



Benefit Choice Options



 *Your Benefits
for Good Health*

Local Government Health Plan

Enrollment Period, May 1 – 31, 2007 • Effective July 1, 2007 – June 30, 2008

Benefit Choice is May 1 - May 31, 2007

**It is each member's responsibility to know
plan benefits and make an informed decision
regarding coverage elections.**

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Important Changes For Plan Year 2008 (July 1, 2007 through June 30, 2008)

The information below presents changes to the Local Government Health Plan (LGHP). Please carefully review all the information in this Benefit Choice Options booklet. Members should review this publication each year to be aware of benefit changes. Benefit Choice is May 1 - 31, 2007. All selections made during Benefit Choice will be effective July 1, 2007.

Benefits Handbook Amendment – Effective this year, the Benefits Handbook will be updated via an amendment contained within the annual Benefit Choice Options booklet. Please tear out pages 3-6 of this booklet and keep with your current Benefits Handbook (dated 2006).

Local Care Health Plan (LCHP) Changes

- Prescription co-payments increase to \$11/\$22/\$44
- Emergency room deductible increases to \$400

NEW! DISEASE MANAGEMENT PROGRAM FOR LCHP PLAN PARTICIPANTS **Well Aware for Better Health® available through CIGNA by Healthways**

LCHP 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 new 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

BENEFIT CHOICE PERIOD IS MAY 1-31, 2007

The Benefit Choice Period is **May 1 through May 31, 2007** for all members. Elections will be effective July 1, 2007. 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.

The Benefit Choice Period is the **only** time of the year, other than when a qualifying change in status occurs, that members may change their coverage elections. Before making benefit changes, compare:

- Services covered
- Deductibles, co-payment levels and out-of-pocket maximums
- 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)
- Local Care Health Plan (LCHP)

See pages 8-14 to review the features for each type of plan.

All Benefit Choice changes should be made on the Benefit Choice Election Form located in the back of this booklet. Members should complete the form **only** if changes are being made. The Local Government Health Plan will process the changes based upon the information indicated on the form.

During the annual Benefit Choice Period, members may:

- Change health plans
- Add or drop dependent coverage

Documentation Requirements

Documentation is required when adding dependent coverage. Members should refer to the documentation requirements chart on the Benefit Choice Election Form Instruction Sheet.

Benefits Handbook Amendment

This document is Amendment I to your Benefits Handbook.

An Amendment adds, modifies, deletes or otherwise changes a benefit listed in your Benefits Handbook. You can make the most of your coverage by reading your Amendments and keeping them with your Benefits Handbook for future reference.

1. Open Access Plan (OAP)
2. LCHP Notification Requirements-General
3. LCHP Notification Requirements-Outpatient Surgery Procedures
4. LCHP Emergency Services
5. LCHP Prescription Drugs
6. LCHP Skilled Nursing
7. LCHP Urgent Care Services
8. LCHP Covered Benefits-Adults
9. LCHP Covered Benefits-Children
10. LCHP Exclusions and Limitations
11. LCDP Prosthodontic Limitations
12. Age 65 & Over-Medicare Eligible
13. Under Age 65-Medicare Due to Disability
14. End Stage Renal Disease (ESRD)
15. Medicare Part B Reduction

AMENDMENT TO THE LOCAL GOVERNMENT HEALTH PLAN (LGHP)

The following is an amendment to the 2006 LGHP Benefits Handbook for LGHP members, retirees and survivors. Please review this document carefully and keep it with your Benefits Handbook for future reference.

1. On pages 34-35 under Open Access Plan (OAP), the following bullet point is added:
 - Tier II and Tier III out-of-pocket maximums cross accumulate.
2. On page 40 under Notification Requirements, the 1st through 6th paragraphs are deleted and replaced with the following:

Notification is the telephone call to the health plan administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility or for an outpatient procedure/therapy/service/supply.

If using a LCHP network provider (formerly PPO provider), the medical provider is responsible for contacting the Notification Administrator on behalf of the Plan Participant.

If using a non-LCHP provider (formerly non-PPO provider), the Plan Participant must direct their non-LCHP medical Provider to contact the Notification Administrator to provide specific medical information, setting and anticipated length of stay to determine medical appropriateness.

Failure to contact the Notification Administrator prior to having a service performed may result in a **financial penalty** and risk incurring non-covered charges deemed not medically necessary.

Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare.

3. On page 40 under Notification is required for the following, the 1st bullet point is deleted and replaced with the following:

Outpatient Surgery, Procedures, Therapies & Supplies/Equipment

- Outpatient surgery and procedures including, but not limited to, items such as imaging (MRI, PET, SPECT and CAT Scan), physical, occupational or speech therapy, foot orthotics, DME supplies, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, breast reduction/enlargement, select injectable drugs, treatment for varicose veins, etc). Services must be authorized before being performed. Contact the Notification Administrator for the most up-to-date list of procedures requiring Notification.
4. On page 48 under Urgent Care or Similar Facility, the bullet is deleted and replaced with the following:
 - 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of Emergency Services as presented in the 2006 Benefits Handbook. The benefit

Benefits Handbook Amendment

applies to professional fees only. Facility charges are not covered when services are performed in a physician's office or an Urgent Care Center. Non-emergency medically necessary services are considered at 80% of U&C.

