

State of Illinois

Rod R. Blagojevich, Governor

Department of Central Management Services

Bureau of Benefits

James P. Sledge, Director



Benefit Choice Options Period 2

Enrollment Period, October 27 – November 14, 2008



State of Illinois

Effective January 1, 2009 – June 30, 2009

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.

TABLE OF CONTENTS

Important Changes for the Remainder of Plan Year 2009	2
Managed Care Plan (HMO/OAP) Changes	2
Quality Care Health Plan (QCHP) Changes	2
Quality Care Dental Plan (QCDP) Changes	2
Message to Plan Members	3
Questions and Answers About Benefit Choice Options Period 2	4
Member Responsibilities	6
Important Reminders	7
Notice of Creditable Coverage	8
Opt Out Options	9
Member and Dependent Monthly Health, Dental and Optional Life Plan Contributions ..	10
Managed Care Plans	12
Important Reminders about Managed Care Plans	12
Managed Care Plans in Illinois Counties (Map)	13
HMO Benefits	14
Open Access Plan (OAP) Benefits	15
The Quality Care Health Plan (QCHP)	16
Prescription Drug Benefit	18
Managed Care Plan Prescription Drug Benefit	19
Medco-Administered Prescription Drug Benefit	19
Flexible Spending Accounts (FSA) Program	20
Vision Plan	21
Life Insurance Plan	21
Dental Options	22
Dental Schedule of Benefits	22
Behavioral Health Services, Employee Assistance Program and Optional Programs ..	27
Optional Programs for QCHP Plan Participants Only	28
Notice of Privacy Practices (HIPAA)	29
Benefit Choice Options Period 2 Election Form and Instructions	31
Statement of Health Form	33
Medical Care Assistance Plan (MCAP) Form	35
Plan Administrators	Inside Front and Back Covers

Important Changes for the Remainder of Plan Year 2009 (Enrollment Period October 27 – November 14, 2008)

The information below represents changes to the State of Illinois benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes. **Benefit Choice Options Period 2 is October 27 - November 14, 2008.** All selections will be effective January 1, 2009.

Managed Care Plan (HMO/OAP) Changes

- New prescription deductible of \$50 per individual per plan year
- Prescription co-payments for preferred brand and non-preferred brand increase to \$22/\$44 respectively (generic remains \$10)
- Employee and dependent health contributions have increased
- Specialist office visit co-payments have increased to \$20

Quality Care Health Plan (QCHP) Changes

- New prescription deductible of \$50 per individual per plan year
- Prescription co-payments for preferred brand and non-preferred brand increase to \$24/\$48 respectively (generic remains \$11)
- General out-of-pocket maximum (individual) increases to \$1,200
- General out-of-pocket maximum (family) increases to \$3,000
- Coinsurance for out-of-network physicians is reduced from 80% to 70% (in-network coinsurance remains 90%)
- Employee and dependent health contributions have increased
- Hospital Bill Audit Program – limit on savings has been eliminated (see page 28 for details)

Quality Care Dental Plan (QCDP) Changes

- Dental deductible increases to \$125 per plan participant per plan year
- Dental contributions have increased

Flexible Spending Accounts (FSA) Program Correction

Contrary to the information published in the Benefit Choice Options Period 1 booklet regarding the Medical Care Assistance Plan (MCAP), the only option allowed during the election period is to enroll with an effective date of January 1, 2009. We regret any inconvenience this may have caused.

Benefit Choice Options Period 2 changes will take effect January 1, 2009, for all programs, benefits/levels, co-payments and deductibles.

MESSAGE TO PLAN MEMBERS

The Benefit Choice Options Period 2 will be held **October 27, 2008 through November 14, 2008** for all members. Members include employees (full-time, part-time, employees working 50% or greater, as well as employees on leave of absence), annuitants, survivors and COBRA participants. Elections will be effective January 1, 2009.

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Options Period 2 Election Form (located on page 31 and online at www.benefitschoice.il.gov). Members should complete the form **only if changes** are being made. Your agency/university Group Insurance Representative (GIR) will process the changes based upon the information indicated on the form. Members can access GIR names and locations by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at www.benefitschoice.il.gov.

