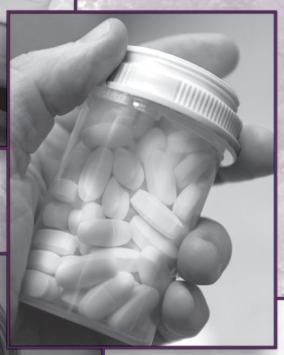
State of Illinois
Rod R. Blagojevich, Governor

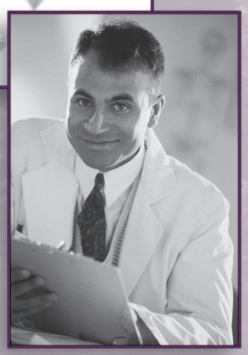
Department of Central Management Services
Bureau of Benefits
Paul J. Campbell, Director

BENEFIT CHOICE OPTIONS

State of Illinois

Your Benefits for Good Health





Enrollment Period, May 1 – 31, 2006
Effective July 1, 2006 – June 30, 2007

Benefit Choice is May 1 - May 31, 2006

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Important Changes For Plan Year 2007
(July 1, 2006 through June 30, 2007)

The information below presents changes to the State of Illinois benefit plans. Please carefully review all the information in this Benefit Choice Options booklet. **This annual Benefit Choice Options Booklet contains updates to the State of Illinois Benefits Handbook and should be retained the entire plan year.** Members should review this publication each year to be aware of benefit changes. Benefit Choice is May 1 - 31, 2006. All selections made during Benefit Choice will be effective July 1, 2006.

Public Act 94-0109 Opt Out Financial Incentive – Non-Medicare State Employees' Retirement System (SERS) annuitants who are enrolled in a State health plan and have other comprehensive medical coverage may elect to OPT OUT of the plan and receive a financial incentive of $150 per month. Contact the Insurance Section of the SERS at (217) 785-7150 for more information.

Domestic Partner – Effective July 1, 2006, same-sex domestic partners may be eligible for health, dental and vision coverage. See your agency Group Insurance Representative (GIR) or visit the Benefits website at **www.benefitschoice.il.gov** for eligibility and enrollment information.

Medicare Part D – The 2006-2007 Notice of Creditable Coverage is available on page 29. This Notice confirms that existing drug coverage through the State Employees Group Insurance Program is as good as, or better than, prescription coverage through Medicare Part D. **Members should not enroll in a Medicare Part D Plan** unless they qualify for low-income/extra-help assistance under the Social Security Administration. Members with questions regarding the Notice of Creditable Coverage should call the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

Managed Care Plan (HMO/OAP) Changes

- Inpatient hospital co-payment increases to $250
- Emergency room visit co-payment increases to $200
- Office visit co-payment increases to $15
- Home health visit co-payment increases to $20
- Prescription co-payments increase to $10/$20/$40
- Employee and dependent health contributions have increased

Quality Care Health Plan (QCHP) Changes

- In-network, out-of-pocket maximum (individual) increases to $1,000
- In-network, out-of-pocket maximum (family) increases to $2,500
- Out-of-network, out-of-pocket maximum (individual) increases to $4,100
- Out-of-network, out-of-pocket maximum (family) increases to $8,200
- Chiropractic visits limited to 30 per plan year
- Prescription co-payments increase to $10/$20/$40
- Employee and dependent health contributions have increased

Optional Programs

Flexible Spending Accounts (FSA) Program

The FSA Program consists of the Medical Care Assistance Plan and the Dependent Care Assistance Plan. Employees who enroll in either plan can save tax dollars for out-of-pocket medical and dependent care expenses that they and their eligible dependents incur during the plan year (certain limitations may apply). Join the FSA program today and start saving money. See pages 24-25 for more information.

Commuter Savings Program (CSP)

The CSP can save employees tax dollars on eligible commuting and parking expenses by having those expenses payroll deducted. Transit passes are mailed directly to the employee's home and parking providers can be paid directly. See page 27 for more information.

Smoking Cessation Program

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

Adoption Benefit Program

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

Deferred Compensation Program

The Deferred Compensation Program is one way to save for the future while enjoying tax savings today. This program provides an investment opportunity for state employees by offering a wide variety of investment options, flexibility to make investment changes and convenient services. See page 26 for more information.

Long-Term Care (LTC) Insurance

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

Member Responsibilities

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

Notify the Group Insurance Representative (GIR) 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
- Payroll deductions for benefits
- Beneficiary Forms (contact the agency GIR or visit the Benefits website for forms)
  - State Employees Group Insurance
  - State Retirement System
  - Deferred Compensation Program

Benefit Choice Period is May 1-31, 2006

The Benefit Choice Period is **May 1 through May 31, 2006** for all members. Elections will be effective July 1, 2006 through June 30, 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
- Premium costs
- Geographic access
- Availability of managed care providers
- Prescription drug coverage

There are three health benefit coverage options available:

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

See pages 11-17 to review the features for each type of plan.