5. On page 52 under Prescription Drugs, the following bullets replace the last bullet in this section:

- Prescription drugs obtained as part of a skilled care facility stay are payable by the Health Plan Administrator.
- Prescription drugs obtained as part of a nursing home stay for custodial care must be submitted to the Prescription Drug Plan Administrator.

6. On pages 53-54 under Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home, the last bullet is deleted and replaced with the following:

- Prescription Drug charges must be submitted to the Health Plan Administrator.

7. On page 56 under Urgent Care Services, the paragraph is deleted and replaced with the following:

Urgent care is treatment for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a Physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. Facility charges are not covered when services are performed in a physician's office or urgent care centers.

8. On page 57 under Covered Benefits – Adults, the following is added:

- Human Papillomavirus (HPV) Vaccine:
 - For female adults through age 26.
 - 80% of U&C for vaccine up to the maximum benefit.
 - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

9. On page 58 under Covered Benefits – Children, the following is added:

- Human Papillomavirus (HPV) Vaccine:
 - For eligible female dependents age 9–26.
 - 80% of U&C for vaccine.
 - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

10. On page 71 under LCHP – Exclusions and Limitations, the following points are added:

39. For legal fees.
40. For treatment and services rendered in a setting other than direct patient-provider contact.

11. On page 76 under Prosthodontics, the 4th bullet point is deleted.

12. On page 85 under Medicare Eligible, the entire section is deleted and replaced with the following:

Age 65 & Over - Medicare Eligible

Plan Participants must contact their local Social Security Administration office upon turning age 65 in order to determine if they are eligible for premium-free Medicare Part A benefits based on their own or their spouse's work history. All Plan Participants are eligible for Medicare Part B benefits upon turning age 65. All **retired** Plan Participants eligible for premium-free Medicare Part A, as well as Plan Participants actively employed with an employer other than the State of Illinois and without other large group health plan coverage or Plan Participants without Current Employment Status (CES), **must** enroll in Medicare Part A and Part B when first eligible.

Plan Participants with CES with other large group health plan coverage may delay enrolling in Medicare Part B until loss of CES, loss of their large group health insurance through their current employer or retirement (whichever is first). Upon this event, a Plan Participant must enroll in

Benefits Handbook Amendment

Medicare Part B in order to avoid a reduction in benefits. See 'Medicare Part B Reduction' in this section for more information.

If Medicare Part B is not purchased at age 65 when the Plan Participant is either retired or no longer in CES, Medicare will impose a 10% penalty for each year without the purchase of Medicare Part B. The annual Medicare general enrollment period is January, February and March; however, coverage is not effective until July 1.

13. *On pages 85-86 under Under Age 65 - Medicare Due to Disability, the entire section is deleted and replaced with the following:*

Under Age 65 - Medicare Due to Disability

In order to apply for Medicare disability coverage, a Plan Participant must contact their local Social Security Administration office. Plan Participants under the age of 65 who are receiving Social Security disability benefits or Railroad Retirement Board disability benefits, will automatically be enrolled in Medicare Parts A and B when determined eligible by the Social Security Administration. If a Plan Participant is retired or without Current Employment Status (CES) and is receiving Medicare benefits, the Plan Participant must remain enrolled in Medicare Part B. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

14. *On page 86 under End Stage Renal Disease (ESRD), the entire section is deleted and replaced with the following:*

End Stage Renal Disease (ESRD)

Plan Participants of any age may qualify for premium-free Medicare Part A on the basis of End Stage Renal Disease (ESRD) if certain criteria are met. In order to apply for Medicare ESRD coverage, a Plan Participant must contact their local Social Security Administration Office. Plan Participants who are receiving regular dialysis treatments or who have had a kidney transplant, must make application for Medicare benefits on the basis of ESRD. If it is determined that the Plan Participant

is eligible for premium-free Medicare Part A, the Plan Participant must accept the Medicare Part A coverage and notify the Central Management Services Medicare COB Unit in order to establish the coordination of benefit period and to determine the date of Medicare primacy.