Members may make the following changes during Benefit Choice Options Period 2:

- Change health plans
- Add or drop dependent coverage
- Increase or decrease member Optional Life insurance coverage
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage
- Enroll unrelated same-sex Domestic Partner, including those previously terminated for non-payment of premium (Domestic Partner Enrollment Packet available online at www.benefitschoice.il.gov)
- Elect to opt out (full-time employees, annuitants and survivors only). The election to opt out will terminate the health, dental, vision **and** prescription coverage for the member and any covered dependents (see page 9). **Note:** Members must provide proof of other comprehensive health coverage.
- Elect to waive health, dental, vision and prescription coverage (part-time employees 50% or greater, annuitants and survivors required to pay a portion of premiums only)
- Elect to waive health, dental, vision and prescription coverage and become a dependent of a State-covered spouse (annuitants only)
- Re-enroll in the Program if previously opted out (full-time employees, survivors or annuitants)
- Re-enroll in the Program if previously waived (part-time employees 50% or greater, annuitants and survivors required to pay a portion of the premium)
- Re-enroll in the Program if coverage is currently terminated due to non-payment of premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums plus the January premium must be paid before coverage will be reinstated. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated for non-payment of premium.
- Elect to participate or not participate in the dental plan
- Enroll in MCAP. (Special Benefit Choice Options Period 2 MCAP Enrollment form required – form available on page 35). See page 20 for limitations. **Note:** You may not enroll in DCAP, nor make changes to a current MCAP or DCAP account.

QUESTIONS AND ANSWERS ABOUT BENEFIT CHOICE OPTIONS PERIOD 2

- 1. Q. I received the Benefit Choice Options 2 booklet and do not want to make any changes. Do I need to complete the election form?**

A. No. Only complete an election form if you want to make changes.
- 2. Q. How long do I have to make a decision regarding my benefits?**

A. The Benefit Choice Period ends November 14, 2008. Any forms turned in to your benefits office after that date will not be accepted.
- 3. Q. Who do I contact for more information about my benefits?**

A. Contact the Group Insurance Representative (GIR) at your employing agency (or your retirement system if you are retired or on a leave of absence and are receiving disability benefits). Visit the Benefits website at www.benefitschoice.il.gov for your GIR's contact information.
- 4. Q. Will I get a new health ID card that indicates the new benefit levels?**

A. It depends on the type of health plan that you have. The managed care plans will be issuing new ID cards; however, the Quality Care Health Plan (QCHP) will not. You will also receive a new ID card if you change health plans.
- 5. Q. Are the prescription drug co-payments going to increase January 1st?**

A. Yes. For both QCHP and the managed care plans, the preferred drug co-payment will increase \$2 and the non-preferred drug co-payment will increase \$4. Generic drug co-payments will remain unchanged.
- 6. Q. Does the new \$50 prescription deductible apply to the Managed Care plans and the Quality Care Health Plan?**

A. Yes.
- 7. Q. How does the new \$50 prescription deductible affect the cost of my prescriptions?**

A. The \$50 prescription deductible will take effect January 1, 2009. Please see the examples on page 18.
- 8. Q. If I pay the \$50 prescription deductible, will it be satisfied for everyone in my family?**

A. No. Each individual on your health plan must satisfy the \$50 prescription deductible.
- 9. Q. I'm enrolled in QCHP. If I have already met my individual out-of-pocket maximum (\$1100), do I still need to satisfy the additional \$100 in out-of-pocket expenses after January 1, 2009?**

A. Yes. The additional \$100 is required for services received January 1, 2009, and after.
- 10. Q. If I have already met my individual dental deductible of \$100, do I still need to satisfy the additional \$25 in out-of-pocket expenses after January 1, 2009?**

A. Yes. The additional \$25 is required for services received January 1, 2009, and after.
- 11. Q. Do I need to submit a Statement of Health form in order to increase my optional life coverage?**

A. Yes. Medical underwriting is the process used to determine an applicant's insurability under the life plan. The Statement of Health form is required any time you increase member optional life coverage or add spouse or child life coverage.
- 12. Q. If I apply for optional life, spouse life or child life coverage during Benefit Choice Options Period 2, when will it become effective?**

A. The coverage will become effective January 1, 2009, if approved prior to that date. If approved after January 1, 2009, the coverage will be effective the first day of the following pay period. The Statement of Health form is available on page 33.

