



Benefit Choice Options



Teachers' Retirement Insurance Program

Enrollment Period, May 1 – 31, 2008 • Effective July 1, 2008 – June 30, 2009

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BENEFIT CHOICE PERIOD IS MAY 1-31, 2008

The Benefit Choice Period is **May 1 through May 31, 2008** for all Benefit Recipients. Elections will be effective July 1, 2008. 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) – administered by HealthLink
- Teachers' Choice Health Plan (TCHP) – administered by CIGNA

See pages 6-9 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 CHANGES FOR PLAN YEAR 2009 (July 1, 2008 through June 30, 2009)

HMO Changes

- Physician office visit co-payment increases to \$15
- Specialist office visit co-payment increases to \$15
- Behavioral health office visit co-payment increases to \$20
- Inpatient hospital, including behavioral health, co-payment increases to \$250
- Outpatient surgery co-payment is \$150
- Prescription co-payments are \$10/\$20/\$40
- Emergency room visit co-payment increases to \$200

Teachers' Choice Health Plan (TCHP) Changes

- Plan year deductible for Medicare and Non-Medicare Primary Participants increases to \$500
- In-network, out-of-pocket maximum (family) is \$2,750
- Out-of-network, out-of-pocket maximum (individual) increases to \$4,400
- Out-of-network, out-of-pocket maximum (family) is \$8,800
- Inpatient hospital deductible, includes transplants, (in-network) increases to \$200
- Inpatient hospital deductible (out-of-network) increases to \$400
- Inpatient hospital coinsurance (out-of-network) is 60%
- Lab and X-ray (out-of-network) is 60% of U&C
- Emergency room visit deductible increases to \$400
- Prescription out-of-pocket maximum increases to \$1,500
- Chiropractic visits limited to 30 per plan year

Open Access Plan (OAP) – administered by HealthLink

There are significant changes within the benefit structure of Tier I, Tier II and Tier III. Refer to page 7 for specific details.

PARTICIPANT RESPONSIBILITIES

It is each participant's responsibility to know plan benefits and make an informed decision regarding coverage elections. Notify the Teachers' Retirement System (TRS) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
 - birth/adoption of a child;
 - marriage, divorce, legal separation, annulment;
 - death of spouse or dependent;
 - dependent(s) loss of eligibility;
 - a court order results in the gain or loss of a dependent;
 - a change in Public Aid recipient status;
 - dependent becomes covered by other group health coverage.
- Change in Medicare status
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their Coordination of Benefits (COB) information to TRS as soon as possible.

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

- Current health plan information
- Current prescription formulary lists which are subject to change without notice
- Current provider networks

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
Benefit Recipient enrolled in any managed care plan	\$56.47	\$175.36	\$238.92	\$69.30
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	\$146.52	\$413.53	\$621.93	\$180.44
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	\$73.26	\$206.77	\$310.97	\$90.22
Dependent Beneficiary enrolled in any managed care plan	\$225.90	\$701.43	\$955.67	\$252.09**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	\$293.04	\$827.06	\$1,243.85	\$360.89
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	\$293.04	\$827.06	\$1,243.85	\$270.67**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See page 12 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.

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 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	\$10
Preferred Brand (Formulary Brand)	\$20
Non-Preferred Brand	\$40

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 \$1,500 applies.
- After meeting the \$1,500 out-of-pocket maximum, prescriptions are covered at 100%.
- Out-of-network claims do not count toward this annual out-of-pocket maximum.
- 20% coinsurance with minimum and maximum co-payments (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.

When the pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic co-payment.

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 PLANS IN ILLINOIS COUNTIES

TRIP MANAGED CARE HEALTH PLANS FOR FISCAL YEAR 2009

- Managed Care Available
- Managed Care Partially Available

If a two-letter code appears in a shaded county, a managed care provider may be available. Contact the plan for information.