When Medicare becomes the primary payer, the purchase of Medicare Part B is required. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be the primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

15. *On page 86 after the End Stage Renal Disease (ESRD) section, add the following new section:*

Medicare Part B Reduction

If Medicare Part B is not purchased, the Plan Participant's health plan (either LCHP or the Plan Participant's Managed Care health plan) will process claims as if Medicare Part B was the primary payer. When Medicare is the primary payer, the standard Medicare Part B plan pays 80% of all Medicare approved amounts. The LCHP pays up to the 20% coinsurance that remains after Medicare Part B pays. If a Plan Participant does not enroll in Medicare Part B when Medicare is primary, the LCHP **will not pay** the initial 80% of the eligible charges. The LCHP will only pay up to 20% of the eligible charges of the claim. Plan Participants enrolled in a managed care health plan should refer to the managed care plan's Certificate of Coverage for reduction information. This reduction of benefits will remain in place until the date that Medicare Part B becomes effective. Plan Participants that terminate Medicare Part B coverage will be subject to claim adjustments by the claims administrator for any claims paid at the incorrect benefit level.

NOTICE OF CREDITABLE COVERAGE

Prescription Drug Information for Local Government Health Plan (LGHP) Medicare Eligible Plan Participants

This notice confirms that your existing prescription drug coverage through the Local Government Health Plan (LGHP) 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 Local Government Health Plan 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 keep your existing group coverage, it is **not** necessary to join a Medicare prescription drug plan this year.

REMEMBER: KEEP THIS NOTICE

MEMBER RESPONSIBILITIES

It is each member's responsibility to know plan benefits and make an informed decision regarding coverage elections.

Notify the Health Plan Representative (HPR) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
 - birth/adoption of a child;
 - marriage, divorce, legal separation, annulment;
 - death of spouse or dependent;
 - an employment status change for the member, the member's spouse or any dependent(s) that affects eligibility under the plan;
 - dependent(s) loss of eligibility;
 - a court order results in the gain or loss of a dependent;
 - a change in Public Aid recipient status;
 - dependent becomes covered by other group health or dental coverage.
- Gain or loss of other group coverage
- Leave of absence
- Change in Medicare status

To ensure that all information is up-to-date, members should periodically review:

- Current health and dental plan information
- Current prescription formulary lists which are subject to change without notice

IMPORTANT REMINDERS

June/July Hospitalizations: Members who change health plans during the annual Benefit Choice Period and are then hospitalized, or have dependents that are hospitalized before July 1, should contact both the current and future health plan administrators and PCPs as soon as possible.

Transition of Services: When electing a new health plan during the Benefit Choice Period, 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 and providers for care.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members. Please contact your unit's HPR for information.

MANAGED CARE PLANS

There are 7 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 health care services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the member pays only a co-payment. No annual plan deductibles apply. The minimum level of HMO coverage provided by all plans is described on page 10. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

Open Access Plan (OAP)

The OAP 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 health care providers with higher out-of-pocket costs. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of care providers. Members enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 11.

IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

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.

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 Local 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.

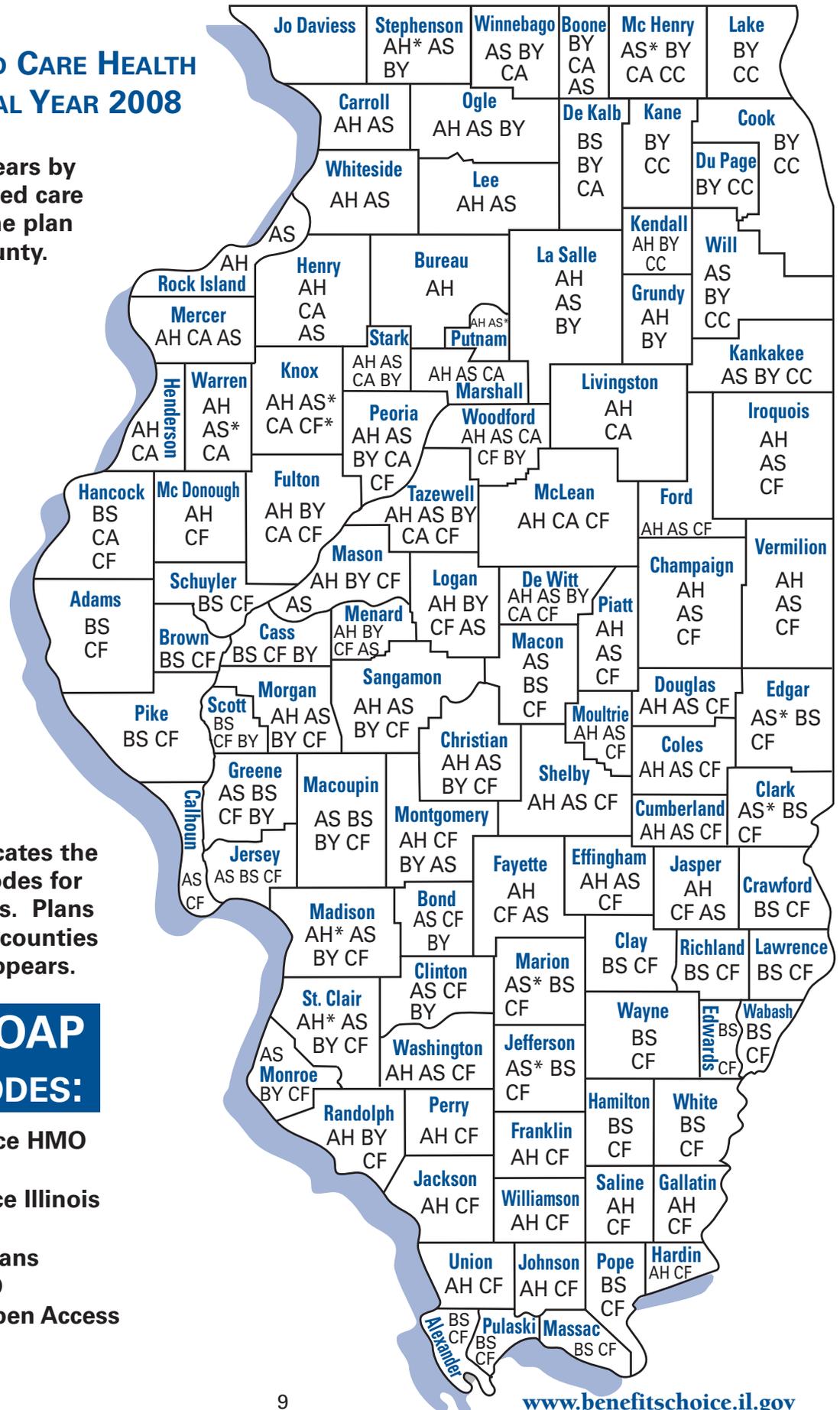
Dependents: Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent contact the managed care plan to understand the plan's guidelines on this type of coverage.