QUESTIONS AND ANSWERS ABOUT BENEFIT CHOICE OPTIONS PERIOD 2

- 13.Q. I am on a leave of absence, but my coverage was terminated for non-payment of premium. Can I re-enroll during the Benefit Choice Options Period 2?**
- A. Yes; however, any outstanding premiums plus the January premium must be paid before coverage will be reinstated.
- 14.Q. Can I keep my health plan, but cancel my dental coverage?**
- A. Yes. You can elect not to participate in the dental plan by completing section D of the election form. If you elect to terminate your dental coverage during Benefit Choice Options Period 2, the effective date of the change will be January 1, 2009.
- 15.Q. If I elect not to participate in the dental plan, can I rejoin the plan at a later date?**
- A. Yes, but only during a future Benefit Choice Period.
- 16.Q. I am enrolled in the QCHP. Is it true that if I find an error on my hospital bill, I will be paid 50% of any savings?**
- A. Yes! The Hospital Bill Audit Program provides that if a QCHP plan participant discovers an error or overcharge on their bill from a hospital, they will be eligible to receive 50% of the resulting savings! New this year, the savings is unlimited!
- 17.Q. If I didn't enroll in MCAP during Benefit Choice Options Period 1, can I enroll during Benefit Choice Options Period 2?**
- A. Yes. The enrollment will be effective January 1, 2009. An MCAP Enrollment form is available on page 35.
- 18.Q. I enrolled in MCAP during Benefit Choice Options Period 1. Can I change that election during the Benefit Choice Options Period 2?**
- A. No.
- 19.Q. May I enroll in or change my deduction amount for the Dependent Care Assistance Program (DCAP) during Benefit Choice Options Period 2?**
- A. No, you may not enroll or change your DCAP deduction amount.
- 20.Q. What is Public Act 95-0958 and how does it affect me?**
- A. PA 95-0958 expands eligibility for participation in the State Employees Group Health Plan for dependents between the ages of 19 and 26 and for certain dependents that were in the military. The Bureau of Benefits will be providing more information regarding the requirements of PA 95-0958 and the impact on members through separate correspondence.

MEMBER RESPONSIBILITIES

Benefit Choice Options Period 2 is **October 27 through November 14, 2008** for all members. Before making benefit changes, compare:

- Services covered
- Deductibles, co-payment levels and out-of-pocket maximums
- Premium costs
- Geographic access
- Availability of managed care providers
- Prescription drug coverage

There are three health benefit coverage options available:

- Health Maintenance Organizations (HMOs)
- Open Access Plan (OAP)
- Quality Care Health Plan (QCHP)

See pages 12-17 to review the features for each type of plan.

You must notify your Group Insurance Representative (GIR) at your employing agency, university or retirement system if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses) must be reported to your GIR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you made on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You or your dependent obtains other coverage.** You **must complete** and forward a Coordination of Benefits Worksheet for yourself and/or any dependent that has other insurance coverage including Medicare or Medicaid. The Coordination of Benefits Worksheet is available at www.benefitschoice.il.gov.
- **You go on a Leave of Absence or have time away from work.** When you go on a Leave of Absence and are not receiving a paycheck or are ineligible for payroll deductions, you are still responsible to pay for your Group Insurance coverage. You should immediately contact your Group Insurance Representative (GIR) for your options, if any, to make changes to your current coverage. Requested changes will be effective the date of the written request if made within 60 days of entering the leave. You will be billed by CMS for the cost of your current coverage. **Paying the bill is not optional.**
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to your GIR when a change in you or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.**
- **You get married or divorced**
- **You have a baby or adopt a child**
- **Your spouse's or dependent's employment status changes**

Contact your GIR if you are uncertain whether or not a life-changing event needs to be reported.

IMPORTANT REMINDERS

Continuity of Care After Health Plan Change: Members who change health plans and are then hospitalized, or have dependents that are hospitalized, should contact both the current and future health plan administrators and Primary Care Physicians as soon as possible to coordinate the transition of services.

Members or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

COBRA Participants: During Benefit Choice Options Period 2, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage. COBRA health and dental rates for the remainder of plan year 2009 (January 1 – June 30, 2009) will be available by October 31, 2008.

Beneficiary Forms: You should periodically review all Beneficiary forms and make the appropriate updates. Remember, you may have death benefits through various state-sponsored programs, each having a separate Beneficiary form:

- State of Illinois life insurance
- Retirement benefits
- Deferred Compensation

Documentation Requirements

- Documentation is required when adding dependent coverage. Members should refer to the documentation requirements chart on the back of the Benefit Choice Options Period 2 Election Form on page 32.
- An approved Statement of Health is required to add or increase member Optional Life coverage or to add Spouse Life or Child Life coverage. Form available on page 33.
- If opting out, proof of other major medical insurance provided by an entity other than the Department of Central Management Services is required.

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

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

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. The new salary-based contributions will begin January 1, 2009, and remain in effect until June 30, 2009. Employees who retire, accept a voluntary salary reduction or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this does not apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions	
\$29,500 & below	Managed Care: \$41.00	Quality Care: \$66.00
\$29,501 - \$44,600	Managed Care: \$46.00	Quality Care: \$71.00
\$44,601 - \$59,300	Managed Care: \$48.50	Quality Care: \$73.50
\$59,301 - \$74,300	Managed Care: \$51.00	Quality Care: \$76.00
\$74,301 & above	Managed Care: \$53.50	Quality Care: \$78.50

Note: Employees who reside in Illinois but do not have access to a managed care plan may be eligible for a lower health plan contribution. Contact the CMS Group Insurance Division, Analysis and Resolution Unit at (800) 442-1300 or (217) 558-4671.

