Benefit Choice Options

State of Illinois

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2005 - June 30, 2006

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Benefit Choice is May 1 - May 31, 2005

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Important Changes For Fiscal Year 2006 effective July 1, 2005

Changes to the Quality Care Health Plan (QCHP)

- **Plan Year Deductibles:**
  - ⇨ Employee - $250/$350/$400, see table on page 7 for details
  - ⇨ Dependent/Retiree/Annuitant/Survivor - $250
  - ⇨ Family Cap- $625/$875/$1000, see table on page 7 for details
- **Individual Out-of-Pocket Maximums:**
  - ⇨ Network PPO Facility - $900
  - ⇨ Out-of-Network - $3,800
- **Family Out-of-Pocket Maximums:**
  - ⇨ Network PPO Facility - $2,250
  - ⇨ Out-of-Network - $7,600
- **Emergency Room** Visit Deductible is $300
- The QCHP Preferred Provider Organization (PPO) Hospital network is subject to change each plan year. To review a complete list of participating hospitals, visit www.benefitschoice.il.gov .
- **NEW Benefit** - Coverage for Hearing Exams and Hearing Aids up to a Maximum of:
  - ⇨ $100 for audiologist fee(s)
  - ⇨ $500 for hearing aid(s)
  - ⇨ Limited to once every three plan years
- Prescription copayments have changed, see page 9 for details. The new Prescription Drug Plan Administrator is Medco Health Solutions. A new identification card will be sent in June.
- Monthly contributions for employee and dependent coverages have changed. See page 7 for details.

Changes to Managed Care Health Plans

- The plans that were available last year continue to be available. Two plans have expanded their service areas. See page 16 for details.
- Inpatient Hospital Copayment is $200
- Emergency Room Copayment is $150
- Home Health Visit Copayment of $15 per visit has been implemented. See page 15 for details.
- **NEW Benefit** - Coverage for Hearing Exams and Hearing Aids up to a Maximum of:
  - ⇨ $100 allowance for audiologist fee(s)
  - ⇨ $500 allowance for hearing aid(s)
  - ⇨ Limited to once every three plan years
- Retail Prescription Drug Benefits for all Managed Care Health Plans copayments are as follows: $9 - generic; $18 - preferred brand; and $36 non-preferred brand. The new Prescription Drug Plan Administrator is Medco Health Solutions for plan participants enrolled in HealthLink OAP, Health Alliance Illinois or OSF Winnebago, see pages 8 & 9 for details. A new identification card will be sent in June.
- No change to the monthly contributions for employee or dependent coverages.

Medicare Part D

- The Federal prescription drug plan benefit will be available January 1, 2006. Affected individuals will be contacted by their health plan administrator prior to the Medicare Part D Open Enrollment Period (November 2005).

Changes to Life Insurance

- Monthly optional life contributions have changed, see page 6 for details.

Changes to Vision Care Benefit Program

- The new Vision Plan Administrator is EyeMed, see page 20 for details.
- No change to copayments.
- Contact Lens Benefit is $100 allowance toward the cost of contacts regardless of the type (hard, soft, extended wear, etc.) of contact lens. The $100 allowance is applied toward the cost of contacts and/or any fees associated with contact lenses such as fitting or follow-up care.

Changes to Quality Care Dental Plan (QCDP)

- Annual deductible is $100 for all covered services except preventive and diagnostic.
- Monthly contributions for employee and dependent coverages have changed. See page 7 for details.

Flexible Spending Account (FSA) Program

- The EZ Reimburse MasterCard makes MCAP participation nearly paperless. There is a $20 annual fee for the card. For more information, see page 13.

Commuter Savings Program (CSP)

- The Qualified Transportation Benefit (QTB) Program has a new name. See page 18 for details.

Your Responsibilities

Benefit Choice is May 1- May 31, 2005. It is the time to review and/or make changes to your health benefit plan. Benefit Choice is the only time, other than a qualifying change in status, that you can change health plans or add/drop dependent coverage. Benefit Choice is also the only time of year you can add/drop dental coverage. The changes made during this period will remain in effect for the plan year July 1, 2005 through June 30, 2006.

Steps to follow to make a Benefit Choice change:

1. **Read the information in this booklet.** It is your responsibility to know the benefit coverages and limitations. If necessary, obtain additional information on the plan in which you are currently enrolled or in which you are considering enrolling. Visit the benefits website at www.benefitschoice.il.gov for links to plan administrator websites.