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

MANAGED CARE PLANS IN ILLINOIS COUNTIES

LGHP MANAGED CARE HEALTH PLANS FOR FISCAL YEAR 2008

* If an asterisk appears by one of the managed care plans, it means the plan is new to that county.



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
- CF – HealthLink Open Access

HMO BENEFITS

The benefits described below represent the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document. It is the member's responsibility to know and follow the specific requirements of the HMO plan selected.

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	
Office visit (including physical exams and immunizations)	100% after \$20 co-payment per visit
Well Baby Care	100% after \$20 co-payment per visit
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 (formulary is subject to change during plan year)	\$10 co-payment for generic \$20 co-payment for preferred brand \$40 co-payment for non-preferred brand
Durable Medical Equipment	80%
Home Health Care	\$20 co-payment per visit

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

THE LOCAL CARE HEALTH PLAN (LCHP)

LCHP is the medical plan that offers a comprehensive range of benefits. Under the LCHP, plan participants can choose any physician or hospital for medical services and any pharmacy for prescription drugs. Plan participants receive enhanced benefits resulting in lower out-of-pocket amounts when receiving services from an LCHP network provider. The **nationwide LCHP network (formerly the PPO network)** consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail pharmacy network) and behavioral health services (Magellan behavioral health network).

Notification to Intracorp, the LCHP notification administrator, is required for certain medical services in order to avoid penalties. Refer to pages 40-41 of the Benefits Handbook (and the amendment in this book), or contact Intracorp at (800) 962-0051, for direction.

Plan participants can access plan benefit and participating LCHP 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	\$400 per participant						
Additional Deductibles* * These are in addition to the plan year deductible.	<table> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>Non-LCHP hospital admission</td> <td>\$400</td> </tr> <tr> <td>Transplant deductible</td> <td>\$250</td> </tr> </table> <p>Note: There is no additional deductible for admission to an LCHP network hospital</p>	Each emergency room visit	\$400	Non-LCHP hospital admission	\$400	Transplant deductible	\$250
Each emergency room visit	\$400						
Non-LCHP hospital admission	\$400						
Transplant deductible	\$250						

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-LCHP hospital charges. Coinsurance and deductibles apply to one or the other, but not both.

General: \$1,500 per individual \$3,750 per family per plan year	Non-LCHP Hospital: \$4,400 per individual \$8,800 per family per plan year
<p>The following do not apply toward out-of-pocket maximums:</p> <ul style="list-style-type: none"> • Prescription Drug benefits 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). • After Medicare pays, LCHP pays 80% of the balance after the LCHP deductible. 	

LCHP - MEDICAL PLAN COVERAGE

Hospital Services	
LCHP Network Hospitals (formerly PPO Network Hospitals)	90% after annual plan deductible. No admission deductible.
Non-LCHP Hospitals (formerly Non-PPO Hospitals)	<ul style="list-style-type: none"> • \$400 per admission deductible. • If the member resides in Illinois or within 25 miles of an LCHP network hospital and the member chooses to use a non-LCHP and/or voluntarily travels in excess of 25 miles when an LCHP network 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 LCHP network hospital available within 25 miles and voluntarily chooses to travel further than the nearest LCHP network hospital, the plan pays 65% after the annual plan deductible. • If the member does not reside in Illinois or within 25 miles of an LCHP network hospital, the plan pays 80% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	80% of Usual & Customary (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 90% of U&C, as applicable, after plan deductible.
Professional and Other Services	
LCHP Physician Network (formerly the PPO Network)	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in LCHP's Network	80% 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 \$250 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.
Behavioral Health Services	
Magellan administers the LCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see page 65 of the Benefits Handbook or call Magellan at (800) 513-2611.	