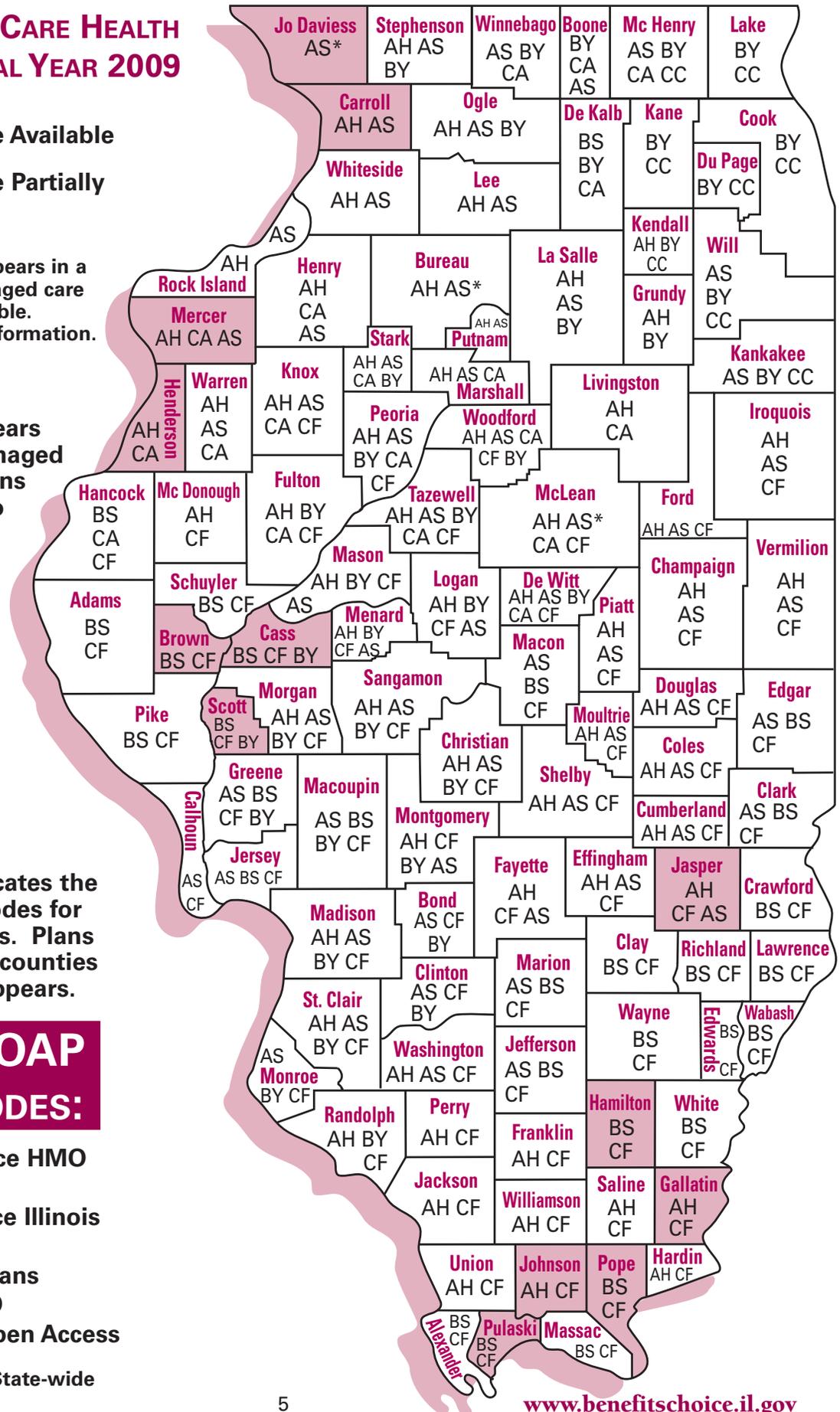
* If an asterisk appears by one of the managed care plans, it means the plan is new to that county.

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

HMO AND OAP CARRIER CODES:

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

Note: TCHP available State-wide



HMO BENEFITS

Members must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the member pays only a co-payment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after \$250 co-payment per admission
Alcohol and substance abuse (maximum number of days determined by the plan)	100% after \$250 co-payment per admission
Psychiatric admission (maximum number of days determined by plan)	100% after \$250 co-payment per admission
Outpatient surgery	100% after \$150 co-payment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after the lesser of \$200 co-payment per visit, or 50% of U&C
Professional and Other Services	
Physician Office visit (including physical exams and immunizations)	100% after \$15 co-payment per visit
Specialist office visit	100% after \$15 co-payment per visit
Psychiatric care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Alcohol and substance abuse care (maximum number of days determined by the plan)	100% of the cost after a 20% or \$20 co-payment per visit
Prescription drugs (formulary is subject to change during plan year)	\$10 co-payment for generic \$20 co-payment for preferred brand \$40 co-payment for non-preferred brand
Durable Medical Equipment	80% of network charges
Home Health Care	100% after \$15 co-payment per visit

