



# *Benefit Choice Options*



 *Your Benefits  
for Good Health*

## *Teachers' Retirement Insurance Program*

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

# **Benefit Choice is May 1 - May 31, 2007**

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

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

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

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

**It is each Benefit Recipient's responsibility to know plan benefits and make an informed decision regarding coverage elections. See page 9 of the Benefits Handbook for a list of your responsibilities.**

Please carefully review all the information in this Benefit Choice Options booklet. Benefit Recipients should review this publication each year to be aware of benefit changes.

**Benefits Handbook Amendment** – Effective this year, the Benefits Handbook will be updated via an amendment contained within the annual Benefit Choice Options booklet. Please tear out pages 3-4 of this booklet and keep with your current Benefits Handbook (dated 2007).

## BENEFIT CHOICE PERIOD IS MAY 1-31, 2007

The Benefit Choice Period is **May 1 through May 31, 2007** for all Benefit Recipients. Elections will be effective July 1, 2007. 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. Any Benefit Recipient or Dependent Beneficiary who was previously covered under TRIP and terminated coverage, may re-enroll only when they or their dependent turns age 65, becomes eligible for Medicare or when coverage is involuntarily terminated by a former plan. Before making changes, compare:

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

There are three health benefit coverage options available:

- Health Maintenance Organizations (HMOs)
- Open Access Plan (OAP)
- Teachers' Choice Health Plan (TCHP)

See pages 6-11 to review the features for each type of plan.

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

### **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.

## IMPORTANT REMINDERS

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

**Transition of Services:** When electing a new health plan during the Benefit Choice Period, plan participants involved in an ongoing course of treatment or who have entered the third trimester of pregnancy, should contact the new plan to coordinate the transition of services and providers for care.

**COBRA Participants:** During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other Benefit Recipients. Please contact TRS for information.

# Benefits Handbook Amendment

**This document is Amendment I to your Benefits Handbook.**

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

1. **Open Access Plan (OAP)**
2. **TCHP Prescription Drugs**
3. **Mail Order Pharmacy**
4. **TCHP Exclusions and Limitations**

## **AMENDMENT TO THE TEACHERS' RETIREMENT INSURANCE PROGRAM (TRIP)**

The following is an amendment to the 2007 TRIP Benefits Handbook for TRIP members, retirees and survivors. Please review this document carefully and keep it with your Benefits Handbook for future reference.

1. *On page 29 under Open Access Plan (OAP), the following bullet point is added:*

- Tier II and Tier III out-of-pocket maximums cross accumulate.

2. *On page 59 under Prescription Drugs, the following bullets replace the last bullet in this section:*

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

3. *On page 67 under Mail Order Pharmacy, replace the entire section with the paragraph below:*

### **Mail Order Pharmacy**

The mail order pharmacy provides up to a 90-day supply of medication at 20% coinsurance with minimum and maximum Co-payments. See the current Benefit Choice Options booklet for Coinsurance and minimum and maximum Co-payment amounts for each category. To receive a 61 to 90-day supply of medication, obtain an original prescription from the attending physician written for a 61 to 90-day supply, plus up to three refills, totaling one year of medication. Complete the mail order form, attach the original prescription and mail to the Prescription Drug Plan Administrator's mail order pharmacy. The mail order form can be found on the plan administrator's website listed in the annual Benefit Choice booklet.

4. *On page 75 under TCHP – Exclusions and Limitations, the following point is added:*