2. Make your health plan choices. Review the features below to help you make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

You have three (3) types of medical plans from which to choose:

- Health Maintenance Organizations (HMO) - Managed Care Health Plan
- Open Access Plan (OAP) - Managed Care Health Plan
- Quality Care Health Plan (QCHP) - Indemnity Plan

Managed care plans have geographic and provider limitations. If you are interested in a managed care plan, carefully review the information on pages 14 and 15 and the map of Managed Care Plans in Illinois Counties on page 16. Network provider directories are available on each plan administrator's website. The QCHP is available regardless of your place of residence.

Remember: There can be changes in your coverage even if you do not change plans. Specific questions regarding coverage should be directed to each respective plan administrator. Telephone numbers and web addresses are listed on page 21.

3. Complete the Benefit Choice Election Form that is located at the end of this booklet. Complete this form only if you want to make a change to your benefits. Submit the completed form to your Group Insurance Representative (GIR) any time during the Benefit Choice election period that ends on May 31, 2005.

4. Review the Verification Statement that will be mailed to you from the Department of Central Management Services to confirm your Benefit Choice election changes. If you make Benefit Choice election changes, this statement will be sent to you after your request has been processed.

Changes to Your Benefit Elections During the Year.

You may change your benefit elections during the year only if you have a qualifying change in status (life event change) that affects your benefit needs. You have 60 days from the date of the qualifying change in status event to notify your GIR. **If the event would normally qualify the person for COBRA, failure to notify your GIR of changes that may affect eligibility for you or your dependents within the 60 day time period will disqualify the affected individual from COBRA continuation of coverage.** You must contact your GIR when one of the following events occur:

- You and/or your dependents have a change of address.
- You experience a life event change that may affect eligibility for you or your dependent(s) such as:
  - birth/adoption of a child (enrollment for a newborn is not automatic. Contact your GIR within 60 days of birth for coverage to be retroactive to the date of birth);
  - marriage, divorce, legal separation or annulment;
  - death of spouse or dependent;
  - employment status change for you, your spouse or your dependent(s) that affects eligibility under the program;
  - dependent(s) loss of eligibility;
  - court order resulting in the gain or loss of a dependent;
  - change in Public Aid recipient status; or,
  - dependent becomes covered by other group health or dental coverage.
- You or your enrolled dependents have other group insurance coverage including Medicare, or gain other coverage during the plan year. Provide a copy of the insurance or Medicare card to your GIR as soon as possible.

The State offers its Members valuable programs...

Flexible Spending Account (FSA) Program

Medical Care Assistance Plan (MCAP) and Dependent Care Assistance Plan (DCAP)

Enrolling in the FSA Program can save you tax dollars for out-of-pocket medical/dental and dependent care expenses incurred during the plan year. FSA allows you to set aside up to $5,000 in each plan for a combined maximum of $10,000 (certain limitations may apply). Join the FSA Program today and start saving! Fringe Benefit Management Company (FBMC) is the Plan Administrator for the FSA Program. See page 13 for details.

Commuter Savings Program (CSP)

Formerly known as the Qualified Transportation Benefit (QTB) Program

The CSP can save you tax dollars 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. WageWorks is the Plan Administrator for the CSP. See page 18 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 employees by offering a wide variety of investment options, flexibility to make investment choices and changes conveniently. Contact the Deferred Compensation Program for more information. See page 19 for contacting the Plan Administrator.

Life Insurance Program

Basic term life insurance coverage is provided at no cost to members. Optional life insurance coverage is also available at group rates to members at their own expense. Minnesota Life Insurance Company is the Life Insurance Plan Administrator. See page 6 for contribution information. See page 17 for more information.

Vision Care Benefit Plan

Annual eye examinations are an important part of your overall health, protecting your visual wellness as well as providing early detection of serious health conditions. **The vision plan provides coverage for an annual exam, as well as lenses and frame (or contact lenses) every 24 months.** EyeMed is the new Vision Plan Administrator. See page 20 for more information.

Long-Term Care (LTC) Insurance

LTC Insurance can help pay expenses not covered by your health plan or disability insurance. MetLife is the LTC Plan Administrator. Contact MetLife for more information. See page 17 for more information.