Retiree, Annuitant and Survivor Monthly Health Plan Contribution	
20 years or more of creditable service	\$0.00
Less than 20 years of creditable service and, <ul style="list-style-type: none"> • SERS/SURS annuitant/survivor on or after 1/1/98, <li style="text-align: center;">or • TRS annuitant/survivor on or after 7/1/99 	Required to pay a percentage of the cost of the basic coverage.
Call the appropriate retirement system for applicable premiums. SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896	

Monthly Optional Term Life Plan Contributions			
Member by Age	Monthly Rate Per \$1,000	Member by Age	Monthly Rate Per \$1,000
Under 30	\$0.06	Ages 75 - 79	\$3.52
Ages 30 - 34	0.08	Ages 80 - 84	4.20
Ages 35 - 44	0.10	Ages 85 - 89	5.20
Ages 45 - 49	0.16	Ages 90 and above	6.50
Ages 50 - 54	0.24	Accidental Death & Dismemberment	0.02
Ages 55 - 59	0.48		
Ages 60 - 64	0.72	Spouse (for \$10,000 coverage)	6.94
Ages 65 - 69	1.38	Dependent Children (for \$10,000 coverage)	0.52
Ages 70 - 74	2.52		

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

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.

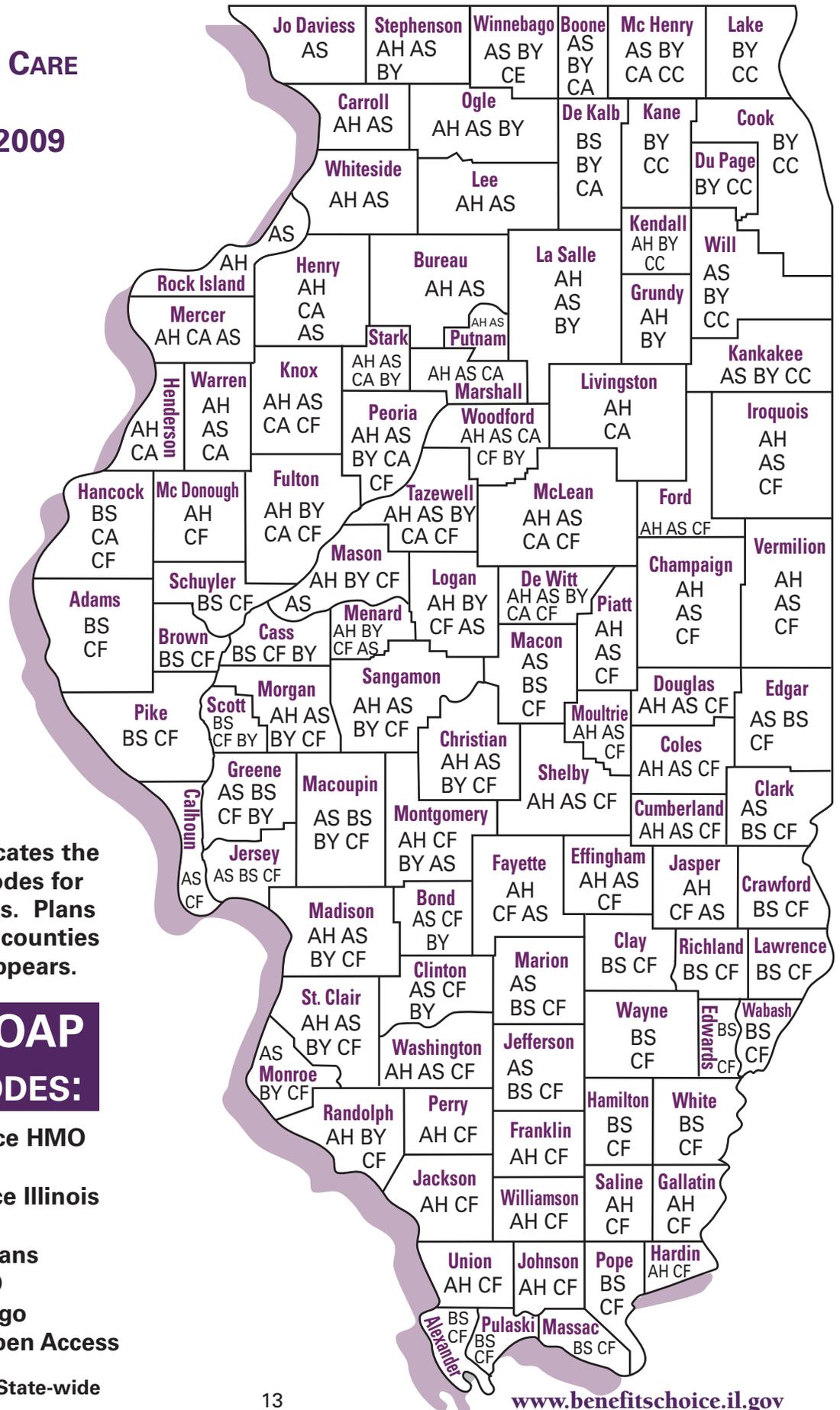
Dependents: Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines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

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

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 Lifetime Maximum	Unlimited 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.	Each emergency room visit \$400 Non-QCHP hospital admission \$200 Transplant deductible \$100 Note: There is no additional deductible for admission to a QCHP network hospital

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.