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

During the annual Benefit Choice Period, members may:

- Change health plans
- Add or drop dependent coverage
- Increase or decrease member Optional Life insurance coverage
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage
- Elect to opt out of health, dental and vision coverage (full-time employees and annuitants only)
- Elect to waive health, dental and vision coverage (part-time employees 50% or greater, annuitants and survivors required to pay a portion of premiums only)
- Elect to waive health, dental and vision coverage and become a dependent of a State-covered spouse (annuitants only)
- Re-enroll in the program if previously opted out (full-time employees or annuitants)
- Re-enroll in the program if previously waived (part-time employees 50% or greater, annuitants and survivors required to pay a portion of the premium)
- Re-enroll in the program if currently terminated due to non-payment of premium while on leave of absence (employees only) **Note:** Survivors and annuitants are not eligible to re-enroll.
- Elect to participate or not participate in the dental plan. **Once elected, this selection will remain in effect the entire plan year and cannot be changed until the next Benefit Choice Period. Members cannot make any changes to this dental election due to any qualifying change in status.**
- Enroll or re-enroll in the Flexible Spending Accounts (FSA) Program (additional enrollment form required)

During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage. COBRA health and dental rates for plan year 2007 will be available on or after May 1, 2006. Please contact the CMS Group Insurance Division, Special Payment Programs Unit at (800) 442-1300 or (217) 558-6194 for information.

Documentation Requirements

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

Member Monthly Health, Dental and Optional Life Plan Contributions

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. Salary-based contributions remain in effect until June 30, 2007, unless the employee retires, accepts a voluntary salary reduction or returns to State employment at a different salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this does not apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions	
$28,600 & below	Managed Care: $31.00	Quality Care: $54.00
$28,601 - $43,300	Managed Care: $36.00	Quality Care: $59.00
$43,301 - $57,600	Managed Care: $38.50	Quality Care: $61.50
$57,601 - $72,100	Managed Care: $41.00	Quality Care: $64.00
$72,101 & above	Managed Care: $43.50	Quality Care: $66.50

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

Retiree, Annuitant and Survivor Monthly Health Plan Contribution	
20 years or more of creditable service	$0.00
Less than 20 years of creditable service and, • SERS/SURS annuitant/survivor on or after 1/1/98, **or** • TRS annuitant/survivor on or after 7/1/99	Required to pay a percentage of the cost of the basic coverage.
Call the appropriate retirement system for applicable premiums. **SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896**	

Monthly Optional Term Life Plan Contributions			
Member by Age	**Monthly Rate Per $1,000**	**Member by Age**	**Monthly Rate Per $1,000**
Under 30	$0.06	Ages 75 - 79	$3.74
Ages 30 - 34	0.08	Ages 80 - 84	4.46
Ages 35 - 39	0.10	Ages 85 - 89	5.50
Ages 40 - 44	0.12	Ages 90 and above	6.82
Ages 45 - 49	0.16	Accidental Death & Dismemberment	0.02
Ages 50 - 54	0.26		
Ages 55 - 59	0.50	Spouse (for $10,000 coverage)	7.14
Ages 60 - 64	0.78		
Ages 65 - 69	1.50	Dependent Children (for $10,000 coverage)	0.56
Ages 70 - 74	2.66		

Member Monthly Quality Care Dental Plan (QCDP) Contributions	
Employee Only	$10.00
Employee plus 1 Dependent	$15.00
Employee plus 2 or more Dependents	$17.50
Retirees, Annuitants, Survivors and Dependents	$0

Contribution Calculation Worksheet

Member Monthly Health Contribution: $_____
(see chart on page 8)

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

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

Monthly Optional Term Life Contribution: $_____
(see chart on page 8)

My Total Monthly Contribution: $_____

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

Dependent Monthly Health Plan Contribution

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

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

Dependent Monthly Health Plan Contributions				
Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
Unicare HMO (Code: CC)	$ 66	$ 97	$ 61	$ 97
HMO Illinois (Code: BY)	$ 67	$100	$ 63	$100
PersonalCare (Code: AS)	$ 76	$114	$ 72	$114
OSF HealthPlans (Code: CA)	$ 76	$114	$ 73	$114
Health Alliance HMO (Code: AH)	$ 78	$117	$ 73	$117
Health Alliance Illinois (Code: BS)	$ 87	$129	$ 84	$129
HealthLink OAP (Code: CF)	$ 89	$133	$ 86	$133
OSF Winnebago (Code: CE)	$ 91	$136	$ 88	$136
Quality Care Health Plan (Code: D3)	$174	$204	$120	$181

Opt Out Options

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

  Members who wish to Opt Out must complete the Opt Out Election Certificate, attach proof of other insurance coverage (such as a copy of an insurance card from another health plan that names you as being insured) and return to the Group Insurance Representative no later than May 31, 2006.

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

  Members opting out of the Program are **not eligible** for the:
  – Free influenza immunizations offered annually by the Department of Healthcare and Family Services
  – COBRA continuation of coverage

  Employees opting out of the Program **are eligible** for the:
  – Flexible Spending Account (FSA) Program
  – Commuter Savings Program (CSP)
  – Paid maternity/paternity benefit
  – Either of the two separate Employee Assistance Programs
  – Long-Term Care Program

- **In accordance with Public Act 94-0109,** non-Medicare State Employees' Retirement System (SERS) annuitants who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the plan and receive a financial incentive of $150 per month. Contact the Insurance Section of the SERS at (217) 785-7150 for more information.

- Individuals who opt out under either public act may re-enroll in the Program only during the annual Benefit Choice period (May 1 - 31 each year), or within 60 days of experiencing an eligible qualifying change in status. Members who re-enroll, and their dependents, are subject to possible health benefit limitations for pre-existing conditions. A Certificate of Creditable Coverage from the previous insurance carrier must be provided to reduce the pre-existing conditions waiting period.

Managed Care Plans

There are 8 managed care plans available based on geographic location. All offer comprehensive benefit coverage.

Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.

Health Maintenance Organizations (HMOs)

Members must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs 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 12. 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 13.

