

FY09 DENTAL SCHEDULE OF BENEFITS CONTINUED

PERIODONTICS	Maximum Benefit	Code
Gingivectomy/Gingivoplasty		
Per quadrant	\$315	D4210
1 - 3 Teeth per quadrant	\$135	D4211
Gingival Flap Procedure		
Per quadrant - includes root planing	\$371	D4240
Gingival Flap - including root planing, 1-3 teeth per quadrant	\$191	D4241
Osseous Surgery (including flap entry and closure)		
4 or More contiguous teeth or bounded teeth spaces per quadrant	\$598	D4260
1-3 contiguous teeth or bounded teeth spaces per quadrant	\$312	D4261
Bone Replacement Graft		
First site in quadrant	\$181	D4263
Each additional site in quadrant	\$ 90	D4264
Pedicle Soft Tissue Graft		
.....	\$442	D4270
Free Soft Tissue Graft		
.....	\$455	D4271
Provisional Splinting		
Intracoronaral	\$185	D4320
Extracoronaral	\$162	D4321
Periodontal Scaling and Root Planing		
4 or More contiguous teeth or bounded teeth spaces per quadrant	\$113	D4341
1-3 contiguous teeth or bounded teeth spaces per quadrant.....	\$ 75	D4342
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis		
.....	\$ 61	D4355
Periodontal Maintenance Procedure		
Following active therapy	\$ 55	D4910
Unscheduled Dressing Change	\$ 52	D4920
PROSTHODONTICS		
Removable Prosthetics		
Complete Denture - Maxillary	\$920	D5110
Complete Denture - Mandibular	\$926	D5120
Immediate Denture - Maxillary	\$907	D5130
Immediate Denture - Mandibular	\$975	D5140
Partial Dentures (removable)		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth)	\$666	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth)	\$774	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	\$910	D5213
Mandibular Partial Denture - cast metal framework, resin base (convention clasps, rests and teeth)	\$921	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth)	\$508	D5281
Adjustments to Dentures		
Adjust complete denture - Maxillary	\$ 43	D5410
Adjust complete denture - Mandibular	\$ 50	D5411
Adjust partial denture - Maxillary	\$ 43	D5421
Adjust partial denture - Mandibular	\$ 43	D5422
Repairs to Complete Dentures		
Repair broken complete denture base	\$ 95	D5510
Replace missing or broken teeth - complete denture (each tooth)	\$ 84	D5520
Repairs to Partial Dentures		
Repair resin denture base	\$105	D5610
Repair cast framework	\$106	D5620
Repair or replace broken clasp	\$122	D5630
Replace broken teeth - per tooth	\$ 91	D5640
Add tooth to existing partial denture	\$108	D5650
Add clasp to existing partial denture	\$130	D5660
Denture Rebase Procedure		
Rebase complete maxillary denture	\$337	D5710
Rebase complete mandibular denture	\$323	D5711
Rebase maxillary partial denture	\$319	D5720
Rebase mandibular partial denture	\$319	D5721