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

HEALTH PLAN COMPARISON

Benefit	LCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000
Patient Responsibilities					
Annual Out-of-Pocket Maximum	General: \$1,500 per enrollee \$3,750 per family/plan year	\$1,500	Not applicable	\$1,000	\$2,000
• Per Enrollee					
• Per Family	Non-LCHP Hospital: \$4,400 per enrollee \$8,800 per family/plan year	\$3,000		\$2,500	\$5,000
Annual Plan Deductible Must be satisfied for all services	\$400 per enrollee	\$0	\$0	\$300 per enrollee	\$500 per enrollee
Other Deductibles/Co-payments: Emergency Room	\$400	\$200	\$200	\$200 + 10% network charges**	\$200 + 20% network charges**
Non-LCHP/Out-of-Network Hospital Admission	\$400	No coverage	See Tier III for benefit level	See Tier III for benefit level	\$400 + 20% of U&C*
Plan Benefit Levels Comparison*					
Physician Office Visit	90% LCHP network 80% of U&C* non-LCHP	\$20 co-payment	\$20 co-payment	90% of network charges** after \$20 co-payment	80% of U&C*
Preventive Services	80% or 100% for specific services	\$20 co-payment	\$20 co-payment	90% of network charges** after \$20 co-payment	Covered in-network only
Inpatient	90% - LCHP network 80% or 65% - non-LCHP	\$250 co-payment	\$250 co-payment	90% of network charges** after \$300 co-payment	80% of U&C* after \$400 co-payment
Outpatient Surgery	90% for LCHP network provider	\$150 co-payment	\$150 co-payment	90% of network charges** after \$150 co-payment	80% of U&C* after \$150 co-payment
Diagnostic Lab and X-ray	80% of U&C*	100%	100%	90% of network charges**	80% of U&C*
Durable Medical Equipment	80% of U&C*	80% of network charges**	80% of network charges**	80% of network charges**	80% of U&C*

* Usual & Customary (U&C) is an amount determined by the health plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition.

**Network charges are the amount the plan determines is the appropriate charge for a covered service.

PRESCRIPTION DRUG BENEFIT

Plan participants enrolled in LGHP have prescription drug coverage available. All prescription medications are compiled on a preferred list (“formulary list”) maintained by each managed care plan or Medco. Formulary lists categorize brand drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount.

PRESCRIPTION DRUG CO-PAYS		
	PRESCRIPTION PLAN	
	LCHP	All Other Plans
Generic	\$11	\$10
Preferred Brand (Formulary Brand)	\$22	\$20
Non-Preferred Brand	\$44	\$40

It is important to note that formulary lists are subject to change any time during the plan year. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified. **Plan participants should consult with their physician to determine if a change in prescription is appropriate.**

Coverage for specific drugs may vary depending upon the health plan. 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.

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. Participants 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. It should be noted that no over-the-counter drugs are covered, even if purchased with a prescription. **Plan participants 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 and the Local Care Health Plan (LCHP) 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 plan year deductible or the medical out-of-pocket maximums. 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 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.

In-Network Pharmacy

Retail pharmacies that contract with Medco and accept the co-payment amount for prescriptions 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 (this includes pharmacies located outside of the continental United States). 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.

Mail Order Pharmacy

The Mail Order Pharmacy provides participants the opportunity to receive medications directly from Medco at a discounted price. 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 at www.benefitschoice.il.gov.

VISION PLAN

- All members and enrolled dependents have the same vision coverage regardless of the health plan selected.
- All vision benefits are available once every 24 months from the last date used.
- Co-payments are required.

For information regarding the vision plan, 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.

Service	Network Provider Benefit	Out-of-Network Provider Benefit
Eye Exam	\$10 co-payment	\$20 allowance
Spectacle Lenses Standard Plastic (single, bifocal and trifocal)	\$10 co-payment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses
Standard Frames	\$10 co-payment (up to \$90 retail frame cost; member responsible for balance over \$90)	\$20 allowance
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	\$20 co-payment for medically necessary \$50 co-payment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance

DENTAL PLAN

All members and dependents have the same dental benefits available regardless of the health plan selected. Dental plan questions should be directed to the Dental Plan Administrator, CompBenefits, at (800) 999-1669 or (312) 829-1298 (TDD/TTY).

Local Government Dental Plan (LGDP)

- Members enrolled in LGDP may go to any dentist.
- **The LGDP reimburses only those services that are listed on the Dental Schedule of Benefits.**
- Listed services are reimbursed at a pre-determined maximum scheduled amount (see the Dental Schedule of Benefits on pages 18-21).
- A \$100 individual plan deductible applies for all services other than those listed as preventive and diagnostic in the Dental Schedule of Benefits.
- Members are responsible for all charges over the scheduled amount.
- **The maximum benefit per plan participant per plan year for all dental services, including orthodontic and periodontic, is \$2,000 after the plan year deductible.**
- The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations.