HMO Benefits

The benefits described below represent the minimum level of coverage an HMO is required to provide. Benefits are subject to the benefit design 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 $100 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 $15 co-payment per visit
Well Baby Care	100%
Psychiatric care* (maximum number of days determined by the plan)	100% of the cost after a 20% co-payment (not to exceed $20) per visit
Alcohol and substance abuse care* (maximum number of days determined by the plan)	100% of the cost after a 20% co-payment (not to exceed $20) 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

* HMOs determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Each plan must provide a minimum of 10 inpatient days and 20 outpatient visits per plan year. These visits are in addition to detoxification benefits, which include diagnosis and treatment of medical complications.

Some HMOs may have benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in the OAP. Benefits are subject to the benefit design outlined in the plan's Summary Plan Document. It is the member's responsibility to know and follow the specific requirements of the OAP plan.

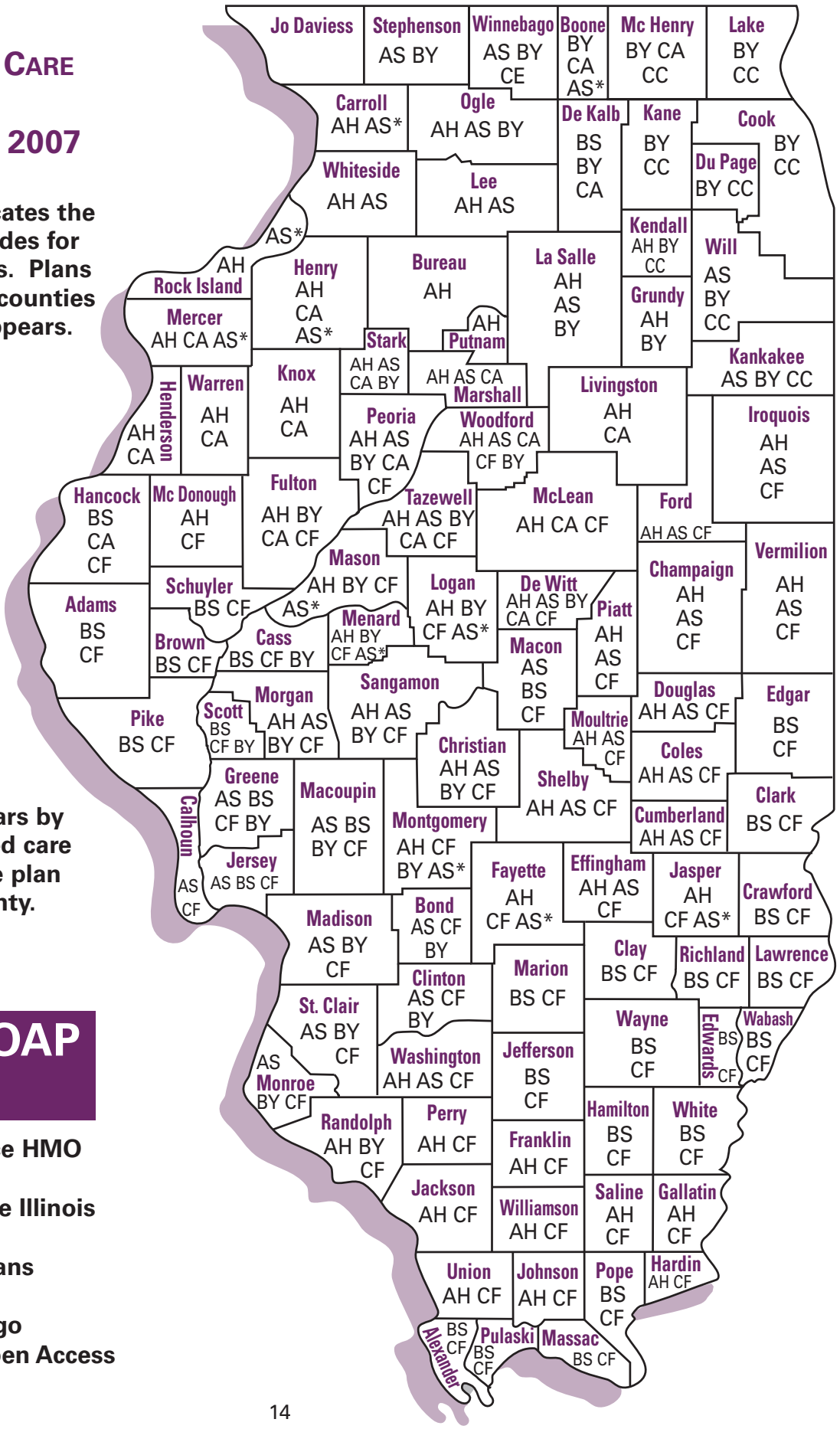
Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	$1,000,000
Annual Out-of-Pocket Maximum Per Individual Enrollee Per Family	Not Applicable	$600 $1,200	$1,500 $3,500
Annual Plan Deductible (must be satisfied for all services)	$0	$200 per enrollee*	$300 per enrollee*
Hospital Services			
Inpatient	Full coverage after $250 co-payment per admission	90% of network charges for covered services after $300 co-payment per admission	80% of U&C for covered services after $400 co-payment per admission
Inpatient Psychiatric	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $250 co-payment per admission, up to 30 days per plan year	90% of U&C for covered services after $250 co-payment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $250 co-payment per admission, up to 10 days rehabilitation per plan year	90% of U&C for covered services after $250 co-payment per admission, up to 10 days rehabilitation per plan year
Emergency Room	Full coverage after $200 co-payment per visit	90% of network charges for covered services after $200 co-payment per visit	80% of U&C for covered services after lesser of $200 co-payment per visit, or 50% of U&C
Outpatient Surgery	Full coverage after $100 co-payment per admission	90% of network charges for covered services	80% of U&C for covered services
Outpatient Psychiatric and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $15 co-payment, up to 30 visits per plan year	90% of U&C for covered charges after $15 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Physician and Other Professional Services			
Physician Office Visits	Full coverage after $15 co-payment	90% of network charges for covered services	80% of U&C for covered services
Preventive Services, Including Immunizations	Full coverage after $15 co-payment	90% of network charges for covered services	Covered in-network only
Well Baby Care	Full coverage	90% of network charges for covered services	Covered in-network 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	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Skilled Nursing Facility	Full coverage	90% of network charges for covered services	Covered in-network only
Transplant Coverage	Full coverage	90% of network charges for covered services	Covered in-network only
Home Health Care	Full coverage after $20 co-payment	90% of network charges for covered services	Covered in-network only