FY09 DENTAL SCHEDULE OF BENEFITS CONTINUED

PROSTHODONTICS CONTINUED	Maximum Benefit	Code
Denture Reline Procedure		
Reline complete maxillary denture (chairside)	\$181	D5730
Reline complete mandibular denture (chairside)	\$190	D5731
Reline maxillary partial denture (chairside)	\$174	D5740
Reline mandibular partial denture (chairside)	\$174	D5741
Reline complete maxillary denture (laboratory)	\$252	D5750
Reline complete mandibular denture (laboratory)	\$247	D5751
Reline maxillary partial denture (laboratory)	\$251	D5760
Reline mandibular partial denture (laboratory)	\$246	D5761
Implant Services		
Surgical placement of implant body: endosteal implant	\$2,000	D6010
Surgical placement: eposteal implant	\$2,000	D6040
Surgical placement: transosteal implant	\$2,000	D6050
Implant/abutment supported removable denture for completely edentulous arch	\$1,680	D6053
Implant/abutment supported removable denture for partially edentulous arch	\$1,680	D6054
Dental implant supported connecting bar	\$571	D6055
Prefabricated abutment – includes placement	\$399	D6056
Custom abutment – includes placement	\$522	D6057
Abutment supported porcelain/ceramic crown	\$1,295	D6058
Abutment supported porcelain fused to metal crown (high noble metal) ..	\$1,232	D6059
Abutment supported porcelain fused to metal crown (predominantly base metal)	\$1,208	D6060
Abutment supported porcelain fused to metal crown (noble metal)	\$1,233	D6061
Abutment supported cast metal crown (high noble metal)	\$1,228	D6062
Abutment supported cast metal crown (predominantly base metal)	\$1,054	D6063
Abutment supported cast metal crown (noble metal)	\$1,117	D6064
Implant supported porcelain/ceramic crown	\$1,274	D6065
Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$1,365	D6066
Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$1,204	D6067
Abutment supported retainer for porcelain/ceramic FPD	\$1,295	D6068
Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$1,278	D6069
Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$1,208	D6070
Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$1,233	D6071
Abutment supported retainer for cast metal FPD (high noble metal)	\$1,258	D6072
Abutment supported retainer for cast metal FPD (predominantly base metal)	\$1,139	D6073
Abutment supported retainer for cast metal FPD (noble metal)	\$1,228	D6074
Implant supported retainer for ceramic FPD	\$1,274	D6075
Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	\$1,241	D6076
Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	\$1,204	D6077
Implant maintenance procedures, including removal of prosthesis, cleaning of prosthesis and abutments and reinsertion of prosthesis	\$106	D6080
Abutment supported crown – (titanium)	\$1,014	D6094
Radiographic/surgical implant index, by report	\$227	D6190
Abutment supported retainer crown for FPD – (titanium)	\$1,045	D6194
Fixed Partial Denture Pontics		
(Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal	\$475	D6210
Pontic-Cast predominantly base metal	\$414	D6211
Pontic-Cast noble metal	\$430	D6212
Pontic-Porcelain fused to high noble metal	\$436	D6240
Pontic-Porcelain fused to predominantly base metal	\$420	D6241
Pontic-Porcelain fused to noble metal	\$433	D6242
Pontic-Resin with high noble metal	\$430	D6250
Pontic-Resin with predominantly base metal	\$397	D6251
Pontic-Resin with noble metal	\$410	D6252

FY09 DENTAL SCHEDULE OF BENEFITS CONTINUED

PROSTHODONTICS CONTINUED	Maximum Benefit	Code
Fixed Partial Denture Retainers - Inlays/Onlays		
Inlay - cast predominantly base metal, two surfaces.....	\$359	D6604
Inlay - cast predominantly base metal, three or more surfaces.....	\$381	D6605
Onlay - cast predominantly base metal, two surfaces.....	\$393	D6612
Onlay - cast predominantly base metal, three or more surfaces.....	\$411	D6613
Fixed Partial Denture Retainers - Crowns		
Crown-Resin with high noble metal	\$486	D6720
Crown-Resin with predominantly base metal	\$461	D6721
Crown-Resin with noble metal	\$469	D6722
Crown-Porcelain fused to high noble metal	\$497	D6750
Crown-Porcelain fused to predominantly base metals	\$464	D6751
Crown-Porcelain fused to noble metal	\$475	D6752
Crown-3/4 cast high noble metal	\$469	D6780
Crown-Full cast high noble metal	\$480	D6790
Crown-Full cast predominantly base metal	\$455	D6791
Crown-Full cast noble metal	\$472	D6792
Other Fixed Partial Denture Services		
Recement Fixed Partial Denture	\$ 58	D6930
Fixed Partial Denture Repair, by report	\$ 49	D6980
ORAL SURGERY		
Extractions		
Coronal Remnants - Deciduous Tooth	\$ 83	D7111
Extraction, Erupted Tooth or Exposed Root (elevation and/ or forceps removal)	\$125	D7140
Surgical Extraction		
(Includes local anesthesia, suturing if needed, and routine postoperative care)		
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$125	D7210
Removal of impacted tooth - soft tissue	\$136	D7220
Removal of impacted tooth - partially bony	\$181	D7230
Removal of impacted tooth - completely bony	\$213	D7240
Removal of impacted tooth - completely bony with unusual surgical complications	\$267	D7241
Surgical removal of residual tooth roots (cutting procedure)	\$125	D7250
Other Surgical Procedures		
Biopsy of oral tissue - hard (bone/tooth)	\$453	D7285
Biopsy of soft tissue - soft (all others)	\$186	D7286
Alveoloplasty in conjunction with extractions, per quadrant	\$127	D7310
Alveoloplasty in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	\$127	D7311
Alveoloplasty not in conjunction with extractions, per quadrant	\$565	D7320
Alveoloplasty not in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	\$565	D7321
Frenulectomy - separate procedure	\$266	D7960
ADJUNCTIVE GENERAL SERVICES		
Surgical Incision		
Palliative (emergency) treatment of dental pain (minor procedure).....	\$ 88	D9110
Anesthesia		
General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.		
General anesthesia - first 30 minutes	\$365	D9220
General anesthesia - each additional 15 minutes	\$149	D9221
Intravenous sedation/analgesia - first 30 minutes	\$300	D9241
Intravenous sedation/analgesia - each additional 15 minutes	\$120	D9242
Miscellaneous Services		
Occlusal guards, by report	\$331	D9940
Occlusal adjustment, limited	\$112	D9951
Occlusal adjustment, complete	\$665	D9952

