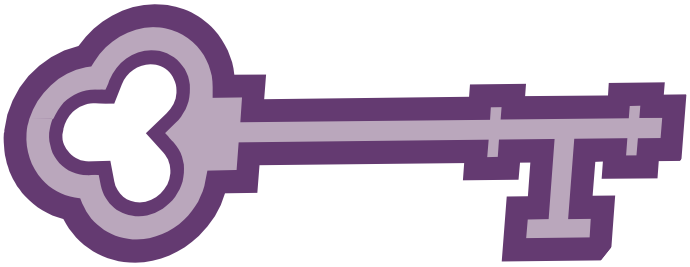
Benefit Choice Options

The Key to Understanding Your Benefits



State of Illinois

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2003 - June 30, 2004

Rod R. Blagojevich, Governor
Michael M. Rumman, Director

Benefit Choice is
May 1-31, 2003

Important Changes For Fiscal Year 2004

The information below presents significant 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.** Members should review this publication each year to be aware of changes in the benefits available. Benefit Choice is May 1-31, 2003. All selections made during Benefit Choice will be effective July 1, 2003.

Changes that Impact All Members

Telephone Enrollment will not be available this plan year. If you need to make benefit changes, contact your agency Group Insurance Representative for information.

Life Changing Events - The Internal Revenue Service (IRS) has released updated information pertaining to the Irrevocability Rule and policy governing tax exempt Plans. If you have a life changing event such as marriage, divorce, etc. , contact your agency Group Insurance Representative to understand how your coverage may be impacted.

Health Insurance Portability and Accountability Act (HIPAA) - Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The Department of Central Management Services, Bureau of Benefits contracts with Business Associates (health plan administrators, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavorial health services and prescription drug benefits.

If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective plan administrator. If you are a plan participant in the QCHP, refer to page 26 for the Notice of Privacy Practices.

Public Act 92-0600 Opt Out - enables eligible Members to elect not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program if proof of other major medical coverage can be provided. See page 37.

Changes specific to Managed Care Plans (HMO/OAP)

Plans no longer available - Humana HMO and Humana POS are no longer available. If you are enrolled in one of these plans, you will need to enroll in another managed care plan or in the Quality Care Health Plan (QCHP). **If you do not make another plan selection before May 31, 2003, you will automatically be enrolled in QCHP effective July 1, 2003.** Information on the managed care plans will be mailed to your home. For details on plans in your area, see pages 14 and 15.

PersonalCare East is merging into PersonalCare. If you are currently enrolled in PersonalCare East and do not make another plan selection before May 31, 2003, you will be automatically enrolled in PersonalCare effective July 1, 2003.

Changes specific to the Quality Care Health Plan (QCHP)

The QCHP Hospital Preferred Provider Organizations - will include 228 hospitals statewide including 3 additions and 6 deletions of providers. Refer to pages 22 - 25 for a complete listing.

Changes specific to the Quality Care Dental Plan (QCDP)

QCDP has a new schedule of benefits effective July 1, 2003. **CompDent has changed their name to CompBenefits.** Refer to pages 30 to 36 for coverage levels.

Changes specific to the Qualified Transportation Benefit (QTB)

The IRS has increased the amount you may elect to contribute to the Parking Assistance Program (PAP) from $185 to $190 per month. See page 39 for details.

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The State offers its Members valuable programs...

Flexible Spending Account (FSA) Program

Enrolling in the FSA Program can save you tax dollars for out-of-pocket medical and dependent care expenses you and your eligible dependents incur during the plan year. The Program allows up to $5,000 to be set aside for one or both plans for a combined maximum of $10,000 (certain limitations may apply). Join the FSA Program today and start saving money. See the Benefits Handbook for more details or contact the FSA Unit listed on page 44.

Qualified Transportation Benefit (QTB) Program

The QTB Program can save you money on your eligible commuting and parking expenses. Contributions are conveniently payroll deducted. Transit passes are mailed directly to your home and parking providers can be paid directly. See page 39 for details.

Smoking Cessation Program

Members and dependents are eligible to receive a rebate towards the cost of an approved Smoking Cessation Program. The maximum rebate is $200 and is limited to one rebate per participant, per year. See your Benefits Handbook for details.

Adoption Benefit Program

State employees working full-time or not less than half-time are eligible for reimbursement of eligible adoption expenses. The adoption must be final before expenses are eligible for this benefit. See your Benefits Handbook for details.

Life Insurance Program

Term life insurance coverage is provided automatically by the State at no cost to active employees. Optional Life Insurance coverage is also available at low cost group rates to Members at their own expense. See your Benefits Handbook for more information.

Deferred Compensation Program

The Deferred Compensation Program is one way to save for the future while enjoying tax savings today. The 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 38 for more information.

Vision Care Benefit Plan

Annual eye examinations are an important part of your overall health, protecting your visual wellness and providing early detection of serious health conditions. **The vision plan provides coverage for an annual exam, plus lenses and a frame or contact lenses once every two years.** You may also coordinate your vision benefits with any other vision coverage you may have available to you. Contact Vision Service Plan (VSP) for details or visit their website at www.vsp.com.

Long-Term Care (LTC) Insurance

Did you know.....your chances of having a house fire are 1 in 1200? But, your chances of needing LTC are 1 in 2. Furthermore, over 40% of the individuals currently using LTC are under age 65. LTC Insurance can help pay expenses not covered by your health plan or disability insurance. To learn more about this valuable benefit, see page 40 .

COBRA

Established under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), eligible State of Illinois employees, their spouses and dependent children enrolled in a CMS-administered group health plan may purchase continued health and dental coverage if their state group health coverage terminates for specific reasons called “qualifying events.”
For detailed information regarding COBRA, see your Benefits Handbook or contact the COBRA Administration Unit at (800) 442-1300.

Member Responsibilities

It is each Member's responsibility to know the benefits. Read the information on the plan in which you are currently enrolled or in which you are considering enrolling.

If you are unsure if an event occurs that your Group Insurance Representative needs to know about, it is in your best interest to contact them for assistance.

Notify your Group Insurance Representative immediately when the following life changing events occur:

- You and/or your dependents have a change of address. Keep in mind you may need to contact the retirement system and the various programs you are enrolled in to advise them of the address change as well. These programs include the Qualified Transportation Benefit Program (QTB) and the Deferred Compensation Program.

- You experience life changing events that may impact eligibility for you or your dependent(s) such as:
  - birth/adoption of a child,
  - marriage, divorce, legal separation, annulment,
  - death of spouse or dependent,
  - an employment status change for you, your spouse or your 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 a Public Aid recipient status,
  - dependent becomes covered by other group health or dental coverage.

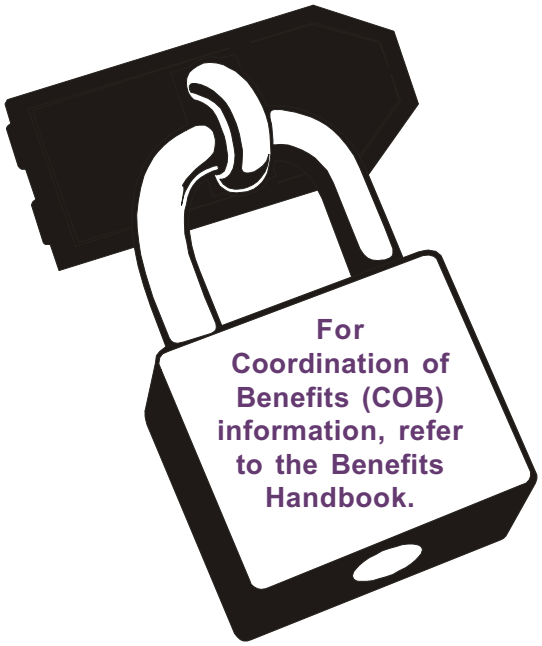
- You have other group insurance coverage, or gain other coverage during the plan year. Provide your Coordination of Benefit (COB) information to your Group Insurance Representative as soon as possible.

- You go on and/or return from a Leave of Absence.

- There is a change in Medicare status for you or your dependent(s).

To ensure that all information is up-to-date, Members should periodically review the following:

- Life insurance Beneficiary Form.
- Deferred Compensation Beneficiary Form.
- Annual Benefit Choice Booklet which details changes affecting all benefit programs each plan year.
- Health and dental information from plans you are currently enrolled in or are considering enrolling in.
- Prescription formulary list. **Remember:** Formularies are subject to change during the plan year without notice.
- Your payroll deductions to ensure they are accurate, based on the type(s) of coverage and programs you have enrolled in for the plan year including FSA, QTB, deferred compensation and health/dental/life premiums.



Benefit Choice Period is May 1-31, 2003

Benefit Choice Period is the time of year to review and/or make changes to your health, dental, and life benefit plans. Benefit Choice is the **only** time, other than a qualifying change in status, that members can change plans or add/drop dependent coverage (see State of Illinois Benefits Handbook). It is also the only time of year active (non-retired) members can enroll or re-enroll in the state's Flexible Spending Account (FSA) program. Eligibility information is available in your Benefits Handbook.

Benefit Choice runs from **May 1 through May 31, 2003.** The plan selections elected during this period will be in force for the plan year July 1, 2003 through June 30, 2004.

All Benefit Choice changes can be processed through your Group Insurance Representative (GIR). If you are unsure who your GIR is, contact your agency's personnel office. Members who do not anticipate making a health and/or dental plan change should carefully review plan coverages and benefits for possible changes. **Remember: There can be changes in your coverage even if you do not change plans. It is each member's responsibility to review this Benefit Choice Options Booklet in its entirety.**

Whether to consider a change in your benefit plan, or to simply compare your current plan to another, review the features below. They will help you determine the best healthcare choices for you and your family.

Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Premium costs and possible geographic limitations
- Healthcare provider selection process
- Prescription drug coverage

The Quality Care Health Plan (QCHP) is available regardless of your place of residence. Managed care plans have geographic and provider limitations. Members interested in a managed care plan should carefully review each plan's benefits, the service area map and county list on pages14 and 15 and the provider directories available from each plan. Specific questions regarding coverage should be directed to each respective plan administrator.

- **Managed Care Plans**
  HMO – Health Maintenance Organization
  OAP – Open Access Plan
- **Quality Care Health Plan**
  QCHP – a medical indemnity plan

For information specific to participating managed care plans, contact the individual plans listed on page 44. For detailed information on the QCHP, refer to your State of Illinois Benefits Handbook. **It is your responsibility to know your benefits.** Read all information on the plan in which you are currently enrolled or in which you are considering enrolling.

Frequently Asked Questions (FAQs) about Benefits

1) Who do I contact for more information about my benefits or to make changes to my existing coverage?

Contact the GIR at your employing agency, or your retirement system if you are retired or on a leave of absence and receiving disability benefits from a retirement system. Your personnel or payroll office can assist you in locating your GIR.

2) Do I get a new medical and prescription drug identification card every plan year?

Normally, the only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card, you may request a replacement card from your plan administrator listed on pages 44-45.

3) I know managed care plans have geographic limitations. Will I have to change plans if I move?

If your current plan is available at your new location, you will remain under that plan unless your Primary Care Physician (PCP) is not accessible to you. Your managed care plan determines whether you continue to be accessible. If your PCP is not accessible to you, you will need to select a new PCP or change plans. If you move out-of-state or out of the country, you will most likely have to enroll in the QCHP.

4) Is enrollment for my newborn for health coverage automatic?

Enrollment for a newborn is <u>not</u> automatic. To enroll a newborn, contact your GIR within 60 days of birth for coverage to be retroactive to birth. The newborn's birth certificate is required for enrollment.

5) What should I, or my dependent, do when we turn 65 and become eligible for Medicare?

Send a copy of the Medicare card to your retirement system if you are either retired or on a leave of absence and receiving disability benefits from a retirement system (i.e., SRS, SURS, or TRS). Active employees should send a copy of the Medicare card to their GIR (refer to your Benefits Handbook for Coordination of Benefits information).

6) I (or my dependent) have just become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD), but I am not yet 65 or retired. What should I do and how will this affect my coverage?

First, send a copy of your Medicare card to your GIR indicating whether you are receiving Medicare Disability or Medicare ESRD. Depending on the type of Medicare you are eligible for and the length of time you have been entitled to it, your State of Illinois coverage may or may not be your primary payer. If you have questions about the coordination of benefits process with Medicare, you can call the Group Insurance Division, Member Services Section at (217) 558-4486.

7) My address has changed. What should I do?

Contact your GIR as soon as possible to update your insurance records.

8) Under what circumstances must I notify my health plan before receiving services?

Notification is required for any hospital or skilled nursing admission, certain outpatient procedures, potential transplants, infertility treatments and maternity care (by the third month). See page 18 for more information.

Employee Monthly Health and Optional Life Premiums

Employee Health Contributions: While the state covers most of the cost of employee health coverage, employees also make monthly salary-based contributions for healthcare coverage. The higher the employee's salary, the higher the contribution. Salary-based contributions remain in effect until June 30, 2004 unless the employee retires, accepts a voluntary salary reduction, or returns to state employment at a different salary (this does not apply to employees returning to work from a leave of absence). Employees who enroll in a managed care plan will pay a lower monthly contribution. Employees who reside in Illinois but do not have managed care accessible should contact the CMS Group Insurance Division (see page 44).

Employee Annual Salary	Employee Monthly Health Contributions	
$27,300 & below	Managed Care: $27.00	Quality Care: $36.00
$27,301 - $41,200	Managed Care: $32.00	Quality Care: $41.00
$41,201 - $54,800	Managed Care: $34.50	Quality Care: $43.50
$54,801 - $68,600	Managed Care: $37.00	Quality Care: $46.00
$68,601 & above	Managed Care: $39.50	Quality Care: $48.50

Note: If you became a SERS/SURS annuitant/survivor on or after 1/1/98, or a TRS annuitant/survivor on or after 7/1/98, and have less than 20 years creditable service, you may be required to pay a percentage of the cost for your basic coverage. Call your retirement system for applicable premiums. SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7876.

Monthly Optional Term Life Insurance Rates

Member by Age	Monthly Rate per $1,000
Under 25	$0.05
Ages 25 - 29	0.06
Ages 30 - 34	0.08
Ages 35 - 39	0.09
Ages 40 - 44	0.10
Ages 45 - 49	0.15
Ages 50 - 54	0.26
Ages 55 - 59	0.48
Ages 60 - 64	0.75
Ages 65 - 69	1.42
Ages 70 - 74	2.54
Ages 75 - 79	3.57
Ages 80 - 84	4.25
Ages 85 - 89	5.25
Ages 90 and above	6.50
Accidental Death & Dismemberment	0.02
Spouse (for $5,000 coverage)	**$3.40**
Dependent Children (for $5,000 coverage)	**$0.26**

Personal Premium Summary

Employee Monthly Health Contribution: $_____
(see chart above)

Dependent Monthly Health Premium: $_____
(if insuring Dependents, see page 9)

Monthly Dental Premium: $_____
(applicable only if QCDP, see page 9)

Monthly Optional Term Life Insurance Rates: $_____
(see chart to left)

My Total Monthly Premium: $_____

Dependent Monthly Health and Dental Premiums

Monthly dependent premiums are **in addition** to employee health contributions. Dependents **must** be enrolled in the same plan as the Member under whom they are enrolled. **Medicare dependent premiums apply only if Medicare is PRIMARY for both Parts A and B.** If you are actively working, and you or your dependents are enrolled in Medicare, questions regarding whether Medicare is primary payer should be directed to your plan administrator. If you or your dependent(s) become eligible for Medicare, notify your GIR immediately or contact CMS Group Insurance Division (see page 44).

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
Quality Care Health Plan (Code: D3)	$150	$180	$ 96	$157
Health Alliance HMO (Code: AH)	$ 74	$ 113	$ 69	$ 113
Health Alliance Illinois (Code: BS)	$ 83	$125	$ 80	$125
HMO Illinois (Code: BY)	$ 63	$ 96	$ 59	$ 96
OSF Health Plan (Code: CA)	$ 72	$ 110	$ 69	$ 110
OSF Winnebago (Code: CE)	$ 87	$132	$ 84	$132
PersonalCare (Code: AS)	$ 72	$ 110	$ 68	$ 110
Unicare HMO (Code: CC)	$ 62	$ 93	$ 57	$ 93
HealthLink OAP (Code: CF)	$ 85	$129	$ 82	$129

Employees who reside in Illinois who enroll dependents, but are not accessible to managed care providers, should contact CMS Group Insurance Division (see page 44) for plan premium rates.

Dental Plan Name	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents	Retirees, Annuitants, Survivors and Dependents
Quality Care	$7.50	$12.50	$15.00	$0
Managed Care	$0	$0	$0	$0

Managed Care Plans

There are 8 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. Members considering managed care are urged to explore and research the various plans available to them.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Members select a Primary Care Physician (PCP) from the HMO's network of participating providers. In conjunction with the health plan, the PCP directs **all** healthcare services for the member, including visits to specialists and hospitalizations. When care is coordinated through the PCP, the member pays only a predetermined copayment. There are no annual plan deductibles for HMO plans. The minimum levels of coverage HMO plans are required to provide are described on page 11.

Open Access Plan (OAP)

The unique feature of the OAP is that there are three benefit levels as shown in the table on page 12. The program offers two managed care networks, a Tier I network and a Tier II network. In addition, Tier III benefits (out-of-network) are available, so you can have great flexibility in selecting care providers. The important thing to remember is the level of benefits you receive is determined by the selection of care providers.

The benefit level for hospitals, physicians and other services will be highest if you select a Tier I provider - often a 100% benefit after a copayment. The Tier II network is generally a 90% benefit. The Tier III benefits (out-of-network) is generally 80% of Usual &Customary (U&C). See the table on page 12 for more details. The plan provider directory contains separate listings of providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive. Another advantage of selecting the network providers is that they have met strict accreditation standards.

It is important to know that you can mix and match providers. For example, you can utilize a Tier II physician and receive care in a Tier I hospital. In this example, your physician claim would be payable under Tier II at a 90% benefit and the hospital would be paid at the Tier I 100% benefit.

In considering the OAP, compare all benefits to other options. There are important similarities and differences in benefits for prescription drug coverages and mental health/substance abuse services, as well as hospital, physician and other services.

HMO Benefits

The benefits described below represent the minimum level of coverage the HMO is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the HMO plan you select.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $150 copayment per admission
Alcohol and substance abuse* *(maximum number of days determined by the plan)*	100% after $150 copayment per admission
Psychiatric admission* *(maximum number of days determined by the plan)*	100% after $150 copayment per admission
Outpatient surgery	100%
Diagnostic lab & X-ray	100%
Emergency room hospital services	100% after $100 or 50% copayment, whichever is less
Professional and Other Services	
Physician visits *(including physical exams & immunizations)*	100%, $10 copayment may apply
Well Baby Care	100%
Psychiatric care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Alcohol and substance abuse care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Prescription drugs	$5 copayment, generic incentive and formulary restrictions may apply. Formulary is subject to change during the plan year.
Durable medical equipment	80%

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

Some HMOs may provide benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage the OAP is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your 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	 $0 $0	 $ 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 $150 copayment per admission	90% of network charges for covered services after $200 copayment per admission	80% of U&C for covered services after $300 copayment per admission
Inpatient Psychiatric	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $150 copayment per admission, up to 30 days per plan year	90% of U&C for covered services after $150 copayment 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 $150 copayment per admission, up to 10 days rehabilitation per plan year	90% of U&C for covered services after $150 copayment per admission, up to 10 days rehabilitation per plan year
Emergency Room	Full coverage after $100 copayment per admission	90% of network charges for covered services after $100 copayment per admission	80% of U&C for covered services after lesser of $100 copayment per admission, or 50% of U&C
Outpatient Surgery	Full coverage	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 $10 copayment, up to 30 visits per plan year	90% of U&C for covered charges after $10 copayment, up to 30 visits per plan year
Diagnostic Lab & 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 $10 copayment	90% of network charges for covered services	80% of U&C for covered services
Preventative Services, including Immunizations	Full coverage after $10 copayment	90% of network charges for covered services	Covered In-network only
Well Baby Care	Full coverage after $10 copayment	90% of network charges for covered services	Covered In-network only
Other Services			
Prescription Drugs - Covered in-network only through WellPoint Pharmacy Management • **Generic -** Full coverage after $5 copayment • **Brand -** Full coverage after $10 copayment • **Non-Formulary -** Full coverage after $25 copayment			
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

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

Important Reminders About Managed Care Plans

Provider Network Changes: Managed care plan provider networks are subject to change. Always call the respective plan to verify participation of particular providers - even if the information is printed in the plan's directory. The provider network is subject to change.

