



Benefit Choice Options Period

Enrollment Period May 1 - May 31, 2009

Teachers' Retirement Insurance Program

Effective July 1, 2009 - June 30, 2010

Plan Administrators

Who to call for information

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
Humana Benefit Plan of Illinois (formerly OSF HealthPlans)	(888) 716-9138	(888) 817-0139	www.humanabenefitplanil.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
Health Plans and the Medicare COB Unit	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
General Eligibility and Enrollment Information	Teachers' Retirement System (TRS) 2815 West Washington P.O. Box 19253 Springfield, IL 62794-9253	(800) 877-7896 (217) 753-0329 (TDD/TTY)	trs.illinois.gov

Plan Administrator information continued on inside back cover.

Table of Contents

Important Changes for Plan Year 2010	1
Benefit Choice Period	2
Participant Responsibilities	2
Notice of Creditable Coverage	3
Coverage and Monthly Premiums	4
Managed Care Plans	5
Managed Care Plans in Illinois Counties (Map)	5
HMO Benefits	6
Open Access Plan (OAP) Benefits	7
The Teachers' Choice Health Plan (TCHP)	8
Prescription Drug Benefit	10
Notice of Privacy Practices (HIPAA)	11
Plan Administrators	Inside front and back covers

Important Changes for Plan Year 2010

(July 1, 2009 through June 30, 2010)

Public Act 95-0958 – Coverage for Adult Children

Coverage for adult children will be effective July 1, 2009. Benefit Recipients must use a separate enrollment form to enroll adult children - **Do Not Use the Benefit Choice Enrollment Form to add an adult child.** Go to the TRIP section of the Benefits website (www.benefitschoice.il.gov) and click on 'adult children' at the top of the page for more information and an enrollment form, or contact the Teachers' Retirement System (TRS).

OSF HealthPlans is now a part of Humana

The Humana Benefit Plan option will continue to provide the same benefits and same quality network of providers that you had available through OSF HealthPlans. If you are a current OSF member, you do not need to complete the Benefit Choice Enrollment form unless you are changing to a plan other than Humana. If you are a current OSF member and decide to stay enrolled with Humana you will receive a new ID card from Humana prior to starting your new plan year July 1, 2009.

Disease Management Programs

Disease Management Programs are utilized by CIGNA and the managed care health plans as a way to improve plan participants' health. You may be contacted by your plan to participate in these programs.

Benefit Choice Period is May 1-31, 2009



The Benefit Choice Period is **May 1 through May 31, 2009**, for all Benefit Recipients. Elections will be effective July 1, 2009. The Benefit Choice Period is the **only** time of the year a Benefit Recipient may change health plans, with the following two exceptions: the Benefit Recipient's permanent address changes affecting availability to the managed care plan or the Primary Care Physician leaves the Benefit Recipient's managed care plan. Benefit Recipients or Dependent Beneficiaries who have never been enrolled in TRIP may enroll during the Benefit Choice Period.

All Benefit Choice changes should be made on the form provided with this booklet. Benefit Recipients should complete the form **only** if changes are being made. Dependent Beneficiaries must be enrolled in the same plan as the Benefit Recipient. If you or your dependent are enrolling in TRIP for the first time, contact TRS for a TRIP enrollment form.

During the annual Benefit Choice Period, Benefit Recipients may:

- Change health plans
- Add dependent coverage if never previously enrolled

Additional Reminders About TRIP

To terminate coverage at any time, notify TRS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit Recipients and Dependent Beneficiaries who terminate from TRIP may re-enroll only upon turning age 65, becoming eligible for Medicare or when coverage is involuntarily terminated by a former plan.

Participant Responsibilities

It is each participant's responsibility to know plan benefits and make an informed decision regarding coverage elections. Notify the Teachers' Retirement System (TRS) 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;
 - 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 coverage.
- Change in Medicare status
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their Coordination of Benefits (COB) information to TRS as soon as possible.

Notice of Creditable Coverage

Prescription Drug Information for Teachers' Retirement Insurance Program (TRIP) Medicare Eligible Plan Participants

This notice confirms that your existing prescription drug coverage through the Teachers' Retirement Insurance Program (TRIP) 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 Teachers' Retirement 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 Teachers' Retirement Insurance Program 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

Coverage and Monthly Premiums

Benefit Recipients who enroll in the Teachers' Retirement Insurance Program (TRIP) receive health, prescription and behavioral health benefits. Dependent Beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the Benefit Recipient.

The health insurance plans available to TRIP members differ in the benefit levels they provide, the doctors and hospitals you can access and the out-of-pocket cost to you. In general, managed care plans, such as

Health Maintenance Organizations (HMOs) and the Open Access Plan (OAP), deliver healthcare through a system of network providers and have a lower monthly premium than the Teachers' Choice Health Plan (TCHP). The TCHP allows plan participants to access any provider nationwide; however, enhanced benefits are available when services are received from a TCHP network provider. The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
	Under Age 23	Age 23-64	Age 65 and Above	All Ages
Benefit Recipient enrolled in any managed care plan	\$56.47	\$175.36	\$238.92	\$69.30
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	\$146.52	\$413.53	\$621.93	\$180.44
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	\$73.26	\$206.77	\$310.97	\$90.22
Dependent Beneficiary enrolled in any managed care plan	\$225.90	\$701.43	\$955.67	\$252.09**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	\$293.04	\$827.06	\$1,243.85	\$360.89
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	\$293.04	\$827.06	\$1,243.85	\$270.67**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See inside front cover for contact information.

** Medicare Primary Dependent Beneficiaries enrolled in a managed care plan, or in TCHP when no managed care plan is available, receive a premium subsidy.

HMO Benefits

Plan participants 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, the plan participant pays only a co-payment. No annual plan deductibles apply. 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.