42. For treatment and services rendered in a setting other than direct patient-provider contact.

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

**REMEMBER: KEEP THIS NOTICE**

# MONTHLY HEALTH PREMIUMS

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          |
| <b>Benefit Recipient</b> enrolled in any managed care plan   | \$53.78              | \$167.01             | \$227.54             | \$66.00           |
| <b>Benefit Recipient</b> enrolled in TCHP when a managed care plan is available in their county of residence         | \$139.54             | \$393.84             | \$592.31             | \$171.85          |
| <b>Benefit Recipient</b> enrolled in TCHP when a managed care plan is not available in their county of residence     | \$69.77              | \$196.92             | \$296.16             | \$85.92           |
| <b>Dependent Beneficiary</b> enrolled in any managed care plan   | \$215.14             | \$668.03             | \$910.16             | \$240.09**        |
| <b>Dependent Beneficiary</b> enrolled in TCHP when a managed care plan is available in their county of residence     | \$279.09             | \$787.68             | \$1,184.62           | \$343.70          |
| <b>Dependent Beneficiary</b> enrolled in TCHP when a managed care plan is not available in their county of residence | \$279.09             | \$787.68             | \$1,184.62           | \$257.78**        |

\* 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 page 16 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.

## MANAGED CARE PLANS

There are 7 managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks. Some managed care health plans may be accessible to Benefit Recipients who reside in certain areas contiguous to Illinois. Please contact the managed care plan directly for information regarding availability.

### Health Maintenance Organizations (HMOs)

Benefit Recipients 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 Benefit Recipient pays only a co-payment. No annual plan deductibles apply. The minimum level of HMO coverage provided by all plans is described on page 8. 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 Benefit Recipients 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. Benefit Recipients enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 9.

## IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

**Provider Network Changes:** Managed care plan provider networks are subject to change. Benefit Recipients 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 plan participant's PCP leaves the managed care plan's network, the Benefit Recipient has three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Teachers' Choice Health Plan. The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

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

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



# HMO BENEFITS

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

| <b>HMO Plan Design</b>  |  |
|---|--|
| Plan year maximum benefit   | Unlimited  |
| Lifetime maximum benefit  | Unlimited  |
| <b>Hospital Services</b>  |  |
| Inpatient hospitalization   | 100% after \$150 co-payment per admission  |
| Alcohol and substance abuse<br>(maximum number of days determined by the plan)      | 100% after \$150 co-payment per admission  |
| Psychiatric admission<br>(maximum number of days determined by plan)                | 100% after \$150 co-payment per admission  |
| Outpatient surgery  | 100%   |
| Diagnostic lab and x-ray  | 100%   |
| Emergency room hospital services  | 100% after \$100 co-payment per visit  |
| <b>Professional and Other Services</b>  |  |
| Office visit<br>(including physical exams and immunizations)                        | 100% after \$10 co-payment per visit   |
| Psychiatric care<br>(maximum number of days determined by the plan)                 | 100% of the cost after a \$10 co-payment per visit   |
| Alcohol and substance abuse care<br>(maximum number of days determined by the plan) | 100% of the cost after a \$10 co-payment per visit   |
| Prescription drugs<br>(formulary is subject to change during plan year)             | \$7 co-payment for generic<br>\$14 co-payment for preferred brand<br>\$28 co-payment for non-preferred brand |
| Durable Medical Equipment   | 80% of network charges   |

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



# 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 **nationwide TCHP network (formerly the PPO network)** consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail pharmacy network) and behavioral health services (Magellan behavioral health network).

Notification to Intracorp, the TCHP notification administrator, is required for certain medical services in order to avoid penalties. Refer to pages 46-47 of the Benefits Handbook, or contact Intracorp at (800) 962-0051, for direction.

Plan participants can access plan benefit and participating TCHP 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](http://www.benefitschoice.il.gov).

## Plan Year Maximums and Deductibles

|  |   |
|--|---|
| Lifetime Maximum   | \$2,000,000   |
| Plan Year Deductible   | \$350 TCHP Primary Participant (Non-Medicare)<br>\$350 Medicare Primary Participant   |
| Additional Deductibles*<br><b>* These are in addition to the plan year deductible.</b> | Each emergency room visit      \$250<br>Non-TCHP hospital admission    \$250<br>Transplant deductible            \$100<br><b>Note: There is no additional deductible for admission to a TCHP network hospital</b> |