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.

THE FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

During Benefit Choice Options Period 2, employees may enroll in the Medical Care Assistance Plan (MCAP) with an effective date of January 1, 2009. The minimum monthly amount for which an employee may enroll is \$20; the maximum monthly amount is \$416.66 (\$555.54 for university employees paid over 9 months). Services incurred prior to January 1, 2009, will not be eligible for reimbursement. Employees wishing to enroll in MCAP may do so by completing the MCAP Benefit Choice Options Period 2 Form on page 35.

The first deduction for a new MCAP enrollment will be taken on a pre-tax basis from the first paycheck issued in January. Employees should carefully review their paycheck to verify the deduction was taken correctly. If you do not see the deduction on your paycheck stub, please contact your payroll office immediately.

Employees who enroll in MCAP may elect the EZ REIMBURSE® MasterCard® to pay for their plan year medical expenses by simply checking the 'EZ REIMBURSE Card' box on the MCAP Enrollment form. There is a \$20 non-refundable fee for the card. Documentation is required to substantiate certain expenses paid with the card; therefore, you should review your monthly statement carefully to ensure you are aware of the documentation requirements.

Employees may not enroll in the Dependent Care Assistance Plan (DCAP) during Benefit Choice Options Period 2, nor may they change their deduction amount if currently enrolled in MCAP or DCAP.

Reimbursement claims for eligible MCAP and DCAP FY09 expenses must be submitted no later than September 30, 2009. Remember - DCAP services incurred after June 30, 2009, are not eligible for reimbursement out of FY09 account funds.

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.

LIFE INSURANCE PLAN

Basic term life insurance is provided at no cost to members. The Basic Life coverage amount is equal to the annual salary of active members. For annuitants under age 60, the Basic Life coverage amount is the annual salary as of the last day of active State employment. For annuitants age 60 or older, the Basic Life coverage amount is \$5,000.

Optional life insurance coverage is available to members at their own expense. Changes to life insurance must be indicated on the Benefit Choice Options Period 2 Election Form (see page 31). For more information regarding the life plan, see pages 99-100 of the Benefits Handbook or contact the plan administrator, Minnesota Life at (888) 202-5525, (800) 526-0844 (TTD/TTY) or by visiting their website at www.lifebenefits.com. Optional life coverages available:

- **Member Optional Life**
- **Member Accidental Death and Dismemberment (AD&D)**
- **Spouse/Child Life**

Adding/increasing member Optional Life, as well as adding Spouse Life and/or Child Life coverage, is subject to prior approval by the Life Insurance Plan Administrator, Minnesota Life Insurance Company. Members must complete and submit a Statement of Health form to Minnesota Life for review. The Statement of Health form is available on page 33 and on the Benefits website at www.benefitschoice.il.gov.

Benefit Choice Options Period 2 life insurance coverage changes requiring Statement of Health approval become effective January 1, 2009, if the approval date from Minnesota Life is January 1st or earlier. If the approval date is after January 1st, the effective date of the changes will be the first day of the pay period following the Statement of Health approval date.

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 (once each plan year, covered through age 18 only) ...	\$ 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	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

BEHAVIORAL HEALTH SERVICES

Behavioral health benefits under the State's medical plans may be used for the treatment of clinical mental illness and for counseling and care related to stressful situations a member or their dependent may be experiencing.

Members enrolled in a managed care plan must obtain a referral from their Primary Care Physician before accessing behavioral health services. Members enrolled in the Quality Care Health Plan (QCHP) must contact Magellan Behavioral Health for prior authorization of services. Contact information can be found on the inside back cover.

Employee Assistance Program

There are two separate programs for active employees and their dependents that provide valuable resources for support and information during difficult times, the Employee Assistance Program (EAP) and Personal Support Program (PSP).

Both programs are free, voluntary and provide problem identification, counseling and referral services to employees and their covered dependents regardless of the health plan chosen. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed unless written permission is received from the employee. Management consultation is available when an employee's personal problems are causing a decline in work performance.

- Active employees NOT represented by the collective bargaining agreement between the State and AFSCME Council 31 must contact the EAP administered by Magellan Behavioral Health.
- Bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME must access EAP services through the AFSCME Personal Support Program.