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

Managed Care Plans in Illinois Counties

State Managed Care Health Plans For Fiscal Year 2007

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



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

HMO and OAP Codes:

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

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 Quality Care Health Plan. The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

Out-of-County Managed Care Plans: Members interested in enrolling in a managed care plan that is not available in their county of residence should contact the plan directly to determine if an exception can be made that would allow the member to participate in the managed care plan.

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.

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.

Psychiatric/Substance Abuse Treatment: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Plans are required to cover a minimum of 10 inpatient days and 20 outpatient visits. These visits are in addition to detoxification benefits that include diagnosis and treatment of medical complications.

Transplant Services: Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. Members should contact the respective managed care plan for specific information at the first indication that a transplant may be needed.

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

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.

The Quality Care Health Plan (QCHP)

QCHP is the medical indemnity plan that offers a comprehensive range of benefits. Under the QCHP, 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 Preferred Provider Organization (PPO). The **nationwide PPO networks** consist of physicians, hospitals, ancillary providers (CIGNA PPO network), pharmacies (Medco retail and maintenance pharmacy network) and behavioral health services (Magellan behavioral health network).

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

Plan Year Maximums and Deductibles	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	The plan year deductible is based upon each employee's annual salary (see chart below for current plan year information)
Additional Deductibles* *** These are in addition to the plan year deductible.**	Each emergency room visit $300 Non-PPO hospital admission $200 Transplant deductible $100 **Note: There is no additional deductible for admission to a PPO hospital**

Plan Year Deductibles		
Employee's Annual Salary (based on each employee's annual salary as of April 1st)	**Member Plan Year Deductible**	**Family Plan Year Deductible Cap**
$57,600 or less	$250	$625
$57,601 - $72,100	$350	$875
$72,101 and above	$400	$1,000
Retiree/Annuitant/Survivor	$250	$625
Dependents	$250	NA

Out-of-Pocket Maximums

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

General: **$1,000 per individual** **$2,500 per family per plan year**	**Non-PPO Hospital:** **$4,100 per individual** **$8,200 per family per plan year**
The following do not apply toward out-of-pocket maximums: • 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). • The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.	

QCHP - Medical Plan Coverage

Hospital Services	
Preferred Provider Organization (PPO) Hospitals	90% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (Non-PPO) Hospitals	• $200 per admission deductible. • If the member resides in Illinois or within 25 miles of a PPO hospital and the member chooses to use a non-PPO and/or voluntarily travels in excess of 25 miles when a PPO 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 PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest PPO hospital, the plan pays 65% after the annual plan deductible. • If the member does not reside in Illinois or within 25 miles of a PPO hospital, the plan pays 80% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	90% 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 80% of U&C, as applicable, after plan deductible.
Professional and Other Services	
CIGNA Healthcare Physician PPO Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in CIGNA's PPO Network	80% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services (limit of 30 visits per plan year)	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after $100 transplant deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.

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

QCHP - Notification and Penalties

Health Plan Notification Requirements

Notification is the telephone call to the health plan notification administrator, **Intracorp**, informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for an outpatient procedure/therapy. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits. Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare. Intracorp can be reached by calling (800) 962-0051.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information and evaluate the procedure, the setting and the anticipated initial length of stay for medical appropriateness. Failure to contact Intracorp within the required time limits will result in an $800 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

A "reference number" will be assigned and should be maintained by the plan participant should there be any questions regarding notification; however, it is not a guarantee of benefits. For benefit confirmation, Intracorp, the Notification Administrator, can transfer the plan participant to CIGNA for assistance.

Notification is required for the following:

- **Elective Inpatient Surgery or Non-Emergency Admission -** The plan participant must contact Intracorp at least seven days prior to the admission.
- **Maternity -** It is recommended that the notification process occur as early in the pregnancy as possible in order to enable Intracorp to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. **Notification of a maternity admission is not automatic enrollment of the newborn.** Contact the agency GIR to enroll the newborn.
- **Skilled Nursing -** In a Skilled Nursing Facility, Extended Care Facility or Nursing Home - The plan participant must contact Intracorp at least seven days prior to the admission. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission -** The plan participant or physician must contact Intracorp within two business days after the admission.
- **Notification for Outpatient Surgery or Procedures/Therapies -** The plan participant must contact Intracorp prior to receiving services such as, but not limited to, speech, physical and occupational therapies and imaging (MRI, PET, SPECT and CAT Scan). **Failure to notify Intracorp of outpatient surgery or procedures may result in a reduction of benefits.**
- **Potential Transplants -** To ensure maximum benefits are available, potential transplant candidates should contact Intracorp at the first indication that a transplant may be necessary. Benefits are available only if authorized by Intracorp.