PCPs Leaving a Network: If your PCP leaves the managed care plan's network, you have 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 to **Primary Care Physicians only leaving the network.** It does not apply to specialists or women's healthcare providers who are not designated Primary Care Physicians.

Out-of-County Managed Care Plans: If you are interested in enrolling in a managed care plan that is not available in your county of residence, contact the plan directly for more information.

Dependents: Eligible dependents who live apart from the member's residence for any part of a plan year may be subject to limited service coverage. If you have such a dependent, it is critical to contact the managed care plan that you are considering to understand the plan's guidelines on this type of coverage.

June/July Hospitalizations: If you change health plans and you or your dependents are hospitalized in June, it is recommended you contact both your current plan/PCP and future plan/PCP well in advance.

Psychiatric/Substance Abuse Treatment: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Plan benefits may vary, but a minimum of 10 inpatient days and 20 outpatient visits are required. These are in addition to detoxification benefits which 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. Contact the respective managed care plan for specific information.

Plan Year Limitations: Certain managed care plans may provide benefit limitations on a **calendar year.** In certain situations, the State's plan year may not coincide with the managed care plan's year.

Transition of Services: If you know you are switching plans and you or your dependents are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, it is imperative that you contact the new plan to coordinate the transition of services for your care.

NCQA Accreditation and Managed Care Plans in Bordering States

One way the quality of managed care plans can be judged is through accreditation by an outside agency. **The National Committee for Quality Assurance (NCQA)** is a leader in accrediting managed care plans. The not-for-profit NCQA prides itself on providing purchasers and consumers of managed care with comparative data on plan quality and value.

The higher the level of the accreditation, the more closely the plan meets NCQA standards. Levels include:

Excellent: This highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA rigorous requirements for consumer protection and quality improvement. Plans earning this level must also achieve Health Plan Employer Data and Information Set (HEDIS) results, the highest range of national or regional performance.

Commendable: Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA requirements for consumer protection and quality improvement.

Accredited: Indicates the plan meets most of NCQA basic requirements.

Provisional: Is an indication that a plan's service and clinical quality meet some, but not all, of NCQA basic requirements.

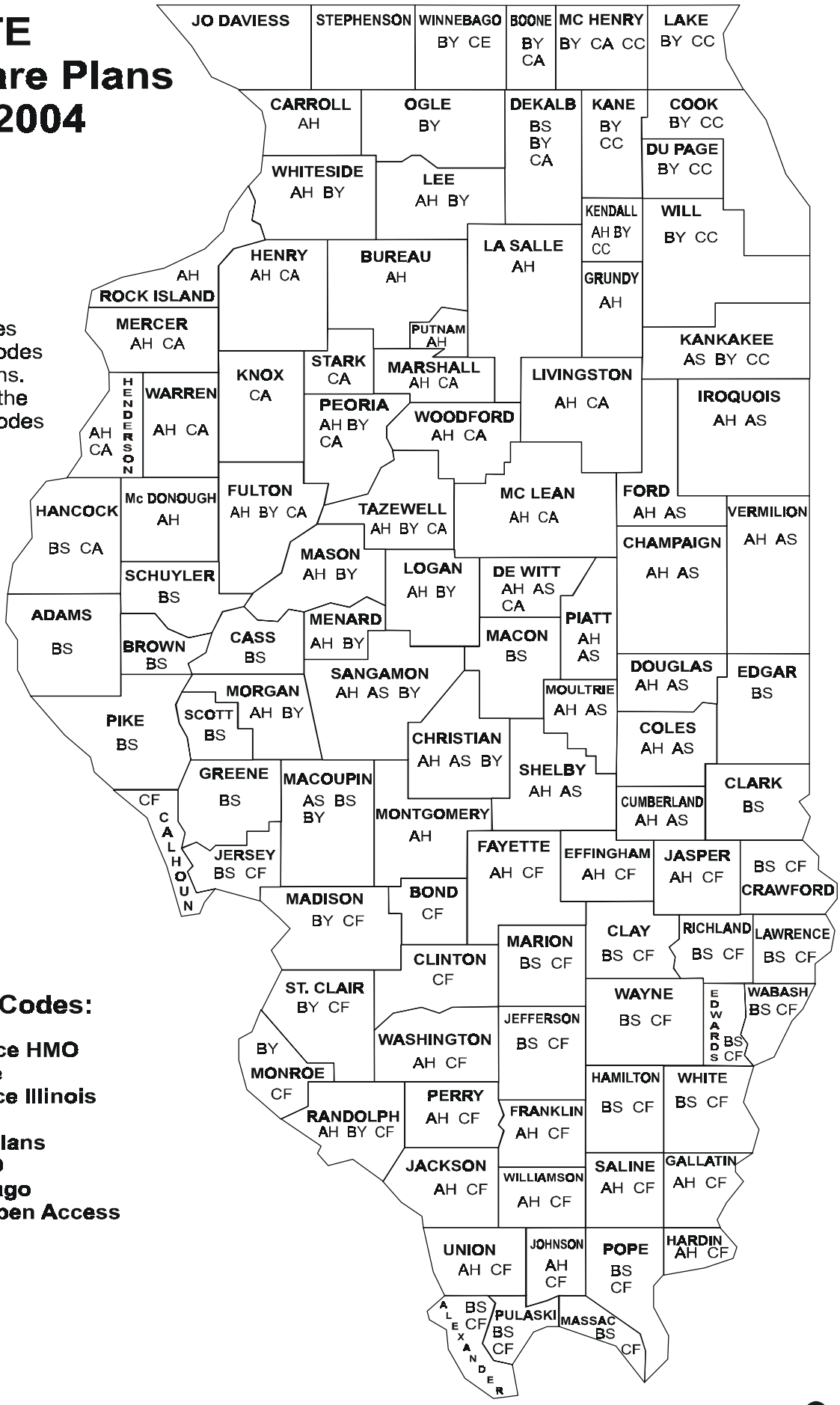
Further information regarding NCQA accreditation, see the chart below or contact NCQA directly at (888) 275-7585 or at their website (http://www.ncqa.org).

Plan Name and Code	Counties in Indiana	Counties in Iowa	Counties in Kentucky	Counties in Missouri	Counties in Wisconsin	NCQA Accreditation
Health Alliance Illinois (Code: BS)	Daviess, Dubois, Gibson, Knox, Martin, Pike, Posey, Spencer, Vanderburgh, Warrick	Lee		Marion, Lewis, Clark		Excellent
Health Alliance HMO (Code: AH)		Scott				Excellent
HealthLink Open Access (Code: CF)	*		*	*		Not Reviewed
HMO Illinois (Code: BY)	Jasper, Lake, Porter				Kenosha, Milwaukee	Excellent
OSF Health Plan (Code: CA)						Excellent
OSF Winnebago (Code: CE)						Excellent
PersonalCare (Code: AS)						Excellent
Unicare HMO (Code: CC)	Lake, Porter					Excellent

* Counties are too numerous to list. Please contact HealthLink for a complete listing.

STATE Managed Care Plans For FY 2004

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



HMO and OAP Codes:

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

The Quality Care Health Plan (QCHP)

QCHP is a medical indemnity plan which offers a comprehensive range of benefits. The QCHP Medical Plan Administrator is CIGNA. Under QCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using a QCHP Preferred Provider Organization (PPO) hospital, the CIGNA Healthcare PPO Network, network pharmacies for prescription drugs and mental health/substance abuse network providers.

Plan Year Maximums and Deductibles

The benefits described in this summary represent the major areas of coverage under QCHP. The plan year is July 1 through June 30 of the following year.	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	The plan year deductible is indexed to salary for employees. See chart below for current plan year information.
Additional Deductibles* ***These are in addition to the plan year deductible.**	Each emergency room visit $200 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
$54,800 or less	$200	$300
$54,801 - $68,600	$300	$400
$68,601 and above	$350	$450
Retiree/Annuitant/Survivor	$200	$300
Dependents	$200	NA

Out-of-Pocket Maximums

There are two separate out-of-pocket maximums: a general and a non-PPO hospital. Coinsurance and deductibles count toward one or the other, but not toward both. See the Member Handbook page 55 for details.	
General: **$800 per individual** **$2,000 per family per plan year**	**Non-PPO Hospital:** **$3,000 per individual** **$7,000 per family per plan year**
The following do not apply toward out-of-pocket maximums: • Prescription Drug benefits or copayments. • Mental Health/Substance Abuse benefits, coinsurance or copayments. • Notification penalties. • Ineligible charges (amounts over 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	
QCHP Preferred Provider Organization Hospitals and CIGNA Healthcare PPO Network	90% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (PPO) Hospital	• $200 per admission deductible. • If the member resides in Illinois or within 25 miles of a QCHP PPO hospital and the member chooses to use a non-PPO and/or voluntarily travels in excess of 25 miles when a QCHP 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 QCHP PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest QCHP 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 QCHP PPO hospital, the plan pays 80% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	100% of Usual & Customary (U&C) after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible. Contact the plan administrator for approval prior to obtaining items.
Licensed Ambulatory Surgical Treatment Center	90% after annual plan deductible.
Professional and Other Services	
CIGNA Healthcare PPO Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician & Surgeon Services	80% of U&C after the annual plan deductible for inpatient, outpatient & office visits.
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 the Notification Administrator prior to beginning evaluation services.