See the inside back cover for website and other contact information.

OPTIONAL PROGRAMS

Commuter Savings Program (CSP)

The CSP can save employees tax dollars on eligible commuting and parking expenses by having those expenses payroll deducted pre-tax. Full-time and part-time employees (working 50% or greater) who have payroll checks processed through the Office of the Comptroller are eligible. Transit passes are mailed directly to the employee's home and parking providers can be paid directly by the CSP vendor. The IRS maximum for calendar year 2008 for parking is \$220 per month for work-related parking expenses and \$115 per month for eligible transit expenses. The IRS maximum may change at the beginning of each calendar year. Refer to www.benefitschoice.il.gov for updates. To enroll, change or cancel a deduction, employees should contact the plan administrator at www.myFBMC.com. See page 117 of the Benefits Handbook for more information.

Smoking Cessation Program

Members and dependents are eligible to receive a rebate up to \$200 for completing an approved smoking cessation program, limited to one rebate per participant, per plan year. One-time procedures are not considered an approved program. See page 119 of the Benefits Handbook for details.

Adoption Benefit Program

State employees working full time or part time (50% or greater) are eligible for reimbursement of eligible adoption expenses. The adoption must be final before expenses are eligible for this benefit. See pages 121-122 of the Benefits Handbook for details.

Long-Term Care (LTC) Insurance

Members may choose an optional group long-term care insurance plan through Metropolitan Life Insurance Company (MetLife). Premiums for this plan are paid entirely by the insured directly to MetLife. Call MetLife toll-free at 800-GET-MET8 (800-438-6388) for an enrollment kit.

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.

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**

BENEFIT CHOICE OPTIONS PERIOD 2

October 27 – November 14, 2008

(Effective January 1, 2009 – June 30, 2009)

SECTION A: EMPLOYEE INFORMATION (required)

SSN: _____

Last Name	First Name	Phone Numbers	
		Home: _____	Work: _____

SECTION B: OPT OUT / OPT IN

OPT OUT/OPT IN – If you elect to opt out, Health, Dental, Vision and Prescription coverage for you and your dependents will be terminated

Opt Out Opt In See Section B on the back for requirements

SECTION C: HEALTH PLAN ELECTIONS (complete ONLY IF CHANGING your health plan)

Health Plan Election *	If you selected Managed Care, you must complete the information below. Go to the health plan's website to find the provider identifier. See the instructions on back for more information.
Elect One: Quality Care Health Plan (QCHP) <input type="checkbox"/> ~ Or ~ Managed Care (HMO or OAP) <input type="checkbox"/>	Provider Identifier _____ (6 or 10 characters) Carrier Code _____ (2 characters – see page 13) Plan Name _____

* You must complete a Coordination of Benefits Worksheet for yourself and/or any dependent that has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at www.benefitschoice.il.gov.

SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your dental election)

Dental Plan Option – If you elect not to participate in the Dental plan, your Dental coverage (and dependent dental coverage) will be terminated (Health, Vision and Prescription coverage will remain active)

I choose not to participate in the dental plan I choose to enroll/re-enroll in the dental plan

SECTION E: OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING your life coverage elections)

OPTIONAL LIFE Member Paid	INCREASE ²	DECREASE	CANCEL	AD&D (Accidental Death & Dismemberment) Member Paid	
<input type="checkbox"/> 1 x Salary	<input type="checkbox"/> 3 x Salary	<input type="checkbox"/> 5 x Salary	<input type="checkbox"/> 7 x Salary	<input type="checkbox"/> CANCEL AD&D	<input type="checkbox"/> BASIC only (Equal to Salary)
<input type="checkbox"/> 2 x Salary	<input type="checkbox"/> 4 x Salary	<input type="checkbox"/> 6 x Salary	<input type="checkbox"/> 8 x Salary		<input type="checkbox"/> COMBINED (Basic + Optional Life)

SECTION F: DEPENDENT INFORMATION ¹ (dependents will be enrolled in the same health plan as the member)

HEALTH			LIFE ²		Name	SSN	Birth Date	Relationship ³	Sex (M/F)	Provider Identifier
A (Add)	D (Drop)	C (Change)	A	D						
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

Notes: ¹ Documentation required to add dependents – see specific documentation requirements on the back.
² Statement of Health form required when increasing Optional Life or adding Spouse or Child Life (form on page 33). Mail completed form to: **Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701.**
³ Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize prevailing premiums to be deducted from my pay or annuity for those plans I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____
 GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office by November 14, 2008

BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

*If you are keeping your current coverage elections you do **not** need to complete this Benefit Choice Election Form*

SECTION A – EMPLOYEE INFORMATION (Complete all fields)

SECTION B – OPT OUT / OPT IN (This election applies to all coverage, except life coverage)

If you wish to opt out of the State Employees Group Insurance Program you must mark the 'Opt Out' box in Section B and submit the form, along with proof of other health coverage, to your agency/university Group Insurance Representative (GIR). The coverage must be provided by an entity other than Central Management Services.