Behavioral Health Services Notification and Authorization Requirements

Contacting the Behavioral Health Plan Administrator, **Magellan**, begins the authorization process for services at all levels of care to avoid penalties or non-authorization of benefits. In an emergency or life-threatening situation, call 911, or go to the nearest hospital emergency room. Contact Magellan within 48 hours to avoid a financial penalty.

A licensed behavioral health professional will conduct a review to determine if treatment meets medical necessity criteria and appropriate level of care. If treatment is authorized, services are eligible for benefit coverage. Services determined not medically necessary will not be eligible for coverage.

For authorization procedures for behavioral health services, see the Behavioral Health Services section on page 81 of the Benefits Handbook or call Magellan at (800) 513-2611.

Prescription Drug Benefit

Plan participants enrolled in all State health plans 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. For plan year 2007 (July 1, 2006 - June 30, 2007), all health plans apply the same co-payments for each level of prescription medication for a 30-day fill.

PRESCRIPTION DRUG CO-PAYS	
Generic	$10
Preferred Brand (Formulary Brand)	$20
Non-Preferred Brand	$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. Partial reimbursement may be provided if the plan participant files a paper claim with the health plan. 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 Benefit Handbook or the Benefits website for more information.

Health Alliance Illinois, HealthLink OAP, OSF Winnebago and the Quality Care Health Plan (QCHP) have prescription benefits administered through the Prescription Benefit Manager (PBM), Medco. Prescription drug benefits are independent of other medical services and are not subject to the 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 from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Participants receiving a drug costing less than the co-payment will only be charged the cost of the drug.

Non-Maintenance Medication

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

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

Maintenance Medication

Maintenance medication is taken on a regular basis for conditions such as high blood pressure and high cholesterol. The Maintenance Medication Program (MMP) was developed to provide an enhanced benefit to plan participants who use **maintenance medications.** To determine whether a medication is considered a maintenance medication, contact a Maintenance Network pharmacist. When plan participants use **either** the Maintenance Network or the Mail Order Pharmacy for maintenance medications, they will receive a 61-90 day supply of medication (equivalent to 3 fills) for only two co-payments ($20/$40/$80).

The Maintenance Network is a network of retail pharmacies that contract with Medco to accept the co-payment amount for maintenance medication. Pharmacies in this network may also be an in-network retail pharmacy as described under the Non-Maintenance Medication section. If a participant uses an in-network pharmacy that does NOT participate in the Maintenance Network, only the first two 30-day fills will be covered at the regular co-payment amount. Subsequent fills will be charged double the co-payment rate ($20/$40/$80). A list of pharmacies participating in the Maintenance Network is available at **www.benefitschoice.il.gov.**

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

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

Dental Options

During the Benefit Choice Period, members have the option to participate in the Quality Care Dental Plan (QCDP) or they may elect not to participate in the 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).

Quality Care Dental Plan (QCDP)

Members enrolled in QCDP may go to any dentist. The QCDP 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 at **www.benefitschoice.il.gov**). A $100 individual plan deductible applies for all services other than those listed as preventive and diagnostic in the Schedule of Benefits. Members are responsible for all charges over the scheduled amount. Most members pay a premium for dental coverage (see the premium chart on page 9 for the applicable premium amount required).

The maximum benefit per plan participant per plan year for all dental services, including orthodontic and periodontic, is $2,000. The maximum lifetime benefit for child orthodontia is $1,500 and is subject to course of treatment limitations.

Election Not to Participate in Dental Plan

The election not to participate in the dental plan will remain in effect the entire plan year, without exception. The annual Benefit Choice Period is the only time members may enroll or re-enroll in the dental plan.

Note: Even though child orthodontics is covered under QCDP, there may still be significant out-of-pocket expenses for orthodontia services. Therefore, members with upcoming child orthodontia services may wish to enroll in the Medical Care Assistance Plan (MCAP), offered under the Flexible Spending Accounts (FSA) Program, to realize even greater savings. See the Flexible Spending Accounts Program section on pages 24-25 for details.

Vision Plan

All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Co-payments are required. For 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	Benefit Frequency
Eye Exam	$10 co-payment	$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	$10 co-payment	$40 allowance for single vision lenses $60 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	$10 co-payment (for frames within the benefit selection)	$50 allowance	Once every 24 months
Contact Lenses** (All contact lenses are in lieu of standard frames and spectacle lenses)	$100 allowance	$100 allowance	Once every 24 months
Low Vision Supplementary Testing***	$10 co-payment	$125 allowance	Once every 12 months
Low Vision Aids***	100% coverage after a 25% co-payment with a $1,000 maximum allowance	100% coverage after a 25% co-payment with a $1,000 maximum allowance	Once every 12 months

* **Spectacle Lenses:** Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

** **Contact Lenses:** The contact lens allowance applies towards the cost of the contact lenses, as well as the professional fees for fitting and evaluation services.

*** Subject to prior approval by the Vision Plan Administrator

Life Insurance Plan

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

Optional life insurance coverage is also available to members at their own expense. Changes to life insurance must be indicated on the Benefit Choice Election Form (see back of this booklet). Optional life coverages available are listed below:

Member Optional Life

- Employees and eligible annuitants under age 60 may elect Optional Life up to 8 times the Basic Life coverage amount with a maximum of $3,000,000 when combined with Basic Life coverage. Optional Life coverage in excess of 4 times the Basic Life coverage amount will terminate when an annuitant turns age 60.