QCHP - Notification and Penalties

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for a specified outpatient procedure. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits.

For notification procedures for mental health/substance abuse services, see the Benefits Handbook section entitled Mental Health/Substance Abuse.

Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare. Allow a minimum of two business days for review. Failure to notify the Notification Administrator within the required time limits will result in a $400 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 in the plan participant's records. This number serves as a reference should there be any questions regarding notification. However, it is not a guarantee of benefits.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the procedure, setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

Notification is required for the following:

- **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
- **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator 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 GIR to enroll the newborn.
- **Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home** - At least seven days before admission, call the Notification Administrator. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission** - The plan participant or physician must phone the Notification Administrator within two business days after the admission.
- **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
- **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the first indication that a transplant may be necessary. Benefits are available only if authorized by the Notification Administrator.
- **Infertility Treatment** - A written predetermination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment. This applies to both medical and prescription benefits. Upon submission of the required documentation, a letter of denial or approval will be mailed to the plan participant. Refer to page 60 of your Benefits Handbook for more information. Please allow a minimum of 5 business days from receipt of all necessary documentation by the Notification Administrator to determine if the treatment is approved or denied.

To satisfy the notification requirement, you can call seven days a week, 24 hours a day:

INTRACORP/CIGNA (800) 962-0051
(800) 526-0844
(TDD/TTY)

QCHP - Prescription Drug Plan

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. The Prescription Drug Plan includes both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription.

Infertility Prescription Benefits - A written pre-determination of benefits must be obtained from the Medical Plan Administrator (CIGNA) prior to beginning infertility treatment. This applies to both medical and prescription benefits (see page 60 of the Benefits Handbook). Upon submission of the required documentation, a letter of denial or approval will be mailed by the Medical Plan Administrator .

The Prescription Drug Plan Administrator must confirm that a pre-determination of benefits has been approved before infertility medication can be dispensed at a retail pharmacy. This may take additional time. If a pre-determination is not on file, the plan participant will be directed to contact the Medical Plan Administrator to start the process; this will slow receipt of any approved medication.

When ordering infertility medication through the Mail Order Pharmacy, a copy of the pre-determination letter from the Medical Plan Administrator must accompany any prescription, in order for these medications to be filled. If the approved pre-determination letter is not enclosed with the infertility medication prescription, the member will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

In-Network Benefits

The pharmacy network consists primarily of retail pharmacies, which accept the copayment and electronically transmits the prescription claim for processing. The Member identification number, which ends in 1400, is printed on the ID card. For the most up-to-date information on network pharmacies, call the Prescription Drug Plan Administrator found on page 45.

In-network benefits when using the Member ID Card/Number:

- No plan year deductibles; no claim forms to file.
- Flat Copayments (1 to 30-day supply):
  - Generic $ 7.00
  - Formulary Brand $14.00
  - Non-Formulary Brand $28.00
- The maximum days supply available at one fill is 60 days. The copayments described above will double for any prescription exceeding 30 days.
- 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 copayment of $7.00.
- If only a brand drug is available, the copayment will be $14.00 or $28.00.
- When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy <u>without</u> presentation of the ID Card/Number, the plan participant will be charged the full retail cost of the medication. A paper claim for reimbursement of the cost must then be sent to the Prescription Drug Plan Administrator. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Plan participants must pay all charges at the time of purchase and file a paper claim form with the Prescription Drug Plan Administrator. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs

will be higher when not using network pharmacies. Claim forms are available from the Prescription Drug Plan Administrator.

Mail Service Program

Maintenance medications are available through mail order at the following copayments:

– Flat Copayments (90-day supply):

- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Contact the Prescription Drug Plan Administrator for mail order forms and information.

Specialty Pharmacy Services

Some medications are only dispensed from the Prescription Drug Plan's Specialty Pharmacy. This pharmacy specializes in the delivery of medications for specific diseases. The types of medications dispensed from the Specialty Pharmacy are for conditions such as: Multiple Sclerosis, Hepatitis B and C, Arthritis, Immune Deficiency and Hemophilia. Medication is usually shipped within 24 hours of receipt of the request; quantities are limited to 30-days or less. For additional information, contact the Prescription Drug Plan Administrator at www.caremark.com or call 1-800-237-2767.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans. However, the appropriate copayment will always be applied.

Medicare Covered Prescriptions

When a plan participant is enrolled in Medicare Part B and Medicare is primary, Medicare provides coverage for certain prescriptions, including diabetic test strips and lancets. Medicare approved retail pharmacies will submit claims for Medicare covered prescriptions directly to Medicare. At the time of purchase, plan participants will generally be responsible for the 20% not covered by Medicare.

Caremark's Mail Order Pharmacy will also submit claims to Medicare for Medicare covered prescriptions, charging only the 20% of the Medicare allowed amount. This process cannot be initiated until the plan participant has signed an assignment of benefit form and mailed it to the Prescription Drug Plan Administrator. To obtain these forms, contact the Prescription Drug Plan Administrator at 1-866-804-5880.

Upon receipt of the Medicare Explanation of Benefits (EOMB) plan participants may submit a paper claim for any reimbursement due (usually a portion of the 20%). The applicable copayment is always applied.

The Prescription Drug Plan Administrator has established a special Medicare Customer Service Team (866-804-5880) to provide forms and answer questions regarding Medicare Coordination of Benefits. For answers to questions about eligibility for Medicare Part A, Part B, or to apply for Medicare, call the Social Security Administration at 1-800-772-1213 or 1-800-325-0778 (TDD/TTY).

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

QCHP- CIGNA HealthCare PPO Networks

QCHP non-Medicare members have available **nationwide** CIGNA HealthCare PPO providers, hospitals and facilities. An enhanced 90% benefit for professional fees, hospital and facility services is available by using a participating network provider. The questions and answers below provide more information about this benefit feature. If you have additional questions, call the Group Insurance Division, see page 44.

What is the CIGNA HealthCare PPO Network?

The CIGNA HealthCare PPO Network is a nationwide network of physicians, hospitals and facilities that have agreed to participate at negotiated rates offering members an enhanced benefit.

What are the advantages of using a CIGNA HealthCare PPO Network provider?

The advantages of using providers participating in the network are that benefits for covered services are paid at 90% of a negotiated fee and usual and customary limits will not be applied.

How do I access services from a CIGNA HealthCare PPO Network provider?

Just make an appointment with a network provider and present your State of Illinois QCHP identification card at the time of service.

What if I do not use a CIGNA HealthCare PPO Network provider?

Standard plan benefits, coinsurance levels, and usual and customary limits apply.

How can I find out which providers are participating in the CIGNA HealthCare PPO Network?

Access the participating provider list on the website at:

http://provider.healthcare.cigna.com/soi.html.
Or, call CIGNA at (800) 962-0051.

QCHP - Hospital Preferred Provider Organizations

Chicagoland Area (Cook, DuPage & Lake Counties)

Advocate Bethany Hospital, Chicago
Advocate Christ Hospital & Med. Ctr., Oak Lawn
Advocate Good Samaritan Hosp., Downers Grove
Advocate Good Shepherd Hospital, Barrington
Advocate Illinois Masonic Medical Center, Chicago
Advocate Lutheran General Hospital, Park Ridge
Advocate South Suburban Hospital, Hazel Crest
Advocate Trinity Hospital, Chicago
Alexian Brothers Medical Ctr., Elk Grove Village

Central DuPage Hospital, Winfield
Children's Memorial Hospital, Chicago
Condell Medical Center, Libertyville
Cook County Hospital, Chicago

Edward Hospital, Naperville
Elmhurst Memorial Hospital, Elmhurst
Evanston Northwestern Healthcare, Evanston

Glen Oaks Hospital, Glendale Heights
Glenbrook Hospital, Glenview
Gottlieb Memorial Hospital, Melrose Park
Grant Community Hospital, Chicago

Highland Park Hospital, Highland Park
Hinsdale Hospital, Hinsdale
Holy Cross Hospital, Chicago
Holy Family Medical Center, Des Plaines

Ingalls Memorial Hospital, Harvey

Jackson Park Hospital, Chicago

LaGrange Memorial Hospital, LaGrange
Lake Forest Hospital, Lake Forest
LaRabida Children's Hospital, Chicago
Little Company of Mary Hospital, Evergreen Park
Loretto Hospital, Chicago
Louis A. Weiss Memorial Hospital, Chicago
Loyola University Medical Center, Maywood

MacNeal Memorial Hospital, Berwyn
Marianjoy Rehabilitation Hospital, Wheaton
Mercy Hospital & Medical Center, Chicago
Methodist Hospital of Chicago, Chicago
Michael Reese Hospital & Medical Ctr., Chicago
Mt. Sinai Hospital, Chicago

Northwest Community Hospital, Arlington Heights
Northwestern Memorial Hospital, Chicago
Norwegian American Hospital, Chicago

Oak Forest Hospital of Cook County, Oak Forest
Oak Park Hospital, Oak Park
Our Lady of the Resurrection Med. Center, Chicago

Palos Community Hospital, Palos Heights
Provena St. Therese Medical Center, Waukegan
Provident Hospital of Cook County, Chicago

Rehabilitation Institute of Chicago, Chicago
Resurrection Medical Center, Chicago
RML Specialty Hospital, Hinsdale
Roseland Community Hospital Assn., Chicago
Rush North Shore Medical Center, Skokie
Rush Pres-St. Luke's Medical Center, Chicago