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

OPEN ACCESS PLAN (OAP) BENEFITS

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with pre-determined co-payments. Tier III (out-of-network) offers members flexibility in selecting healthcare providers with higher out-of-pocket costs. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of care providers. Members enrolled in the OAP can mix and match providers. The benefits described below represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact HealthLink for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	\$0 \$0	\$700 \$1,400	\$1,700 \$3,600
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*
Hospital Services			
Inpatient	100% after \$250 co-payment per admission	80% of network charges after \$300 co-payment per admission	60% of U&C after \$400 co-payment per admission
Inpatient Psychiatric	100% after \$250 co-payment per admission, up to 30 days per plan year	80% of network charges after \$300 co-payment per admission up to 30 days per plan year	60% of U&C after \$400 co-payment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	100% after \$250 co-payment per admission, up to 10 days rehabilitation per plan year	80% of network charges after \$300 co-payment per admission up to 10 days rehabilitation per plan year	60% of U&C after \$400 co-payment per admission, up to 10 days rehabilitation per plan year
Emergency Room	100% after \$200 co-payment per visit	80% of network charges after \$200 co-payment per visit	60% of U&C after lesser of \$200 co-payment per visit, or 50% of U&C
Outpatient Surgery	100% after \$150 co-payment	80% of network charges after \$150 co-payment	60% of U&C after \$150 co-payment
Outpatient Psychiatric and Substance Abuse	100% after \$20 co-payment, up to 30 visits per plan year	80% of network charges after \$20 co-payment, up to 30 visits per plan year	60% of U&C after \$20 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C
Physician and Other Professional Services			
Physician Office Visits	100% after \$15 co-payment	80% of network charges after \$15 co-payment	60% of U&C
Specialist Office Visits	100% after \$15 co-payment	80% of network charges after \$15 co-payment	60% of U&C
Preventive Services, including immunizations, Well Baby care, allergy testing and treatment	100% after \$15 co-payment	80% of network charges after \$15 co-payment	Covered under Tier I and Tier II only
Other Services			
Prescription Drugs – Covered through State of Illinois administered plan, Medco			
	Generic \$10	Preferred Brand \$20	Non-Preferred Brand \$40
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 co-payment	80% of network charges after \$15 co-payment	Covered under Tier I and Tier II only

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

THE TEACHERS' CHOICE HEALTH PLAN (TCHP)

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

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

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

Plan Year Maximums and Deductibles

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

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. 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 network hospital charges. Coinsurance and deductibles apply to one or the other, but not both.

General: \$1,200 per individual \$2,750 per family per plan year	Non-TCHP Hospital: \$4,400 per individual \$8,800 per family per plan year
<p>The following do not apply toward out-of-pocket maximums:</p> <ul style="list-style-type: none"> • Prescription Drug benefits, coinsurance 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. 	

TCHP - MEDICAL PLAN COVERAGE

Hospital Services	
TCHP Network Hospitals	80% after annual plan deductible. \$200 per admission deductible.
Non-TCHP Hospitals	60% after annual plan deductible. \$400 per admission deductible.
Outpatient Services	
Lab/X-ray	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Licensed Ambulatory Surgical Treatment Centers	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Professional and Other Services	
TCHP Physician Network	80% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in the TCHP Network	60% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services - medical necessity required (limit of 30 visits per plan year)	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after inpatient deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
Behavioral Health Services	
Magellan administers the TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see page 69 of the Benefits Handbook or call Magellan at (800) 513-2611.	

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

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 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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

How We May Use or Disclose Your PHI:

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

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

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

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

Legal Requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights:

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

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

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

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

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

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

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

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

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

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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the program is maintained for the exclusive benefit of the Teachers' Retirement Insurance Program (TRIP) Benefit Recipients. TRIP reserves the right to change any of the benefits and contributions described in this Benefit Choice Options booklet. This booklet is produced annually and is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options booklet, the Benefits Handbook and state or federal law, the law will control.

**Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
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