SECTION C – HEALTH PLAN ELECTIONS

Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan directly in order to make this change.

If you wish to change your **health** plan you must check either the Quality Care Health Plan (QCHP) or the managed care plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see map on page 13 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see inside front cover of this booklet for website addresses).

SECTION D – DENTAL PLAN OPTION

- If you are currently participating in the **dental** plan and wish not to participate you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you elect not to participate, you can re-enroll **only** during a future Benefit Choice election period.
- If you **currently are not** participating in the **dental** plan and wish to enroll/re-enroll you must check the 'I choose to enroll/re-enroll in the dental plan' box. Benefit Choice is the only time you can enroll/re-enroll in the dental plan.

SECTION E – OPTIONAL LIFE INSURANCE

Complete this section if you wish to add/drop/increase or decrease Optional Life¹ or Accidental Death and Dismemberment (AD&D) coverage. **Note:** Optional Life Coverage subject to \$3,000,000 maximum (basic + optional life). AD&D Combined maximum is 5 times the employee salary (basic plus 4 times optional coverage).

SECTION F – DEPENDENT INFORMATION

Complete this section if you are adding, dropping or changing your dependent health or life¹ coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below:**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate indicating your spouse is the child's parent, marriage certificate and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19 (age 23 if enrolled as a full-time student), 2) a diagnosis from a physician with an ICD-9 diagnosis code and 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
* The Dependent Coverage Certification Statement (CMS-138) is available through your agency Group Insurance Representative (GIR) or online at www.benefitschoice.il.gov .	

¹ If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to **Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701**. The application is available on page 33.

SIGNATURE: You must sign and date the Benefit Choice Options Period 2 Election Form and give to your agency GIR by **November 14, 2008** in order for your elections to be effective January 1, 2009. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**

**State of Illinois Policy Number 32491-G
Group Life Insurance Statement of Health**

MINNESOTA LIFE

Mail to: Minnesota Life Insurance Company - A Securian Company
Springfield Branch Office • 1 North Old Capitol Plaza, Suite, 305 • Springfield, Illinois 62701

EMPLOYEE INFORMATION

First name	Middle initial	Last name	Date of birth	Social Security number	
Street address			City	State	Zip code
Date employed	Member status (check all that apply) <input type="checkbox"/> Actively working <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Annuitant <input type="checkbox"/> Immediate <input type="checkbox"/> Deferred <input type="checkbox"/> Survivor				
Height	Weight	Occupation	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		

TOTAL INSURANCE DESIRED - Check the boxes which indicate your total coverage level desired.

Optional Life (member-paid)*		Dependent Life (member-paid)	
<input type="checkbox"/> 1x salary	<input type="checkbox"/> 3x salary	<input type="checkbox"/> 5x salary	<input type="checkbox"/> 7x salary
<input type="checkbox"/> 2x salary	<input type="checkbox"/> 4x salary	<input type="checkbox"/> 6x salary	<input type="checkbox"/> 8x salary
* Annuitants age 60 and over are not eligible for 5-8x salary.		<input type="checkbox"/> Spouse life coverage equal to \$10,000*	<input type="checkbox"/> Child life coverage equal to \$10,000
		* Spouses of annuitants age 60 and over receive \$5,000 coverage.	<input type="checkbox"/> Adding another child

SPOUSE INFORMATION - Complete only if applying for spouse coverage.

SPOUSE

First name	Middle initial	Last name	Social Security number	
Date of birth	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

DEPENDENT CHILD(REN) INFORMATION - Complete only if applying for dependent coverage.

Child's Name	Sex	Birth Date	Social Security Number	If Age 19+ / Full Time Student
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No
	M/F			<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS - Complete only if changing coverage.

EMPLOYEE	SPOUSE	CHILD(REN)	
YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	3. Have you ever been treated or diagnosed by a physician as having AIDS, or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment on the reverse side of this form.

NOTE: EMPLOYEE/APPLICANT MUST SIGN AND DATE THE REVERSE SIDE OF THIS FORM

FOR HOME OFFICE USE ONLY:

Employee <input type="checkbox"/> New hire <input type="checkbox"/> Benefit choice enrollment <input type="checkbox"/> Change of status			
Optional in force <input type="checkbox"/> NONE <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x <input type="checkbox"/> 7x <input type="checkbox"/> 8x	Annual base salary \$	Agency name	Date
Spouse coverage in force <input type="checkbox"/> Yes <input type="checkbox"/> No	Child coverage in force <input type="checkbox"/> Yes <input type="checkbox"/> No	GIR name	Organizational processing code
Employee <input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	Spouse <input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	Child <input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Incom.	
By	Date	By	Date

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
 Minnesota Life Insurance Company
 400 Robert Street North
 St. Paul, Minnesota 55101-2098
 Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
 50 Braintree Hill, Suite 400
 Braintree, MA 02184-8734
 MIB Telephone: (866) 692-6901
 MIB TTY: (866) 346-3642
 Website: www.mib.com

ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR APPLICANT, SPOUSE OR CHILD.