Schwab Rehabilitation Hospital, Chicago
South Shore Hospital, Chicago
SSM St. Francis Hosp. & Hlth. Ctr., Blue Island
St. Alexius Medical Center, Hoffman Estates
St. Anthony Hospital, Chicago
St. Bernard Hospital & Health Care Center, Chicago
St. Elizabeth Hospital, Chicago (closing in late 2003)
St. Francis Hospital, Evanston
St. James Hospital & Health Center, Chicago Hts.
St. James Hospital & Health Center, Olympia Fields
St. Joseph Hospital, Chicago
St. Margaret Mercy Healthcare Ctr., Hammond, IN
St. Margaret Mercy Healthcare Center, Dyer, IN
St. Mary of Nazareth Hospital Center, Chicago
Swedish Covenant Hospital, Chicago

The Community Hospital, Munster, IN
Thorek Hospital & Medical Center, Chicago

University of Chicago Hospital, Chicago
University of Illinois Medical Center, Chicago

Victory Memorial Hospital, Waukegan

West Suburban Hospital Medical Center, Oak Park
Westlake Community Hospital, Melrose Park

QCHP - Hospital Preferred Provider Organizations

Northern Illinois

CGH Medical Center, Sterling
Children's Hospital of Wisconsin, Milwaukee
Copley Medical Center, Aurora

Delnor Community Hospital, Geneva
DeWitt Community Hospital, DeWitt, IA

Freeport Memorial Hospital, Freeport

Genesis Medical Center East, Davenport, IA
Genesis Medical Center West, Davenport, IA

Hammond-Henry District Hospital, Geneseo
Harvard Memorial Hospital, Inc., Harvard

Illini Hospital, Silvis

Katherine Shaw Bethea Hospital, Dixon
Kishwaukee Community Hospital, DeKalb

Memorial Medical Center, Woodstock
Mendota Community Hospital, Mendota
Mercer County Hospital, Aledo
Mercy Medical Center, Clinton, IA
Morris Hospital, Morris
Morrison Community Hospital, Morrison

Northern Illinois Medical Center, McHenry

Provena Mercy Center, Aurora
Provena St. Joseph Hospital, Elgin
Provena St. Joseph Medical Center, Joliet
Provena St. Mary's Hospital, Kankakee

Riverside Medical Center, Kankakee
Rochelle Community Hospital, Rochelle
Rockford Memorial Hospital, Rockford

Saint Anthony Medical Center, Rockford
Sherman Hospital, Elgin
Silver Cross Hospital, Joliet
St. Anthony Medical Center, Crown Point, IN
Swedish American Hospital, Rockford

The Monroe Clinic, Monroe, WI
Trinity Med. Ctr., North Campus, Davenport, IA
Trinity Medical Center, 7th St., Moline
Trinity Medical Ctr., West Campus, Rock Island

Univ. of Wisconsin Hospital, Madison, WI

Valley West Community Hospital, Sandwich

QCHP - Hospital Preferred Provider Organizations

Central Illinois

Abraham Lincoln Memorial Hospital, Lincoln
Blessing Hospital, Quincy
BroMenn Regional Medical Center, Bloomington

Carle Foundation Hospital, Urbana
Carlinville Area Hospital, Carlinville
Community Hospital of Ottawa, Ottawa
Comm. Med. Ctr. of Western Illinois, Monmouth
Community Memorial Hospital, Staunton

Decatur Memorial Hospital, Decatur
Doctors Hospital, Springfield
Dr. John Warner Hospital, Clinton

Eureka Community Hospital, Eureka

Galesburg Cottage Hospital, Galesburg
Gibson Community Hospital, Gibson City
Graham Hospital, Canton

Hillsboro Area Hospital, Hillsboro
Hoopeston Comm. Memorial Hosp., Hoopeston

Illini Community Hospital, Pittsfield
Illinois Valley Community Hospital, Peru
Iroquois Memorial Hospital, Watseka

Jersey Community Hospital, Jerseyville
Julia Rackley Perry Memorial Hospital, Princeton

Keokuk Area Hospital, Keokuk, IA

Mason District Hospital, Havana
McDonough District Hospital, Macomb
Memorial Hospital Association, Carthage
Memorial Medical Center, Springfield
Methodist Medical Center of Illinois, Peoria

Pana Community Hospital, Pana
Paris Community Hospital, Paris
Passavant Memorial Area Hospital, Jacksonville
Pekin Hospital, Pekin
Proctor Hospital, Peoria
Provena Covenant Medical Center, Urbana
Provena United Samaritans Med. Ctr., Danville

Saint Francis Medical Center, Peoria
Saint James Hospital, Pontiac
Sarah Bush Lincoln Health Center, Mattoon
Sarah D. Culbertson Mem. Hosp., Rushville
Shelby Memorial Hospital, Shelbyville
St. Francis Hospital, Litchfield
St. John's Hospital, Springfield
St. Joseph Medical Center, Bloomington
St. Margaret's Hospital, Spring Valley
St. Mary Medical Center, Galesburg
St. Mary's Hospital, Decatur
St. Mary's Hospital, Streator
St. Vincent Memorial Hospital, Taylorville

The John & Mary E. Kirby Hospital, Monticello
Thomas H. Boyd Memorial Hospital, Carrollton

QCHP - Hospital Preferred Provider Organizations

Southern Illinois and Metro-East

Alton Memorial Hospital, Alton
Anderson Hospital, Maryville

Barnes-Jewish Hospital, St. Louis
Barnes-Jewish St. Peter's Hospital, St. Peters, MO
Barnes-Jewish West County Hospital, Creve Coeur

Christian Hospital, NE, St. Louis
Christian Hospital, NW, Florissant
Clay County Hospital, Flora
Crawford Memorial Hospital, Robinson
Crossroads Comm. Hospital, Mt. Vernon

Des Peres Hospital, St. Louis

Edward A. Utlaut Hospital, Greenville

Fairfield Memorial Hospital, Fairfield
Fayette County Hospital, Vandalia
Ferrell Hospital, Eldorado
Forest Park Hospital, St. Louis

Gateway Regional Medical Center, Granite City
Good Samaritan Hospital, Vincennes, IN
Good Samaritan R.H.C., Mt. Vernon

Hamilton Memorial Hospital, McLeansboro
Hardin County General Hospital, Rosiclare
Harrisburg Medical Center, Harrisburg
Heartland Regional Medical Center, Marion
Herrin Hospital, Herrin

Lawrence County Memorial Hospital, Lawrenceville
Lourdes Hospital, Paducah, KY

Marshall Browning Hospital, DuQuoin
Massac Memorial Hospital, Metropolis
Memorial Hospital, Belleville
Memorial Hospital, Chester
Memorial Hospital of Carbondale, Carbondale
Missouri Baptist Medical Center, St. Louis

Pinckneyville Community Hosp., Pinckneyville

Red Bud Hospital, Red Bud
Richland Memorial Hospital, Olney

Saint Anthony's Health Center, Alton
Saint Clare's Hospital, Alton
Saint Francis Medical Center, Cape Girardeau, MO
Salem Township Hospital, Salem
South Pointe Hospital, St. Louis
Southeast Missouri Hospital, Cape Girardeau
Sparta Community Hospital, Sparta
SSM Cardinal Glennon Children's Hosp., St. Louis
SSM DePaul Health Center, Bridgeton, MO
SSM Rehabilitation Institute, St. Louis (all sites)
SSM St. Mary's Health Center, Richmond Heights
St. Alexius Hospital, St. Louis
St. Anthony's Medical Center, St. Louis
St. Anthony's Memorial Hospital, Effingham
St. Elizabeth's Hospital, Belleville
St. John's Mercy Medical Center, St. Louis
St. Joseph's Hospital, Highland
St. Joseph's Hospital, Breese
St. Joseph Memorial Hospital, Murphysboro
St. Louis Children's Hospital, St. Louis
St. Louis University Hospital, St. Louis
St. Luke's Episcopal Presbyterian Hosp., Chesterfield
St. Mary's Hospital, Centralia
St. Mary's Hospital of E. St. Louis, E. St. Louis, IL

Touchette Regional Hospital, Centreville

Union County Hospital District, Anna

Wabash General Hospital, Mt. Carmel
Washington County Hospital, Nashville
White County Medical Center, Carmi

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

NOTICE OF PRIVACY PRACTICES

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.

Effective April 14, 2003

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act of 1971 including the Quality Care Health Plan and the Quality Care Dental Plan. The term "we" in this Notice means the Bureau 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 Bureau contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. You may not have coverage with all of our Business Associates. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on behalf of the Bureau in performing their respective functions. When we seek help from individuals or entities who are not part of the Bureau 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. Caremark is the Pharmacy Benefit Plan Administrator. Magellan Behavioral Health is the Mental Health and Substance Abuse Plan Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a Notice from the respective plan administrator 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 the 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 Benefits:

CIGNA HealthCare
Privacy Office
P.O. Box 5400
Scranton, PA 18503
800-762-9940

For Pharmacy Benefits:

Caremark, Inc.
Privacy Officer
2211 Sanders Road
Northbrook, IL 60062
800-559-4700

For Mental Health and Substance Abuse Benefits:

Magellan Behavioral Health
Privacy Official
10 S. Riverside Plaza
11th Floor
Chicago, IL 60604
800-424-4020

For Dental Plan Benefits:

CompBenefits
Privacy Officer
100 E. Mansell Court E.
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: www.state.il.us/cms/employee/grpins/.

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 at the Office of the Chief Counsel, 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, DC. if you feel your privacy rights have been violated.

Dental Plans

Members have the option of enrolling in an indemnity or managed dental care plan, regardless of the type of health plan they choose. **Both plans are administered by CompBenefits, formerly known as CompDent.** Dental plan questions should be directed to **CompBenefits, at (800) 999-1669, or (312) 829-1298 (TDD/TTY).**

Quality Care Dental Plan (QCDP)

Members enrolled in QCDP may go to the dentist of their choice. A $50 individual plan deductible applies for all services other than those listed as preventive or diagnostic services in your Benefits Handbook. QCDP reimburses covered services at a pre-determined maximum allowable scheduled amount. Members are responsible for any charges over the scheduled amount. A premium is required if a member enrolls in QCDP (see chart on page 9).