- Eligible annuitants age 60 and over may elect Optional Life up to 4 times the Basic Life coverage amount of $5,000.

- Survivors prior to Sept. 22, 1979 may elect up to 4 times the Basic Life coverage amount of $2,000.

Accidental Death and Dismemberment (AD&D)

- Members may elect up to 5 times the Basic Life coverage amount (Basic Life plus 4 times optional coverage).

Spouse/Child Life

- Spouse Life coverage is $10,000, except for spouses of annuitants age 60 or over and survivors of employees and immediate annuitants prior to September 22, 1979, in which case coverage is $5,000.

- Child life coverage is $10,000, except for survivors of employees and immediate annuitants prior to September 22, 1979, in which case coverage is $5,000.

Adding/increasing member Optional Life, as well as adding Spouse Life and/or Child Life coverage, is subject to prior approval by the Life Insurance Plan Administrator, Minnesota Life Insurance Company. Members must complete and submit a Statement of Health form to Minnesota Life for review. Contact the agency Group Insurance Representative (GIR) to obtain a Statement of Health form or visit the Benefit Choice website at **www.benefitschoice.il.gov.**

Life insurance coverage changes requiring Statement of Health approval become effective July 1st if the approval date from Minnesota Life is July 1st or earlier. If the approval date is after July 1st, the effective date of the changes is the first day of the pay period following the Statement of Health approval date.

The Flexible Spending Accounts (FSA) Program

The FSA Program is an optional benefit that consists of two plans, the Medical Care Assistance Plan (MCAP), which allows members to pay eligible out-of-pocket medical and dental expenses incurred during the plan year with tax-free dollars, and the Dependent Care Assistance Plan (DCAP), which allows members to pay eligible child and/or adult day care expenses incurred during the plan year with tax-free dollars. Participants must re-enroll on an annual basis to take advantage of this benefit. To enroll, employees should obtain an enrollment form from their agency Group Insurance Representative (GIR) or the Benefits website located at **www.benefitschoice.il.gov.** Currently enrolled participants will receive a re-enrollment form each year prior to the Benefit Choice Period to re-enroll in the program.

Eligible MCAP expenses include:

- Prescriptions
- Orthodontic treatment
- Eyeglasses
- Dental fees
- Surgery
- Doctor fees
- Over-the-Counter drugs
- Hearing aids and exams

Eligible DCAP expenses include:

- After-school care
- In-home care/au pair services
- Baby-sitting fees
- Nursery and pre-school
- Day-care services
- Summer day camps

Eligible employees may set aside up to $5,000 tax free to one or both of the plans for a combined maximum of $10,000. The amount designated is payroll deducted and deposited into the account(s) prior to federal, state and Social Security tax withholdings, thereby lowering taxable income and increasing disposable income. Fringe Benefit Management Company (FBMC) is the plan administrator for the FSA Program.

The normal period of coverage for participants who enroll during the annual Benefit Choice Period is July 1 – June 30. Participants who experience a qualifying change in status event after the plan year begins may enroll, terminate enrollment, increase deductions or decrease deductions, consistent with the qualifying event. Participants who change the deduction amount during the plan year will have two or more "split periods of coverage" (dependent upon the number of times the deduction amount is changed). Allowable expenses for each "period" must be incurred during that timeframe. Expenses are reimbursed based upon the enrolled amount. Claims for eligible MCAP and DCAP expenses incurred from July 1, 2006 through June 30, 2007 may be submitted to FBMC for reimbursement until September 30, 2007.

EZ REIMBURSE® MasterCard® Card Program

Using the EZ REIMBURSE® MasterCard® Program, MCAP participants have the option to have their MCAP account automatically debited when an eligible, uninsured medical expense is incurred. There is a non-refundable $20 annual EZ Reimburse® MasterCard® fee that is automatically deducted from the annual amount.

The EZ Reimburse® card electronically deducts funds from the member's MCAP account. All health, dental and vision services, as well as prescription drugs purchased at an FBMC participating network pharmacy (see below) paid with the EZ Reimburse® card, will be automatically paid out of the account. FBMC does not require follow-up documentation for transactions that have a known co-payment amount (such as the $15 HMO physician visit co-pay). Participants who use the card for transactions that do not have a set co-payment or deductible amount (such as dental procedures) will have the charges paid from their MCAP account, but must provide follow-up documentation to FBMC within 60 days.

FBMC has a **pharmacy network** that, when used by the participant, allows the pharmacy to be paid at the time of purchase. Participants who use a network pharmacy do not need to provide follow-up documentation after using the card. A list of participating pharmacies can be accessed by selecting the "EZ REIMBURSE® MasterCard® Card Pharmacy Locator" link available on the Benefits website. Participants who use a pharmacy that does not participate in the network must pay for the medication and then provide documentation to FBMC for reimbursement.

Like other debit cards, there is no risk of overspending or exceeding account limits. If funds are not available because the annualized amount has been spent down, the transaction will be denied. Because no credit is being extended, cards are available to anyone who signs up for MCAP.

Participants currently enrolled in the EZ Reimburse® MasterCard® Program who wish to re-enroll in the Program for the 2007 plan year must check the appropriate box on the re-enrollment form that will be mailed directly to the participant's home. Current cards can be reloaded with the new annual election amount and ready for use beginning July 1.

Deferred Compensation Program

The Deferred Compensation Program is a long-term supplemental retirement program that provides State of Illinois employees the opportunity to save for the future by offering tax-savings, a variety of investment options, the flexibility to make investment changes and convenient services.