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT
Employee				
Spouse				
Child(ren)				

The answers provided on this application are representations of each person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months unless withdrawn by me in writing. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice above, and I understand that I can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

Employee signature X	Daytime telephone number ()	Evening telephone number ()	Date signed
Spouse signature X	Daytime telephone number ()	Evening telephone number ()	Date signed

MEDICAL CARE ASSISTANCE PLAN

Benefit Choice Options Period 2 Enrollment

Election Period: October 27 – November 14, 2008

Employees not currently enrolled in MCAP may enroll during this election period with an effective date of January 1, 2009. Only claims incurred on or after January 1, 2009 are eligible for reimbursement for the FY09 plan year. Employees currently enrolled in MCAP may not change their deduction amount during this period.

Section A – Employee Information

Social Security Number	Last Name	First	Initial
			()
Street Address	City	State	Zip Code
			Home Phone
			()
Agency			Work Phone

Section B – Deduction Information and Authorization

Deduction Information and Authorization - I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my MCAP account, beginning with the first check issued in January 2009.

Employees enrolling during Benefit Choice Options Period 2 must complete this section. Use the following to determine the number of deductions:

The number of deductions for semi-monthly or bi-weekly payrolls is 12.

The number of deductions for monthly payrolls is 6 (university employees could have less than 6).

$$\begin{array}{r}
 \$ \underline{\hspace{2cm}} \quad \times \quad \underline{\hspace{2cm}} \quad = \quad \$ \underline{\hspace{2cm}} \\
 \text{Deduction Amt Per Pay} \quad \quad \quad \text{Number of Deductions} \quad \quad \quad \text{Total MCAP Expenses *} \\
 \text{(Monthly Minimum = \$20.00;} \\
 \text{Max. = \$416.66; Max for University} \\
 \text{employees paid over 9 mo. \$555.54)} \quad \quad \quad \text{(cannot exceed 6 for monthly} \\
 \text{Or 12 for semi-monthly payrolls)}
 \end{array}$$

* If you elect to receive the EZ REIMBURSE® MasterCard® (below), you must include the non-refundable \$20.00 card fee in your deduction calculation. The amount eligible for reimbursement is the total annual deduction amount less the \$20.00 fee.

Section C – EZ REIMBURSE® MasterCard® Request

EZ REIMBURSE Card

Yes! I want the EZ REIMBURSE® MasterCard®. I understand that even if I had the card during a previous plan year, **I must REQUEST the card for the plan year in which I am enrolling.** I understand there is an annual non-refundable \$20.00 fee which will be automatically deducted from my MCAP account. I agree to submit proper documentation for all EZ card transactions that are not a known co-payment amount, as required by the IRS.

~ Sign the Reverse Side and Return to your Group Insurance Representative ~

Section D – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period. The run-out period ends September 30th following the last day of the plan year.*
- *I understand that deductions must continue during any paid leave of absence.*
- *I do not anticipate terminating state service, retiring or going on an unpaid leave of absence before the end of the FY09 plan year.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed, up to and including filing an order of involuntary withholding through the Office of the Comptroller.*
- *I understand that due to the IRS Grace Period, I can submit claims and use my EZ REIMBURSE[®] MasterCard[®] for eligible services incurred from the end of the plan year through September 15th and that those charges will be deducted from the prior plan year's account balance, if any. Expenses incurred during the Grace Period that exceed the previous year's account balance, as well as expenses incurred after September 15th, will be reimbursed out of that plan year's account, if enrolled.*
- *If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.*

Employee Signature: _____ **Date** ____ / ____ / ____

Please return the signed, completed form to your agency Group Insurance Representative.

Section E – Agency Approval (To be completed by Group Insurance Representative)

Effective Date: January 1, 2009

Deduction Start Date: ____ / ____ / ____

Universities Only: If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction: ____ / ____ / ____

Organizational Processing Code: _____

Pay Code: _____

GIR Signature: _____

Date: ____ / ____ / ____

Telephone () _____ - _____

GIR Instructions: Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

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.

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

Address Service Requested

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

**Printed by the authority of the State of Illinois
(CMS-BEN2002-02-197M-09/08)
Printed on recycled paper**