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 the lesser of \$200 co-payment per visit, or 50% of U&C

Professional and Other Services

Physician Office visit (including physical exams and immunizations)	100% after \$15 co-payment per visit
Specialist Office visit	100% after \$15 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% of network charges
Home Health Care	100% after \$15 co-payment per visit

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

Open Access Plan (OAP) Benefits

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 co-payments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. 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. 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.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% 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	\$0 \$0	\$700 \$1,400	\$1,700 \$3,600
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*

Hospital Services

Inpatient	100% after \$250 co-payment per admission	80% of network charges after \$300 co-payment per admission	60% 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	80% of network charges after \$300 co-payment per admission up to 30 days per plan year	60% 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	80% of network charges after \$300 co-payment per admission up to 10 days rehabilitation per plan year	60% 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	80% of network charges after \$200 co-payment per visit	60% 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	80% of network charges after \$150 co-payment	60% of U&C after \$150 co-payment
Outpatient Psychiatric and Substance Abuse	100% after \$20 co-payment, up to 30 visits per plan year	80% of network charges after \$20 co-payment, up to 30 visits per plan year	60% of U&C after \$20 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C

Physician and Other Professional Services

Physician Office Visits	100% after \$15 co-payment	80% of network charges	60% of U&C
Specialist Office Visits	100% after \$15 co-payment	80% of network charges	60% of U&C
Preventive Services, including immunizations, Well Baby care, allergy testing and treatment	100% after \$15 co-payment	80% of network charges	Covered under Tier I and Tier II only

Other Services

	Prescription Drugs – Covered through State of Illinois administered plan, Medco		
	Generic \$10	Preferred Brand \$20	Non-Preferred Brand \$40
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 co-payment	80% 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 Teachers' Choice Health Plan (TCHP)

TCHP is the medical plan that offers a comprehensive range of benefits. Under the TCHP, 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 a TCHP network provider. The TCHP 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 TCHP notification administrator, is required for certain medical services in order to avoid penalties. Refer to the Benefits Handbook, or contact Intracorp at (800) 962-0051, for direction.

Plan participants can access plan benefit and participating network information, Explanation of Benefits (EOB) statement 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

Lifetime Maximum	\$2,000,000
Plan Year Deductible	\$500 TCHP Primary Participant (Non-Medicare) \$500 Medicare Primary Participant
Additional Deductibles*	Each emergency room visit \$400 TCHP hospital admission \$200 Non-TCHP hospital admission \$400
* These are in addition to the plan year deductible.	

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: a general one and one for non-TCHP network hospital charges. Coinsurance and deductibles apply to one or the other, but not both. 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.

General: \$1,200 per individual \$2,750 per family per plan year	Non-TCHP Network 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, coinsurance or co-payments. • Behavioral Health benefits, coinsurance or co-payments. • Notification penalties. • Ineligible charges (amounts over Usual and Customary (U & C), charges for non-covered services and charges for services deemed not to be medically necessary). • The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay.

TCHP - Medical Plan Coverage

Hospital Services

TCHP Network Hospitals	80% after annual plan deductible. \$200 deductible per hospital admission.
Non-TCHP Hospitals	60% after annual plan deductible. \$400 deductible per hospital admission.

Outpatient Services

Lab/X-ray	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Licensed Ambulatory Surgical Treatment Centers	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.

Professional and Other Services

TCHP Physician Network	80% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in the TCHP Network	60% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services - medical necessity required (up to a maximum of 30 visits per plan year)	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.

Transplant Services

Organ and Tissue Transplants	80% of negotiated fee after inpatient 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 TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.

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 TRIP health plan have prescription drug benefits included in the coverage. 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. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic co-payment. This cost difference does not apply toward the annual prescription out-of-pocket maximum. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan’s PBM for Coordination of Benefits (COB) information. Plan participants whose PBM is Medco can receive a 90-day supply of medication through the Mail Order Program for two co-payments. TCHP has 20% coinsurance with minimum and maximum co-payments.

PRESCRIPTION DRUG CO-PAYS FOR ALL MANAGED CARE PLANS (30-DAY SUPPLY)	
Generic	\$10
Preferred (Formulary) Brand	\$20
Non-Preferred Brand	\$40

PRESCRIPTION DRUG CO-PAYS/COINSURANCE FOR TCHP (30-DAY SUPPLY)		
	Minimum	Maximum
Generic	\$7	\$50
Preferred (Formulary) Brand	\$14	\$100
Non-Preferred Brand	\$28	\$150

- Annual prescription drug out-of-pocket maximum of \$1,500 applies.
- After meeting the \$1,500 out-of-pocket maximum, prescriptions are covered at 100%.
- Out-of-network claims do not count toward this annual out-of-pocket maximum.
- 20% coinsurance with minimum and maximum co-payments.
- The maximum supply at one fill is 60 days.
- Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums.
- Prescription plan benefits are included in the lifetime maximum.



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, 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 they are considering. 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.

NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the Teachers' Choice Health Plan (TCHP)

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 Teachers' Choice Health 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. 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>	

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, 2009**

Plan Administrators

Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Teachers' Choice Health Plan (TCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	CIGNA Group Number 2457482 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
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of \$1,000 applies	Intracorp, Inc.	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator TCHP (1402TD3) Health Alliance Illinois (1402TBS) HealthLink OAP (1402TCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1402TD3, 1402TBS, 1402TCF 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
TCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	Magellan Behavioral Health Group Number 2457482 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the program is maintained for the exclusive benefit of the Teachers' Retirement Insurance Program (TRIP) Benefit Recipients. TRIP 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.

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

**Printed by the authority of the State of Illinois
(CMS-BEN2002-02-56,300-04/09)
Printed on recycled paper**