Managed Dental Care Plan (MDCP)

Members may enroll in the managed dental care plan and receive a comprehensive range of benefits through a network of providers. Included in the network are specialists such as orthodontists and oral surgeons. Preventive and diagnostic services such as cleanings, sealants and x-rays are provided at no cost to plan participants. All other services require a copayment when service is rendered. There are no monthly premiums charged for this plan. **See your managed dental care benefits brochure for a full list of covered services.**

Note: Child orthodontics are covered benefits under both dental plans. There can be significant out-of-pocket expenses for this service. Orthodontic expenses are eligible under the Medical Care Assistance Program (MCAP) and significant savings can be achieved by enrolling in the program during the Benefit Choice Period. Contact the FSA Unit for details.

Dental Plan Comparison

Plan Design	Managed Dental Care Plan	Quality Care Dental Plan
Premium	None	Required
Annual Deductible	None	$50 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits in the Benefits Handbook.
Maximum Benefit Limit	No lifetime limitation	$2,000 per person per plan year after plan deductible.
Maximum Benefit Level for Child Orthodontics (under age 19)	No lifetime limitation but member copay is required	$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above. **Contact CompBenefits for a pre-treatment estimate.**
Claim forms	None	Required
Dentist selection	Participating providers only	Member's choice of provider

FY2004 QCDP - Schedule of Benefits

Diagnostic Services	Maximum Benefit	Code
Periodic Oral Examination	$ 23	D0120
Limited Oral Evaluation (specific oral health problem)	$ 38	D0140
Comprehensive Oral Examination	$ 40	D0150
Radiographs/Diagnostic Imaging		
Intraoral Complete Series (once in a period of three plan years, including bitewings)	$ 70	D0210
Intraoral - Periapical First Film	$ 13	D0220
Intraoral - Periapical Each Additional Film	$ 10	D0230
Bitewing Single Film	$ 15	D0270
Bitewing Two Films	$ 22	D0272
Bitewing Four Films	$ 31	D0274
Panoramic Film, (once in a period of three plan years)	$ 65	D0330
Preventive Services	**Maximum Benefit**	**Code**
Prophylaxis Adult - Twice each plan year	$ 49	D1110
Prophylaxis Child - Twice each plan year	$ 34	D1120
Topical Application of Fluoride - Child **(including** prophylaxis) (once each plan year, covered through age 18 only)	$ 51	D1201
Topical Application of Fluoride - Child **(not including** prophylaxis) (once each plan year, covered through age 18 only)	$ 20	D1203
Sealant - per tooth, covered through age 18 only	$ 27	D1351
Space Maintainers (Passive Appliances)		
Fixed Unilateral	$173	D1510
Fixed Bilateral	$229	D1515
Removable Unilateral	$215	D1520
Removable Bilateral	$294	D1525

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

FY2004 QCDP - Schedule of Benefits

Restorative Services	Maximum Benefit	Code
Amalgam Restorations		
Amalgam One Surface, Primary or Permanent	$ 59	D2140
Amalgam Two Surfaces, Primary or Permanent	$ 76	D2150
Amalgam Three Surfaces, Primary or Permanent	$ 92	D2160
Amalgam Four or more Surfaces, Primary or Permanent	$ 112	D2161
Resin-Based Composite Restorations		
One Surface, Anterior	$ 72	D2330
Two Surfaces, Anterior	$ 92	D2331
Three Surfaces, Anterior	$112	D2332
Four or more Surfaces or involving incisal angle (anterior)	$133	D2335
One Surface Posterior	$ 81	D2391
Two Surface Posterior	$112	D2392
Three Surface Posterior	$139	D2393
Four or More Surfaces, Posterior	$172	D2394
Crowns/Single Restorations Only		
Crown-Resin (laboratory)	$200	D2710
Crown-Resin with high noble metal	$493	D2720
Crown-Resin predominantly base metal	$462	D2721
Crown-Resin with noble metal	$472	D2722
Crown-Porcelain/Ceramic Substrate	$506	D2740
Crown-Porcelain fused to high noble metal	$499	D2750
Crown-Porcelain fused to predominantly base metal	$465	D2751
Crown-Porcelain fused to noble metal	$476	D2752
Crown-3/4 cast predominately base metal	$359	D2781
Crown-Full cast high noble metal	$482	D2790
Crown-Full cast predominantly base metal	$456	D2791
Crown-Full cast noble metal	$465	D2792
Other Restorative Services		
Recement Inlay	$ 41	D2910
Recement Crown	$ 43	D2920
Prefabricated stainless steel Crown (primary tooth)	$117	D2930
Prefabricated stainless steel Crown (permanent tooth)	$132	D2931
Prefabricated Resin Crown	$144	D2932

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

FY2004 QCDP - Schedule of Benefits

Endodontics	Maximum Benefit	Code
Pulp Capping		
Pulp Cap - Direct (excluding final restoration)	$ 37	D3110
Pulp Cap - Indirect (excluding final restoration)	$ 29	D3120
Pulpotomy - Therapeutic (excluding final restoration)	$ 87	D3220
Root Canal Therapy (include intra-operative radiographs)		
Anterior (excludes final restoration)	$367	D3310
Bicuspid (excludes final restoration)	$448	D3320
Molar (excludes final restoration)	$578	D3330
Retreatment of Previous Root Canal Therapy		
Anterior	$493	D3346
Bicuspid	$582	D3347
Molar	$699	D3348

Periodontics	Maximum Benefit	Code
Gingivectomy/Gingivoplasty		
Per quadrant	$159	D4210
Per tooth	$ 43	D4211
Gingival Flap Procedure		
Per quadrant - includes root planning	$187	D4240
Gingival Flap - including root planning, 1-3 teeth per quadrant	$117	D4241
Osseous Surgery (including flap entry and closure)		
Per quadrant	$302	D4260
Bone Replacement Graft		
First site in quadrant	$228	D4263
Each additional site in quadrant	$173	D4264
Pedicle Soft Tissue Graft	$224	D4270
Free Soft Tissue Graft	$230	D4271
Provisional Splinting		
Intracoronal	$129	D4320
Extracoronal	$113	D4321
Periodontal Scaling and Root Planing		
Per quadrant	$ 70	D4341

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

FY2004 QCDP - Schedule of Benefits

Periodontics (continued)	Maximum Benefit	Code
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$ 46	D4355
Periodontal Maintenance Procedure		
Following active therapy	$ 42	D4910
Unscheduled Dressing Change	$ 36	D4920

Prosthodontics	Maximum Benefit	Code
Removable Prosthetics		
Complete Denture - Maxillary	$523	D5110
Complete Denture - Mandibular	$523	D5120
Immediate Denture - Maxillary	$571	D5130
Immediate Denture - Mandibular	$571	D5140
Partial Dentures (removable)		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth)	$442	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth)	$513	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	$578	D5213
Mandibular Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	$578	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth)	$337	D5281
Adjustments to Dentures		
Adjust complete denture - Maxillary	$ 29	D5410
Adjust complete denture - Mandibular	$ 29	D5411
Adjust partial denture - Maxillary	$ 29	D5421
Adjust partial denture - Mandibular	$ 29	D5422
Repairs to Complete Dentures		
Repair broken complete denture base	$ 57	D5510
Replace missing or broken teeth - complete denture (each tooth)	$ 48	D5520
Repairs to Partial Dentures		
Repair resin denture base	$ 62	D5610
Repair cast framework	$ 67	D5620
Repair or replace broken clasp	$ 81	D5630
Replace broken teeth - per tooth	$ 53	D5640
Add tooth to existing partial denture	$ 72	D5650
Add clasp to existing partial denture	$ 86	D5660
Denture Rebase Procedure		
Rebase complete maxillary denture	$213	D5710
Rebase complete mandibular denture	$203	D5711
Rebase maxillary partial denture	$201	D5720
Rebase mandibular partial denture	$201	D5721

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

FY2004 QCDP - Schedule of Benefits

Prosthodontics (continued)	Maximum Benefit	Code
Denture Reline Procedure		
Reline complete maxillary denture (chairside)	$120	D5730
Reline complete mandibular denture (chairside)	$120	D5731
Reline maxillary partial denture (chairside)	$110	D5740
Reline mandibular partial denture (chairside)	$110	D5741
Reline complete maxillary denture (laboratory)	$160	D5750
Reline complete mandibular denture (laboratory)	$160	D5751
Reline maxillary partial denture (laboratory)	$158	D5760
Reline mandibular partial denture (laboratory)	$158	D5761
Fixed Partial Denture Pontics		
(Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal	$277	D6210
Pontic-Cast predominantly base metal	$260	D6211
Pontic-Cast noble metal	$270	D6212
Pontic-Porcelain fused to high noble metal	$274	D6240
Pontic-Porcelain fused to predominantly base metal	$253	D6241
Pontic-Porcelain fused to noble metal	$267	D6242
Pontic-Resin with high noble metal	$270	D6250
Pontic-Resin with predominantly base metal	$249	D6251
Pontic-Resin with noble metal	$257	D6252
Fixed Partial Denture Retainers - Crowns		
Crown-Resin with high noble metal	$305	D6720
Crown-Resin with predominantly base metal	$289	D6721
Crown-Resin with noble metal	$294	D6722
Crown-Porcelain fused to high noble metal	$312	D6750
Crown-Porcelain fused to predominantly base metals	$291	D6751
Crown-Porcelain fused to noble metal	$298	D6752
Crown-3/4 cast high noble metal	$294	D6780
Crown-Full cast high noble metal	$301	D6790
Crown-Full cast predominantly base metal	$286	D6791
Crown-Full cast noble metal	$296	D6792
Other Fixed Partial Denture Services		
Recement Fixed Partial Denture	$ 37	D6930
Fixed Partial Denture Repair, by report	$ 49	D6980