Benefits from Participation in the Deferred Compensation Program

Combined pension and Social Security benefits may not be sufficient for retirement needs. Deferred Compensation is one way to save for the future while enjoying tax benefits today. Participating in the Plan will not affect Social Security benefits, pension benefits or the ability to save independently.

- **Reduce taxable income**
  The amount contributed to a deferred compensation account reduces taxable income, which allows more savings, less taxes and more disposable income.
- **Investment earnings grow tax-free**
  The money contributed and any interest or earnings on contributions grow free of taxes until withdrawal. At that point, only federal taxes are payable. Deferred Compensation distributions are not subject to Illinois State taxes.

Eligibility

All State of Illinois employees, including contractual and temporary employees, are eligible to participate in this Program.

Enrollment

There is no specific enrollment period; State employees may enroll at any time. An enrollment form is available from the Deferred Compensation Division or from the Agency Liaison. Participants can also access the Plan's website for comprehensive information and download the necessary forms at **www.state.il.us/cms/employee/defcom.** The enrollment form must be submitted in the month prior to the month in which deferrals begin. All contributions are through payroll deduction only.

Contribution Limitations

Contribution amounts may be as little as $20 per month, up to $15,000 annually, for tax year 2006. Participants who are age 50 and older will be allowed an additional "catch-up" amount for a total contribution of $20,000 for tax year 2006.

Investment Choices

There are a variety of funds in which to invest from which participants can easily customize an investment strategy. Individuals decide how much and where to invest the money deferred. Money may be exchanged between funds once per calendar quarter at no charge. Additional exchanges cost $10 per transaction.

Cost of Participation

By State statute, the Plan must be administered so there are no expenses to the State. That is, all costs must be borne by the participants. An administrative fee is charged to participants to cover expenses such as recordkeeping, consultant projects, staff payroll, plan materials and mailing costs. The annual charge to participants is 0.15% of account balances with a maximum fee of $35 for calendar year 2006.

Distribution

There are specific distribution events:

- Money may be withdrawn at retirement or termination of employment with the State of Illinois, regardless of age. At that time, only federal taxes are payable. There are several distribution options from which to choose, including lump sum and installment payouts.
- Money may be withdrawn from the account prior to retirement or termination of employment only in the event of a severe financial hardship.
- Upon death of the plan participant, the account is paid to the named beneficiary(ies).

For More Information

Contact the Deferred Compensation Division or the Agency Liaison for additional information. See page 32 for the Deferred Compensation Plan Administrator.

Commuter Savings Program (CSP)

The Commuter Savings Program (CSP) is an optional benefit that gives eligible employees the opportunity to use tax-free dollars to pay out-of-pocket, work-related commuting and/or parking expenses. This benefit allows employees to lower their taxable income and increase disposable income. There is no specific enrollment period. State employees may enroll, cancel or change deductions at any time.

Full-time and part-time employees (working 50% or greater) who have payroll checks processed through the Office of the Comptroller are eligible. Deductions are made before federal, state and social security taxes are withheld.

Eligible employees may elect a monthly pre-tax deduction up to:

- $105 for bus or train transit passes or vanpooling expenses incurred for work-related commuting costs. The transit media selected is conveniently mailed directly to the participant's home before the beginning of the month.

- $205 for work-related parking expenses. The parking provider may be paid directly, or the participant may be reimbursed by submitting a claim form and proof of services to the CSP Plan Administrator.

Benefits for elections made by the 10th of any month will be effective the following month. Payroll deductions will coincide with the first pay period of the benefit month. For example, a selection made on or before February 10th would begin in March; therefore, the first payroll deduction would be taken from the March 1st – 15th pay period for a semi-monthly employee.

To enroll, change or cancel a deduction, employees should contact the plan administrator indicated on the Benefits website at **www.benefitschoice.il.gov**.

Support for Employees and their Families

The Employee Assistance Program (EAP) provides a valuable resource for support and information during difficult times. The EAP is a free, voluntary and confidential program that provides problem identification, counseling and referral services for employees and their covered dependents regardless of the health plan chosen. Employees will be directed to counseling services to assist them with a variety of concerns. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed unless written consent is given. Management consultation is available when an employee's personal problems are causing a decline in work performance. Critical Incident Stress Management is also available through the EAP. For further information regarding the EAP, refer to pages 123-124 of the Benefits Handbook.

Eligibility

- Active employees and their eligible dependents participating in the State Employees Group Insurance Program may access this benefit.

- Active employees, full time and part time (50% or greater), who have elected not to participate in the health, dental and vision coverage of the State Employees Group Insurance Program may access this benefit.

Accessing Services

There are two separate Employee Assistance Programs for active employees, EAP through the Behavioral Health Administrator, Magellan, and the Personal Support Program (PSP) through AFSCME Council 31. See page 33 for plan administrator and website information.

- Active employees **not** represented by the collective bargaining agreement between the State and AFSCME must contact Magellan Behavioral Health. Getting help is easy, convenient and available 24 hours a days, seven days a week.

- Bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME must access EAP services through the Personal Support Program.