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Health Care Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Website Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
OSF HealthPlans	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
OSF Winnebago	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
UniCare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	EyeMed Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com/stil
Quality Care Dental Plan (QCDP) Administrator	CompBenefits Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY)	www.compbenefits.com
Life Insurance Plan	Minnesota Life Insurance Company 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
Long-Term Care (LTC) Insurance	MetLife	(800) 438-6388 (800) 638-1004 (TDD/TTY)	
Flexible Spending Accounts (FSA) Program	Fringe Benefits Management Company P.O. Box 1810 Tallahassee, FL 32302-1810	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax) (866) 440-7152 (toll-free fax)	www.myFBMC.com
Commuter Savings Program (CSP)			
Health/Dental Plans, Medicare COB Unit, FSA Unit, Premium Collection Unit, Life Insurance, Adoption and Smoking Cessation Benefits	CMS Group Insurance Division 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

Plan Administrator information continued on inside back cover.

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits	CIGNA Group Number 3181456 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of \$800 applies	Intracorp, Inc.	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator QCHP (1400SD3) Health Alliance Illinois (1400SBS) OSF Winnebago (1400SCE) HealthLink OAP (1400SCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1400SD3, 1400SBS, 1400SCE, 1400SCF Paper Claims: Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 Mail Order Prescriptions: Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
QCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	Magellan Behavioral Health Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services, ID cards	Magellan Behavioral Health -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Personal Support Program (PSP – AFSCME EAP)	Confidential assessment and assistance services	AFSCME Council 31 -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) www.afscme31.org

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

NOTICE OF CREDITABLE COVERAGE

Prescription Drug Information for State of Illinois Medicare Eligible Plan Participants

This notice confirms that your existing prescription drug coverage through the State Employees Group Insurance Program is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). **You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.**

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop your entire group coverage through the State Employees Group Insurance Program and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your State Employees Group Insurance coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after the loss of creditable coverage.**

If you keep your existing group coverage, it is **not** necessary to join a Medicare prescription drug plan this year.

REMEMBER: KEEP THIS NOTICE

NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the Quality Care Health Plan (QCHP) and the Quality Care Dental Plan (QCDP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau), and the Department of Healthcare and Family Services are charged with the administration of the self-funded plans available through the State Employees Group Insurance Act. These plans include the Quality Care Health Plan and the Quality Care Dental Plan. The term “we” in this Notice means the Bureau, the Department of Healthcare and Family Services and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

The Department of Healthcare and Family Services contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on our behalf in performing their respective functions. When we seek help from individuals or entities in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Medco Health Solutions is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a notice from the HMO regarding its privacy practices.

How We May Use or Disclose Your PHI:

Treatment: We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party. We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.

Health Care Operations: We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.

Appointment Reminders: Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

Legal Requirements:

We may use and disclose PHI **as required or authorized by law**. For example, we may use or disclose your PHI for the following reasons.

Public Health: We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.

Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Organ Procurement: We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.

Release of Information to Family Members: In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.

Research: You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.

Fundraising and Marketing: We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

Plan Sponsors: Your employer is not permitted to use PHI for any purpose other than the administration of your benefit plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate.

Illinois Law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

Your Rights:

You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing to the appropriate plan administrator. These plan administrators are as follows:

For the Medical Plan Administrator and Notification/Medical Case Management: CIGNA HealthCare, Privacy Office P.O. Box 5400 Scranton, PA 18503 800-762-9940	For Pharmacy Benefits: Medco Health Solutions, Privacy Services Unit P.O. Box 800 Franklin Lakes, NJ 07417 800-987-5237
For Behavioral Health Benefits: Magellan Behavioral Health, Privacy Officer 1301 E. Collins Blvd. Suite 100 Richardson, TX 75081 800-513-2611	For Dental Plan Benefits: CompBenefits, Privacy Officer 100 Mansell Court East, Suite 400 Roswell, GA 30076 800-342-5209

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are "in danger" and we will accommodate your request.

Inspect and Access: You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

Amendment of your Records: If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to amend. We will send you a letter stating how we handled your request.

Accounting of Disclosures: You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one Accounting in a 12-month period.

Copy of Notice and Changes to the Notice: You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within sixty (60) days of the material change. You can also access a revised Notice on our website at "<http://www.benefitschoice.il.gov/>"

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective plan administrator. If the Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C. if you feel your privacy rights have been violated. **EFFECTIVE DATE: July 1, 2006**

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

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