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

FY2004 QCDP - Schedule of Benefits

Oral Surgery	Maximum Benefit	Code
Extractions		
Coronal Remnants - Deciduous Tooth	$74	D7111
Extraction, Erupted Tooth or Exposed Root (elevation or forceps removal)	$70	D7140
Surgical Extraction		
(Includes local anesthesia, suturing if needed, and routine postoperative care)		
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 68	D7210
Removal of impacted tooth - soft tissue	$ 86	D7220
Removal of impacted tooth - partially bony	$114	D7230
Removal of impacted tooth - completely bony	$134	D7240
Removal of impacted tooth - completely bony with unusual surgical complications	$168	D7241
Surgical removal of residual tooth roots (cutting procedure)	$ 72	D7250
Other Surgical Procedures		
Biopsy of oral tissue - hard (bone/tooth)	$285	D7285
Biopsy of soft tissue - soft (all others)	$117	D7286
Alveoloplasty in conjunction with extractions, per quadrant	$ 80	D7310
Alveoloplasty not in conjunction with extractions, per quadrant	$355	D7320
Frenulectomy - separate procedure	$167	D7960

Adjunctive General Services	Maximum Benefit	Code
Surgical Incision		
Palliative (emergency) treatment of dental pain (minor procedure)	$ 46	D9110
Miscellaneous Services		
Occlusal guards, by report	$146	D9940
Occlusal adjustment, limited	$ 59	D9951
Occlusal adjustment, complete	$333	D9952
Anesthesia		
General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.		
General anesthesia - first 30 minutes	$187	D9220
General anesthesia - each additional 15 minutes	$ 78	D9221
Intravenous sedation/analgesia - first 30 minutes	$180	D9241
Intravenous sedation/analgesia - each additional 15 minutes	$ 75	D9242

Coverage of eligible charges after applicable deductibles. All benefits are subject to QCDP exclusions (see Benefits Handbook).

Opt Out

What is Opt out?

Public Act 92-0600 (opt out) enables eligible Members to elect **not** to participate in the health, dental and vision coverage of the State Employees Group Insurance Program if proof of other major medical coverage can be provided. Members must be enrolled in the state-paid basic life insurance plan. Optional life insurance is available for members electing to opt out.

Who is eligible?

State of Illinois full-time employees, retirees/annuitants and survivors are eligible to opt out of the Program.

When can I opt out?

Newly hired employees can elect to opt out effective date of hire if an Opt Out Election Certificate is completed and appropriate documentation submitted to the agency GIR within the first ten days of hire. Current employees can opt out within 60-days of a qualifying change in status or during the annual Benefit Choice period. See your agency GIR if you wish to opt out.

What documentation is required to opt out?

Members must furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source **other** than those plans administered by the Department of Central Management Services, including the Local Government Health Plan, Teachers' Retirement Insurance Program, or College Insurance Program **before** coverage will be terminated.

How does opt out impact my eligibility for other benefits?

Members electing to opt out continue to be eligible for participation in the Flexible Spending Account (FSA) Program, Qualified Transportation Benefit (QTB) Program, Employee Assistance Program (EAP) and AFSCME Council 31 Personal Support Program (PSP).

Members are **not** eligible for the free influenza immunizations, paid maternity/paternity leave of absence or COBRA continuation.

Will opting out impact the percentage of group insurance premium an employee may have to pay at the time of retirement?

No, the percentage an employee may have to pay at the time of retirement is based upon years of service, not years enrolled in group insurance. At this time, opting out of group insurance will not impact years of service.

If my spouse is a State of Illinois employee, or covered by a Plan administered by the Department of Central Management Services, can I elect to opt out and be covered as dependent under that Plan?

No.

If I elect to opt out, when can I re-enroll in the State of Illinois Group Insurance Program?

Employees may re-enroll within 60-days of a qualifying change in status or during the annual Benefit Choice period. However, pre-existing condition limitations may apply. A Certificate of Creditable Coverage from the previous insurance carrier will be requested when a Member requests to opt into the Program. If the Member has a break in coverage of more than 63 days, pre-existing condition limitations may apply.

For More Information

Contact your agency GIR or the CMS Group Insurance Division for additional information.

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 of Deferred Compensation

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 spendable 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.

Enrollment

There is no specific enrollment period; state employees may enroll at any time. An enrollment packet is available from the Deferred Compensation Division or from the Agency Liaison. The enrollment form must be submitted in the month prior to the month in which deferrals begin. All contributions are through payroll deductions only.

Contribution Limitations

Contribution amounts may be as little as $20 per month up to $12,000 for tax year 2003 and $13,000 for tax year 2004.

Investment Choices

There are a variety of funds in which to invest. This makes it easy to customize an investment strategy that is just right for you. 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

The Plan has currently accumulated sufficient reserves to cover the administrative expenses for the 2003 tax year. Therefore, the .15% administrative fee (maxiumum cap of $45) will not be charged against participant accounts. A review will be conducted to determine administrative fees for the 2004 tax year.

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 44 for the Deferred Compensation Plan Administrator.

Qualified Transportation Benefit (QTB) Program

The Qualified Transportation Benefit Program (QTB) is an optional benefit that gives eligible employees the opportunity to use tax-free dollars to pay for their out-of-pocket, work-related commuting and/or parking expenses.

The QTB offers two plans:

The Transit Assistant Program (TAP) allows you to use up to $100 per month of pre-tax dollars to pay for transit passes or vanpooling expenses incurred for work-related commuting costs. The transit media you select is conveniently mailed directly to your home

The Parking Assistant Program (PAP) allows you to use up to $190 per month of pre-tax dollars to pay for work-related parking expenses.

How QTB Works

Employees may contribute a combined annual maximum of $3,480 in pre-tax dollars for both programs. TAP and PAP contributions are deducted from your paycheck before state, federal and Social Security taxes are withheld. This amount does not appear on your W-2 Form as taxable income thereby lowering your taxable income and providing you with more spendable income.

If enrolled in PAP, you may elect to pay your parking provider directly by selecting WageWorks Direct Pay Program. Or, you may be reimbursed for parking if you pay each day at a ramp or meter, by selecting WageWorks Expense Reimbursement Process.

Participating in both TAP and PAP will provide the maximum savings benefit on expenses you incur.

Eligibility

Full-time and part-time employees working more than 50% that have not waived insurance coverage and who have payroll checks processed through the Office of the Comptroller for the State of Illinois are eligible to participate in QTB. Life insurance only members are not eligible for this program.

How to Enroll

Contact your GIR to obtain the QTB brochure or call WageWorks at the number listed in the next column.

Review the information to ensure your expenses meet IRS/QTB requirements and are eligible for TAP/PAP. Eligible employees may enroll in the Program at any time. There is no qualifying change in status required to enroll mid-year and you may stop or change your deductions at any time. New IRS regulations require you to elect your benefit in advance of the month the benefit is used. Therefore, your enrollment or benefit change must be received by WageWorks by the 10th of the month for the benefit to begin the next month. For example, a selection made on January 10th would begin in February, a selection made between January 11th and February 10th would begin in March.

There are 3 ways to enroll, change or terminate the benefit:

- Online – www.illinois.wageworks.com.
- Fill out appropriate paper enrollment form and send them to your GIR or to the Enrollment Center, C/O WageWorks, 2 Waters Park Drive, Suite 250, San Mateo, CA 94403.
- Enroll by telephone, 1-877-924-3967 (toll-free).

Distribution of Transit Passes and Payment to Parking Vendors

Transit passes, payments to parking vendors and reimbursements to participants are mailed once per month. Plan participants will receive their transit passes **before** the beginning of the month the passes are to be used.

Secretary of State Parking Payroll-Deducted Parking Fees

Effective March 15, 2003, employees in the Springfield area who have payroll deductions for Secretary of State parking places will now pay these fees with tax-free dollars. **Employees are not required to sign up for this benefit—it will be automatic.** Employees should notice a small tax savings from this newly-available feature of the Qualified Transportation Benefit Program.

Long-Term Care Insurance

The State Employees Group Insurance Program now offers 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.

You may request an enrollment kit from MetLife at any time by calling 1-800-GET-MET8 (1-800-438-6388).

What is Long-Term Care?

Long-term care is the type of service a person needs when they are no longer able to care for themselves independently; when simple everyday activities, such as getting out of bed, eating or bathing become too difficult to do on their own. This care may be needed due to age, but often needed in younger persons because of illness or accidental injury.

Is Long-Term Care covered under most medical plans?

Most medical plans are designed to cover acute care or skilled care and rarely, if ever, cover custodial care. Most people discover this when they are faced with an actual long-term care situation.

Does Long-Term Disability Insurance cover Long-Term Care?

Absolutely not. Disability insurance is designed to replace a portion of income when a person can no longer work due to a disabling condition.

Who is eligible?