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

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

# TCHP - MEDICAL PLAN COVERAGE

| Hospital Services  |  |
|--|--|
| TCHP Network Hospitals<br>(formerly PPO Network Hospitals)   | 80% after annual plan deductible.<br>No admission deductible.  |
| Non-TCHP Hospitals<br>(formerly Non-PPO Hospitals)   | <ul style="list-style-type: none"> <li>\$250 per admission deductible.</li> <li>If the Benefit Recipient resides in Illinois or within 25 miles of a TCHP network hospital and they choose to use a non-TCHP and/or voluntarily travel in excess of 25 miles when a TCHP network hospital is available within the same travel distance, the plan pays 60% after the annual plan deductible.</li> <li>If the Benefit Recipient resides in Illinois and has no TCHP network hospital available within 25 miles and voluntarily chooses to travel further than the nearest TCHP network hospital, the plan pays 60% after the annual plan deductible.</li> <li>If the Benefit Recipient does not reside in Illinois or within 25 miles of a TCHP network hospital, the plan pays 70% after the annual plan deductible.</li> </ul> |
| Outpatient Services  |  |
| Lab/X-ray  | 80% of Usual & Customary (U&C) after annual 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<br>(formerly the PPO Network)   | 80% of negotiated fee after the annual plan deductible. U&C charges do not apply.  |
| Physician and Surgeon Services not included in TCHP's Network  | 60% of U&C after the annual plan deductible for inpatient, outpatient and office visits.   |
| Chiropractic Services - medical necessity required (limit of \$1,000 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 \$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.  |
| Behavioral Health Services   |  |
| Magellan administers the TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see page 69 of the Benefits Handbook or call Magellan at (800) 513-2611. |  |

**TCHP 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 TRIP 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. TCHP has separate minimum and maximum co-payments/coinsurance amounts that apply.

### PRESCRIPTION DRUG CO-PAYS FOR ALL MANAGED CARE PLANS

|                                   |      |
|-----------------------------------|------|
| Generic                           | \$7  |
| Preferred Brand (Formulary Brand) | \$14 |
| Non-Preferred Brand               | \$28 |

### PRESCRIPTION DRUG CO-PAYS/COINSURANCE FOR TCHP

|                                   | Minimum | Maximum |
|-----------------------------------|---------|---------|
| Generic                           | \$7     | \$50    |
| Preferred Brand (Formulary Brand) | \$14    | \$100   |
| Non-Preferred Brand               | \$28    | \$150   |

- Annual prescription drug out-of-pocket maximum of \$1250 applies.
- After meeting the \$1250 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 (1-30 day supply).
- 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.

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

Coverage for specific drugs may vary depending upon the health plan. To compare formulary lists (preferred drug lists), cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan.

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

## MANAGED CARE PLAN PRESCRIPTION DRUG BENEFIT

**Health Alliance HMO, HMO Illinois, OSF HealthPlans, PersonalCare and Unicare HMO** all administer prescription drug benefits through the respective health plan. Participants who elect one of these plans must utilize a pharmacy participating in the health plan’s pharmacy network or the full retail cost of the medication will be charged. It should be noted that no over-the-counter drugs are covered, even if purchased with a prescription. **Plan participants should direct prescription benefit questions to the respective health plan administrator.**

# MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT

**Health Alliance Illinois, HealthLink OAP and the Teachers' Choice Health Plan (TCHP)** have prescription benefits administered through the Prescription Benefit Manager (PBM), Medco. In order to receive the best value, plan participants enrolled in one of the Medco-administered health plans should carefully review the various prescription networks outlined below. Most drugs purchased with a prescription are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Participants receiving a drug costing less than the minimum co-payment will be charged the cost of the drug.

**Note for TCHP:** Prescription drug benefits of plan participants enrolled in the Teachers' Choice Health Plan (TCHP) are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums. A separate annual prescription in-network out-of-pocket maximum of \$1,250 applies. After meeting the \$1,250 out-of-pocket maximum, in-network prescriptions are covered at 100%. 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 appropriate co-payment/coinsurance amount. The cost difference does not apply to the \$1,250 annual prescription out-of-pocket maximum.