NOTICE OF CREDITABLE COVERAGE

Prescription Drug Information for State of Illinois Medicare Eligible Plan Participants

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

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop your entire group coverage through the State Employees Group Insurance Program and do not enroll in a Medicare Part D Plan after your existing group coverage ends, 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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

How We May Use or Disclose Your PHI:

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

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

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

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

Legal Requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights:

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

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

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

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

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

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

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

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

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

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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan Administrator	**EyeMed** Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com
Life Insurance Plan Administrator	**Minnesota Life Insurance Company** 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
Long-Term Care (LTC) Insurance	**MetLife**	(800) 438-6388 (800) 638-1004 (TDD/TTY)	
Deferred Compensation Program	**CMS Deferred Compensation Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(800) 442-1300 (800) 526-0844 (TDD/TTY)	www.state.il.us/cms/ employee/defcom
Flexible Spending Accounts (FSA) Program Plan Administrator	**Fringe Benefits Management Company** P.O. Box 1800 Tallahassee, FL 32302-1800	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax)	www.fbmc-benefits.com
Commuter Savings Program (CSP)	See website	See website	www.benefitschoice.il.gov
Health/Dental Plans, Medicare COB Unit, FSA Unit, Special Payment Programs Unit, Life Insurance, Adoption and Smoking Cessation Benefits	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits	**CIGNA** Group Number 3181456 **CIGNA HealthCare** P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of $800 applies	**Intracorp, Inc.**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator QCHP (1400SD3) Health Alliance Illinois (1400SBS) OSF Winnebago (1400SCE) HealthLink OAP (1400SCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Medco** Group Number: 1400SD3, 1400SBS, 1400SCE, 1400SCF **Paper Claims:** Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
QCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	**Magellan Behavioral Health** Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services, ID cards	**Magellan Behavioral Health** -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Personal Support Program (PSP – AFSCME EAP)	Confidential assessment and assistance services	**AFSCME Council 31** -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) www.afscme31.org
Quality Care Dental Plan (QCDP) Administrator	Dental services, claim filing and ID cards	**CompBenefits** Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1699 (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.

Notes

BENEFIT CHOICE ELECTION FORM

May 1 – 31, 2006 (Changes effective July 1, 2006)

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: OPT OUT / OPT IN

OPT OUT/OPT IN of Health & Dental		
☐ Opt Out	☐ Opt In	**See Section B for requirements (on back)**

SECTION C: HEALTH PLAN ELECTIONS (complete only if CHANGING your health plan)

Health Plan Election *	If Managed Care is selected you must complete the information below. Go to the provider's website to find the physician's PCP or NPI number. See the instruction sheet for more information.
Elect One:	PCP or NPI # _____ (maximum 10 digits)
Quality Care Health Plan (QCHP) ☐	Carrier Code _____ (2 alpha characters – see page 14))
~ Or ~	Plan Name _____
Managed Care: ☐ HMO or ☐ OAP	

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

SECTION D: DENTAL PLAN OPTION

Dental Plan Option	
I choose not to participate in the dental plan ☐	I choose to re-enroll in the dental plan ☐

SECTION E: OPTIONAL LIFE INSURANCE (complete only if CHANGING life coverage elections)

OPTIONAL LIFE	☐ INCREASE [2]	☐ DECREASE	☐ CANCEL	AD&D	
☐ 1 x Basic	☐ 3 x Basic	☐ 5 x Basic	☐ 7 x Basic	☐ CANCEL AD&D	☐ BASIC only (Basic)
☐ 2 x Basic	☐ 4 x Basic	☐ 6 x Basic	☐ 8 x Basic		☐ COMBINED (Basic + Optional Life)

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

A (Add) / D (Drop) / C (Change)					Name	SSN	Birth Date	Relationship[3]	PCP/NPI
HEALTH			LIFE [2]						
A	D	C	A	D					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					

Notes:
[1] Documentation required to add dependents – see specific documentation requirements on the back of this form.
[2] Statement of Health form required when increasing Optional Life or adding Spouse or Child Life (form available at www.benefitschoice.il.gov).
[3] Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

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

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office by May 31, 2006.

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 – OPT OUT / OPT IN
If you wish to opt out or opt in to the State Employees Group Insurance Program you must complete the 'Opt Out/Opt In' portion of Section B and submit an 'Opt Out/Opt In Election Certificate' to your agency/university Group Insurance Representative (GIR). The form is available through your agency GIR or online at www.benefitschoice.il.gov.

SECTION C – HEALTH PLAN ELECTIONS
Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your carrier directly in order to make this change.
If you wish to change your **health** plan, you must check either the Quality Care Health Plan (QCHP) or one of the managed care plan boxes (HMO or OAP). If electing/changing managed care plans, you must enter the managed care plan's carrier code (see page 14 for carrier codes), the plan's name and the Primary Care Physician (PCP) number or National Provider Identifier (NPI). The PCP or NPI number may be found in the online directory on the individual plan's website (see page 32 for managed care plan administrator contact information).

SECTION D – DENTAL PLAN OPTION
If you wish not to participate in the **dental** plan you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you waive dental coverage, you can re-enroll **only** during the annual Benefit Choice election period.

SECTION E – OPTIONAL LIFE INSURANCE
Complete this section if you wish to add/drop/increase or decrease Optional Life[1] or Accidental Death and Dismemberment (AD&D) coverage. Note: Optional Life Coverage subject to $3,000,000 maximum (basic + optional life). AD&D Combined maximum is 5 times the employee salary (basic plus 4 times optional coverage).

SECTION F – DEPENDENT INFORMATION
Complete this section if you are adding, dropping or changing your dependent health or life[1] coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below**:

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

[1] If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to ***Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701***. The Statement of Health application is available at www.benefitschoice.il.gov or through your agency GIR.

SIGNATURE
You must sign and date the Benefit Choice Election Form and give to your agency GIR by **May 31, 2006** in order for your elections to be effective July 1, 2006. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period.

If documentation is not provided within the 10 days your dependents will not be added.

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

Address Service Requested

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