FY08 DENTAL SCHEDULE OF BENEFITS

The LGDP reimburses only those services that are 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	\$ 18	D0120
Limited Oral Evaluation (specific oral health problem)	\$ 18	D0140
Comprehensive Oral Examination- new or established patient	\$ 28	D0150
Radiographs/Diagnostic Imaging		
Intraoral Complete Series (once in a period of three plan years, including bitewings)	\$ 60	D0210
Intraoral - Periapical First Film	\$ 13	D0220
Intraoral - Periapical Each Additional Film	\$ 10	D0230
Bitewing Single Film	\$ 11	D0270
Bitewing Two Films	\$ 20	D0272
Bitewing Four Films	\$ 31	D0274
Panoramic Film, (once in a period of three plan years)	\$ 50	D0330
PREVENTIVE SERVICES		
Prophylaxis Adult - Twice each plan year	\$ 41	D1110
Prophylaxis Child - Twice each plan year	\$ 28	D1120
Topical Application of Fluoride - Child (including prophylaxis) (once each plan year, covered through age 18 only)	\$ 44	D1201
Topical Application of Fluoride - Child (not including prophylaxis) (once each plan year, covered through age 18 only)	\$ 17	D1203
Sealant - per tooth, covered through age 18 only	\$ 28	D1351
Space Maintainers (Passive Appliances)		
Fixed Unilateral	\$ 86	D1510
Fixed Bilateral	\$ 97	D1515
Removable Unilateral	\$ 86	D1520
Removable Bilateral	\$ 97	D1525

RESTORATIVE SERVICES	Maximum Benefit	Code
Amalgam Restorations		
Amalgam One Surface, Primary or Permanent	\$ 47	D2140
Amalgam Two Surfaces, Primary or Permanent	\$ 67	D2150
Amalgam Three Surfaces, Primary or Permanent	\$ 77	D2160
Amalgam Four or More Surfaces, Primary or Permanent	\$ 85	D2161
Resin-Based Composite Restorations		
One Surface, Anterior	\$ 55	D2330
Two Surfaces, Anterior	\$ 71	D2331
Three Surfaces, Anterior	\$ 88	D2332
Four or More Surfaces or involving incisal angle (anterior)	\$ 95	D2335
One Surface Posterior	\$ 97	D2391
Two Surface Posterior	\$134	D2392
Three Surface Posterior	\$167	D2393
Four or More Surfaces, Posterior	\$206	D2394
Crowns/Single Restorations Only		
Crown-Resin (indirect)	\$103	D2710
Crown-Resin with high noble metal	\$300	D2720
Crown-Resin predominantly base metal	\$258	D2721
Crown-Resin with noble metal	\$289	D2722
Crown-Porcelain/Ceramic Substrate	\$304	D2740
Crown-Porcelain fused to high noble metal	\$305	D2750
Crown-Porcelain fused to predominantly base metal	\$284	D2751
Crown-Porcelain fused to noble metal	\$295	D2752
Crown-3/4 cast predominately base metal	\$302	D2781
Crown-Full cast high noble metal	\$272	D2790
Crown-Full cast predominantly base metal	\$280	D2791
Crown-Full cast noble metal	\$295	D2792
Other Restorative Services		
Recement Inlay	\$ 20	D2910
Recement Crown	\$ 22	D2920
Prefabricated stainless steel Crown (primary tooth)	\$ 70	D2930
Prefabricated stainless steel Crown (permanent tooth)	\$ 74	D2931
Prefabricated Resin Crown	\$ 65	D2932
ENDODONTICS		
Pulp Capping		
Pulp Cap - Direct (excluding final restoration)	\$ 31	D3110
Pulp Cap - Indirect (excluding final restoration)	\$ 24	D3120
Pulpotomy - Therapeutic (excluding final restoration)	\$ 74	D3220
Root Canal Therapy (include intra-operative radiographs)		
Anterior (excludes final restoration)	\$293	D3310
Bicuspid (excludes final restoration)	\$365	D3320
Molar (excludes final restoration)	\$492	D3330
Retreatment of Previous Root Canal Therapy		
Anterior	\$319	D3346
Bicuspid	\$379	D3347
Molar	\$518	D3348
PERIODONTICS		
Gingivectomy/Gingivoplasty		
Per quadrant	\$186	D4210
1 - 3 Teeth per quadrant	\$ 40	D4211
Gingival Flap Procedure		
Per quadrant - includes root planing	\$186	D4240
Gingival Flap - including root planing, 1-3 teeth per quadrant	\$140	D4241
Osseous Surgery (including flap entry and closure)		
4 or More contiguous teeth or bounded teeth spaces per quadrant	\$269	D4260
1-3 contiguous teeth or bounded teeth spaces per quadrant	\$234	D4261
Bone Replacement Graft		
First site in quadrant	\$137	D4263
Each additional site in quadrant	\$ 68	D4264
Pedicle Soft Tissue Graft	\$166	D4270