## **In-Network Pharmacy**

Retail pharmacies that contract with Medco and accept the co-payment or coinsurance amounts for prescriptions are referred to as in-network pharmacies. The maximum supply allowed at one fill is 60 days, although two co-payments/coinsurance amounts 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](http://www.benefitschoice.il.gov) or by calling Medco at (800) 899-2587.

## **Out-of-Network Pharmacy**

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

## **Mail Order Pharmacy**

The Mail Order Pharmacy provides participants the opportunity to receive medications directly from Medco. 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](http://www.medco.com). Order forms are also available on the Benefits website.

## 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><b>For the Medical Plan Administrator and Notification/Medical Case Management:</b><br/>CIGNA HealthCare, Privacy Office<br/>P.O. Box 5400<br/>Scranton, PA 18503<br/>800-762-9940</p> | <p><b>For Pharmacy Benefits:</b><br/>Medco Health Solutions, Privacy Services Unit<br/>P.O. Box 800<br/>Franklin Lakes, NJ 07417<br/>800-987-5237</p> |
| <p><b>For Behavioral Health Benefits:</b><br/>Magellan Behavioral Health, Privacy Officer<br/>1301 E. Collins Blvd.<br/>Suite 100<br/>Richardson, TX 75081<br/>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, 2006**

## WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

| Plan Component  | Administrator's Name and Address  | Customer Service Phone Numbers                               | Website Address  |
|---|---|--|--|
| <b>Health Plans and the Medicare COB Unit</b>         | <b>CMS Group Insurance Division</b><br>201 East Madison Street<br>P.O. Box 19208<br>Springfield, IL<br>62794-9208   | (217) 782-2548<br>(800) 442-1300<br>(800) 526-0844 (TDD/TTY) | <a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a> |
| <b>General Eligibility and Enrollment Information</b> | <b>Teachers' Retirement System (TRS)</b><br>2815 West Washington<br>P.O. Box 19253<br>Springfield, IL<br>62794-9253 | (800) 877-7896<br>(217) 753-0329 (TDD/TTY)                   | <a href="http://trs.illinois.gov">trs.illinois.gov</a>                   |

# WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

| Plan Component  | Contact For:   | Administrator's Name and Address  | Customer Service Contact Information   |
|---|--|---|--|
| <b>Teachers' Choice Health Plan (TCHP) Medical Plan Administrator</b>   | Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits | <b>CIGNA</b><br>Group Number 2457482<br><b>CIGNA HealthCare</b><br>P.O. Box 5200<br>Scranton, PA 18505-5200   | (800) 962-0051 (nationwide)<br>(800) 526-0844 (TDD/TTY)<br><a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a> |
| <b>TCHP Notification and Medical Case Management Administrator</b>  | Notification prior to hospital services<br><br>Non-compliance penalty of \$1,000 applies   | <b>Intracorp, Inc.</b>  | (800) 962-0051 (nationwide)<br>(800) 526-0844 (TDD/TTY)<br><a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a> |
| <b>Prescription Drug Plan Administrator</b><br><br>TCHP (1402TD3)<br><br>Health Alliance Illinois (1402TBS)<br><br>HealthLink OAP (1402TCF) | Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing           | <b>Medco</b><br>Group Number: 1402TD3, 1402TBS, 1402TCF<br><b>Paper Claims:</b><br>Medco Health Solutions<br>P.O. Box 14711<br>Lexington, KY 40512<br><br><b>Mail Order Prescriptions:</b><br>Medco<br>P.O. Box 30493<br>Tampa, FL 33630-3493 | (800) 899-2587 (nationwide)<br><br>(800) 759-1089 (TDD/TTY)<br><br><a href="http://www.medco.com">www.medco.com</a>  |
| <b>TCHP Behavioral Health Administrator</b>   | Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services                              | <b>Magellan Behavioral Health</b><br>Group Number 2457482<br>P.O. Box 2216<br>Maryland Heights, MO 63043  | (800) 513-2611 (nationwide)<br>(800) 526-0844 (TDD/TTY)<br><a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>  |

## 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**

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