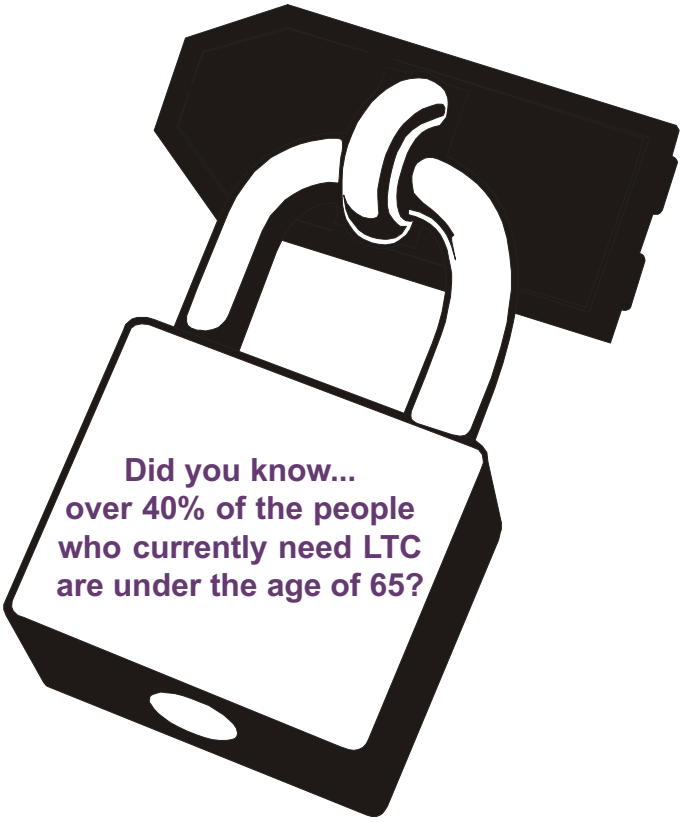
Employees (full-time employees and part-time employees working more than 50% that have not waived coverage), annuitants/retirees, spouses, survivors, parents and parents-in-law.

Must I provide evidence of good health (medical underwriting)?

Yes. A form will accompany the enrollment materials for you to complete and return. All applicants must provide a full statement of health and be approved for coverage by MetLife. Once approved for coverage, you will receive a Certificate of Insurance. However, new employees do not require underwriting if they apply within 90 days of their hire date.

How do I find out more information about this plan and get premium rates?

Call MetLife at 1-800-438-6388. Please say "State of Illinois" when asked for your company name. A customer service representative will answer your questions and send you details about the plans available including premium rates and a personalized enrollment kit. You may select the comprehensive plan that covers care received in a nursing home, assisted living facility, hospice facility, at-home or in an adult day care center. Or, you may select the Facility Only Plan that offers care in a nursing home, hospice or assisted living facility.



Employee Assistance Program (EAP)

Support for You and Your Family

The Employee Assistance Program (EAP) provides a valuable resource for support and information during difficult times. The EAP is a confidential assessment and referral service that will link you to EAP counselors, who will help you develop the life management skills needed to enjoy life more fully.

Getting help is easy, convenient and confidential. Trained customer service representatives and EAP care managers are available via a toll-free telephone number. You will be directed to counseling services to assist you with a variety of concerns.

The EAP is a voluntary and confidential program that provides problem identification, counseling, and referral services for employees and their families. EAP counselors are experienced in providing support, understanding and guidance for a broad range of needs. The EAP provides confidential assistance on a variety of concerns including:

- Anger management
- Anxious feelings
- Conflict at work or home
- Domestic violence
- Elder care issues
- Family/parenting issues
- Feelings of worry or the blues
- Financial/debt management
- Grief/loss
- Problems with alcohol or drugs
- Stress

Getting Assistance

Face-to-face evaluations will easily provide the help you need. The EAP counselor will help clarify the reason you are seeking assistance, identify options and develop a plan. Short-term counseling may be all that is required with your EAP counselor.

If you are referred for additional services for help beyond the scope of services provided by the EAP and you elect to use those services, the resulting costs and copayments, as applicable, are your responsibility. If mental health and/or substance services are needed, refer to the Mental Health/Substance Abuse section under your health plan benefits for coverage of services.

Privacy and Confidentiality

All calls and counseling sessions are confidential, except as required by law. No information will be disclosed about you unless your written consent is given.

Frequently Asked Questions

Who can use the EAP?

Active State employees and their eligible dependents covered under the State Employees Group Insurance Act may access this benefit. Active State of Illinois employees who have elected not to participate (opt out) in the health, dental and vision coverage of the Group Insurance Program may continue to access this benefit.

What number do I call for services?

There are two separate Employee Assistance Programs for active employees, the EAP through Magellan Behavorial Health and the Personal Support Program (PSP) through AFSCME Council 31.

All non-AFSCME Council 31 employees must access services by calling the Magellan Behavorial Health EAP at (866) 659-3848.

AFSCME Council 31 employees must access EAP services through the Personal Support Program (PSP) by calling (800) 647-8776.

Will I be charged for using the EAP?

No. The EAP is a free benefit for you. However, if you need help beyond the scope of the EAP, your EAP counselor may refer you for additional services.

If you are referred for additional services for help beyond the scope of services provided by the EAP and you elect to use those services, the resulting costs and copayments, as applicable, are your responsibility. If mental health and/or substance services are needed, refer to the Mental Health/Substance Abuse section under your health plan benefits for coverage of services.

Is the EAP just for workplace problems?

No. You can use the EAP to help you deal with most concerns such as: parenting issues, marital or relationship problems, problems with alcohol or drugs.

Can I call the EAP even if my concern is not a crisis?

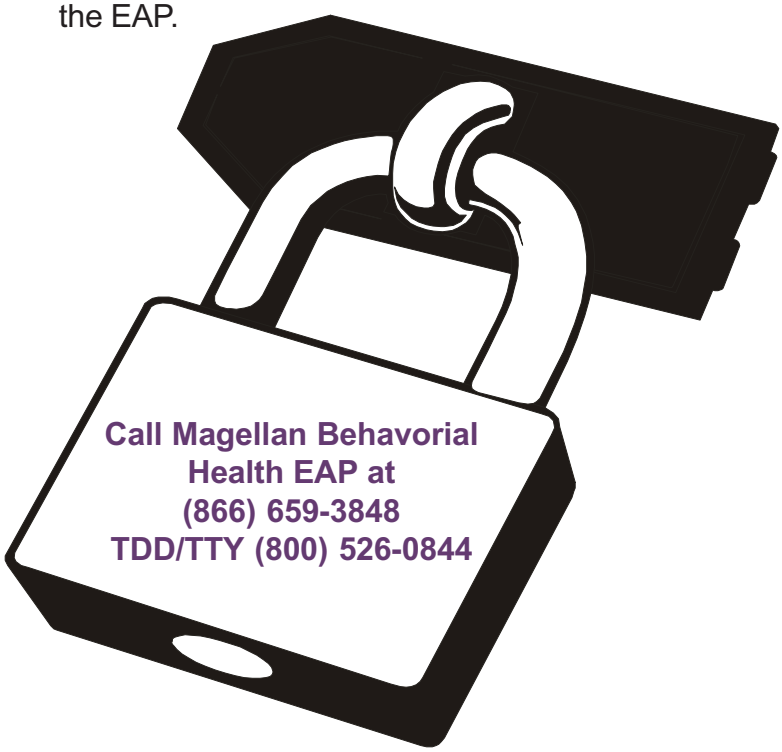
Yes. The EAP is a life management tool designed to help you sort through whatever is happening in your life. Call the EAP when you need a new perspective on how to deal with things in your life.

How can the EAP help me as a supervisor or manager?

Management consultation is available when an employee's personal problems are causing a decline in work performance. Assistance to facilitate Fitness for Duty evaluations are also available through the EAP. Consultation services are as easy as dialing the toll-free number.

As a manager, how is help provided with critical incidents in the workplace?

Critical Incident Stress Debriefings and Grief Support Group counseling are available through the EAP.



Notes

Plan Administrators

Only **general** plan questions should be directed to the CMS Group Insurance Division or your Group Insurance Representative. Direct all specific claim inquiries to the plan administrators.

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site 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
OSF Health Plan	(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	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Vision Plan Administrator	Vision services, benefits,network providers, claim forms and filing.	**Vision Service Plan (VSP)** Plan 222 P.O. Box 997105 Sacramento, CA 95899-7105	(800) 877-7195 (800) 428-4833 (TDD/TTY) www.vsp.com
Life Insurance Plan Administrator	Life insurance coverage and claim information.	**Minnesota Life Insurance Company** 1 North Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)
Long-Term Care (LTC) Insurance	Long-term care insurance coverage.	**MetLife** (no address required)	(800) 438-6388 (800) 638-1004 (TDD/TTY)
Deferred Compensation Program	Long-term supplemental retirement savings program. Provides investment opportunities with payroll deducted, pre-tax dollars.	**CMS Deferred Compensation Division** 200 W. Washington Street Springfield, IL 62701	(800) 442-1300 (800) 526-0844 (TDD/TTY)
FSA Claim Processor	Information on medical and dependent care expenses (MCAP/DCAP) and claim reimbursement approval.	**Fringe Benefits Management Company** P.O. Box 1800 Tallahassee, FL 32302-1800	(800) 342-8017 (800) 955-8771 (TDD/TTY)
Qualified Transportation Benefit (QTB) Program	Information on setting aside pre-tax dollars for transportation and parking expenses.	**WageWorks** 2 Waters Park Drive, Suite 250 San Mateo, CA 94403	(877) 924-3967 (800) 526-0844 (TDD/TTY)
Health/Dental Plans, FSA Unit, COBRA Unit, Life Insurance, Adoption and Smoking Cessation Benefits	General information on the state health plans or other benefits.	**CMS Group Insurance Division** 600 Stratton Building Springfield, IL 62706	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)

Plan Administrators

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, 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 $400 applies. See page 23 for more information.	**Intracorp, Inc.** (no address required)	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com.soi.html
QCHP Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing.	**Caremark, Inc.** Group Number 1400 **Paper Claims:** P.O. Box 686005 San Antonio, TX 78268-6005 **Mail Order Prescriptions:** P.O. Box 7624 Mt. Prospect, IL 60056-7624	(866) 212-4751 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
Member Assistance Program - QCHP MH/SA Plan Administrator	Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution.	**Magellan Behavioral Health** Group Number 3181456 P.O. Box 909782 Chicago, IL 60690	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanAssist.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services, ID cards.	**Magellan Behavioral Health** P.O. Box 543253 Chicago, IL 60654	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanAssist.com
Quality Care Dental Plan (QCDP) Administrator	Dental services, claim forms, ID cards and filing.	**CompBenefits, Inc.** Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com
Managed Dental Care Plan Administrator	Copies of the managed dental care brochure.		

Illinois Department of Central Management Services
Bureau of Benefits
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