PERIODONTICS CONTINUED	Maximum Benefit	Code
Free Soft Tissue Graft	\$214	D4271
Provisional Splinting		
Intracoronaral	\$ 88	D4320
Extracoronaral	\$101	D4321
Periodontal Scaling and Root Planing		
4 or More contiguous teeth or bounded teeth spaces per quadrant	\$ 84	D4341
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	\$ 42	D4355
Periodontal Maintenance Procedure		
Following active therapy	\$ 34	D4910
Unscheduled Dressing Change	\$ 17	D4920
PROSTHODONTICS		
Removable Prosthetics		
Complete Denture - Maxillary	\$543	D5110
Complete Denture - Mandibular	\$543	D5120
Immediate Denture - Maxillary	\$530	D5130
Immediate Denture - Mandibular	\$552	D5140
Partial Dentures (removable)		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth)	\$458	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth)	\$533	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	\$600	D5213
Mandibular Partial Denture - cast metal framework, resin base (convention clasps, rests and teeth)	\$600	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth)	\$208	D5281
Adjustments to Dentures		
Adjust complete denture - Maxillary	\$ 30	D5410
Adjust complete denture - Mandibular	\$ 30	D5411
Adjust partial denture - Maxillary	\$ 30	D5421
Adjust partial denture - Mandibular	\$ 30	D5422
Repairs to Complete Dentures		
Repair broken complete denture base	\$ 58	D5510
Replace missing or broken teeth - complete denture (each tooth)	\$ 50	D5520
Repairs to Partial Dentures		
Repair resin denture base	\$ 58	D5610
Repair cast framework	\$ 69	D5620
Repair or replace broken clasp	\$ 65	D5630
Replace broken teeth - per tooth	\$ 49	D5640
Add tooth to existing partial denture	\$ 71	D5650
Add clasp to existing partial denture	\$ 89	D5660
Denture Rebase Procedure		
Rebase complete maxillary denture	\$215	D5710
Rebase complete mandibular denture	\$211	D5711
Rebase maxillary partial denture	\$208	D5720
Rebase mandibular partial denture	\$208	D5721
Denture Reline Procedure		
Reline complete maxillary denture (chairside)	\$124	D5730
Reline complete mandibular denture (chairside)	\$124	D5731
Reline maxillary partial denture (chairside)	\$114	D5740
Reline mandibular partial denture (chairside)	\$114	D5741
Reline complete maxillary denture (laboratory)	\$166	D5750
Reline complete mandibular denture (laboratory)	\$166	D5751
Reline maxillary partial denture (laboratory)	\$164	D5760
Reline mandibular partial denture (laboratory)	\$164	D5761
Fixed Partial Denture Pontics (Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal	\$298	D6210
Pontic-Cast predominantly base metal	\$263	D6211
Pontic-Cast noble metal	\$269	D6212

	Maximum Benefit	Code
Fixed Partial Denture Pontics Continued		
Pontic-Porcelain fused to high noble metal	\$299	D6240
Pontic-Porcelain fused to predominantly base metal	\$272	D6241
Pontic-Porcelain fused to noble metal	\$284	D6242
Pontic-Resin with high noble metal	\$281	D6250
Pontic-Resin with predominantly base metal	\$272	D6251
Pontic-Resin with noble metal	\$308	D6252
Fixed Partial Denture Retainers - Crowns		
Crown-Resin with high noble metal	\$294	D6720
Crown-Resin with predominantly base metal	\$276	D6721
Crown-Resin with noble metal	\$253	D6722
Crown-Porcelain fused to high noble metal	\$300	D6750
Crown-Porcelain fused to predominantly base metals	\$278	D6751
Crown-Porcelain fused to noble metal	\$277	D6752
Crown-3/4 cast high noble metal	\$288	D6780
Crown-Full cast high noble metal	\$294	D6790
Crown-Full cast predominantly base metal	\$276	D6791
Crown-Full cast noble metal	\$281	D6792
Other Fixed Partial Denture Services		
Recement Fixed Partial Denture	\$ 28	D6930
Fixed Partial Denture Repair, by report	\$ 49	D6980
ORAL SURGERY		
Extractions		
Coronal Remnants - Deciduous Tooth	\$ 75	D7111
Extraction, Erupted Tooth or Exposed Root (elevation and/ or forceps removal)	\$ 70	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	\$ 60	D7210
Removal of impacted tooth - soft tissue	\$ 80	D7220
Removal of impacted tooth - partially bony	\$108	D7230
Removal of impacted tooth - completely bony	\$128	D7240
Removal of impacted tooth - completely bony with unusual surgical complications	\$145	D7241
Surgical removal of residual tooth roots (cutting procedure)	\$ 55	D7250
Other Surgical Procedures		
Biopsy of oral tissue - hard (bone/tooth)	\$ 79	D7285
Biopsy of soft tissue - soft (all others)	\$ 68	D7286
Alveoloplasty in conjunction with extractions, per quadrant	\$ 55	D7310
Alveoloplasty in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	\$ 55	D7311
Alveoloplasty not in conjunction with extractions, per quadrant	\$ 74	D7320
Alveoloplasty not in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	\$ 74	D7321
Frenulectomy - separate procedure	\$100	D7960
ADJUNCTIVE GENERAL SERVICES		
Surgical Incision		
Palliative (emergency) treatment of dental pain (minor procedure)	\$ 14	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	\$187	D9220
General anesthesia - each additional 15 minutes	\$ 73	D9221
Intravenous sedation/analgesia - first 30 minutes	\$180	D9241
Intravenous sedation/analgesia - each additional 15 minutes	\$ 75	D9242
Miscellaneous Services		
Occlusal guards, by report	\$132	D9940
Occlusal adjustment, limited	\$ 47	D9951
Occlusal adjustment, complete	\$ 92	D9952

NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the Local Care Health Plan (LCHP) and the Local Government Dental Plan (LGDP)

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 Local Care Health Plan and the Local Government 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:

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

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**

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
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 Administrator	EyeMed Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvisioncare.com
Health/Dental Plans, Medicare COB Unit 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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits	CIGNA Group Number 2457474 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
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of \$400 applies	Intracorp, Inc.	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator LCHP (1401LD3) Health Alliance Illinois (1401LBS) HealthLink OAP (1401LCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1401LD3, 1401LBS, 1401LCF 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
LCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	Magellan Behavioral Health Group Number 2457474 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Local Government Dental Plan (LGDP) Administrator	Dental services, claim filing and ID cards	CompBenefits Group Number 960 P.O. Box 4721 Chicago, IL 60680-4721	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com

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 produced annually and 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.

BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

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

SECTION A – EMPLOYEE INFORMATION

Complete all fields.

SECTION B – HEALTH PLAN ELECTION

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 Local Care Health Plan (LCHP) or the managed care plan box. If **electing/changing managed care plans**, you must enter the managed care plan’s carrier code (see page 9 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 page 24 for website addresses).

SECTION C – DEPENDENT INFORMATION

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

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child’s parent and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	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, 2) a diagnosis from a physician with an ICD-9 diagnosis code <u>and</u> 3) a statement from the Social Security Administration with the Social Security disability determination.
Other (dependent who has received an organ transplant after 6/30/2000)	Proof of transplant, Dependent Coverage Certification Statement (CMS-138)* <u>and</u> member’s tax return or other documentation proving financial dependency.
* The Dependent Coverage Certification Statement (CMS-138) is available from your HPR.	

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your HPR by **May 31, 2007** in order for your elections to be effective July 1, 2007. Dependent documentation must be submitted to your HPR 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.

Local Government Health Plan BENEFIT CHOICE ELECTION FORM

May 1 – May 31, 2007 (Changes effective July 1, 2007)
COMPLETE THIS FORM ONLY TO MAKE A CHANGE IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

SSN: — —

Last Name	First Name	Phone Numbers	
		Home:	Work:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

- (1) If you are changing to a managed care plan from the Local Care Health Plan (LCHP), or if you are changing to a different managed care plan, you must enter a provider identifier.
- (2) If you have Medicare or other insurance you must give your Health Plan Representative (HPR) a copy of your Medicare/other insurance card.

HEALTH PLAN ELECTION	If Managed Care is selected <u>you must complete the information below. Go to the health plan's website to find the provider identifier.</u> See the Instruction Sheet on page 26 for more information.
<p><i>Elect One:</i></p> <p>Local Care Health Plan (LCHP) <input type="checkbox"/></p> <p style="text-align: center;">~ Or ~</p> <p>Managed Care <input type="checkbox"/></p>	<p>Provider Identifier _____ (6 or 10 characters)</p> <p>Carrier Code _____ (2 alpha characters – see page 9)</p> <p>Plan Name _____</p>

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

- (1) You must provide documentation to add dependents – see the Instructions Sheet on page 26 for specific documentation requirements.
- (2) If the dependent has Medicare or other insurance, you must give your HPR a copy of the Medicare/other insurance card.
- (3) If you are changing to a managed care plan from the LCHP, or if you are changing to a different managed care plan, you must enter the provider identifier for each dependent in your plan.

A (Add) / D (Drop) / C (Change)			Name	SSN	Birth Date	Relationship *	Provider Identifier
A	D	C					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

* Spouse, son, daughter, stepchild, adopted child

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 Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your unit's HPR by May 31, 2007.

**You must
return this form
to your
Health Plan
Representative by
May 31, 2007**

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

Address Service Requested

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