Smoking Cessation Program

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

Adoption Benefit Program

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.

COBRA

Established under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), eligible 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 Special Payment Programs Unit. See page 21 for more information.

Employee Assistance Program (EAP)

The Employee Assistance Program provides a valuable resource for support and information during difficult times. See page 10 for more information.

Frequently Asked Questions (FAQs)

For All Plan Participants:

Q. What if I don't want dental coverage?
A. You can elect not to participate in the QCDP by completing Section D of the Benefit Choice Election Form. Declining participation in the dental plan does not affect your coverage under the medical plan.

Q. If I elected to not participate in the dental plan, can I rejoin the plan at a later date?
A. Yes, but only during a Benefit Choice Period.

Q. What if I have a mid-year qualifying change in status and I'm enrolled in the FSA Program (MCAP/ DCAP)?
A. The normal period of coverage for participants who enroll in the Program during Benefit Choice is July 1-June 30 each plan year. For participants who experience a mid-year qualifying change in status event and subsequently change their FSA deduction amount, your plan year will be divided into two or more periods of coverage (dependent upon the number of qualifying changes in status you experience). Allowable expenses for each period must be incurred during that timeframe and expenses are reimbursed based upon the enrolled amount.

For Plan Participants currently enrolled in or considering enrollment in the Quality Care Health Plan (QCHP), Health Alliance Illinois, HealthLink OAP or OSF Winnebago:

Q. I understand that a Maintenance Medication Program exists, but where do I find information on which drugs are considered maintenance and which retail pharmacies participate in the Program?
A. During the Benefits Choice Period, you may obtain this information by calling Medco at 800-899-2587, accessing our Website: www.benefitschoice.il.gov, or calling our office at 800-442-1300. If you are enrolled in one of the plans that have this benefit, beginning July 1, you may register on Medco's website www.Medco.com to obtain additional prescription information.

Q. Under the Maintenance Medication Program, I am supposed to obtain my maintenance medication from Medco's Mail Order Pharmacy or a Retail Maintenance Network pharmacy. What will happen if I don't use either of these?
A. Maintenance medication may be obtained from any pharmacy, at differing copays. To obtain the best benefit, maintenance medications should be obtained from Medco's mail order pharmacy or a Retail Maintenance Network pharmacy; you receive a 3-month supply of medication for 2 copayments. To find a listing of participating retail pharmacies, visit our website at www.benefitschoice.il.gov .

Q. How do I order medications through Medco's Mail Order Pharmacy?
A. To order from Medco's Mail Order Pharmacy, you must obtain an original 61-90 day written prescription plus up to three 61-90 day refills from your doctor and complete a Mail Order Form available at www.benefitschoice.il.gov . Send the original prescription, the completed Mail Order Form and the appropriate copayment to Medco at the address listed on the form. Your prescription should be shipped within 11 days.

Q. How do I order refills through Medco's Mail Order Pharmacy?
A. Once enrolled, you will receive a refill form from Medco with each mail order prescription. For quicker processing, you can also order refills via the Internet or by telephone. Visit Medco's website at www.Medco.com or call Medco at 800-899-2587.

Employee Monthly Health, Dental and Optional Life Contributions

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 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. For full-time employees currently enrolled or considering enrollment in a managed care health plan, the contribution levels have not increased.

Employee Annual Salary	Employee Monthly Health Contributions	
$27,800 & below	Managed Care: $27.00	Quality Care: $46.00
$27,801 - $42,000	Managed Care: $32.00	Quality Care: $51.00
$42,001 - $55,900	Managed Care: $34.50	Quality Care: $53.50
$55,901 - $70,000	Managed Care: $37.00	Quality Care: $56.00
$70,001 & above	Managed Care: $39.50	Quality Care: $58.50

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 health coverage. Call your retirement system for applicable contributions. SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7876.

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

Employee Monthly Dental Contributions Quality Care Dental Plan (QCDP)	
Employee Only	$10.00
Employee + 1 Dependent	$17.50
Employee + 2 or more Dependents	$20.00
Retirees, Annuitants, Survivors and Dependents	$0

Contribution Calculation Worksheet

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

Dependent Monthly Health Contribution: $_____
(if insuring Dependents, see page 7)

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

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

My Total Monthly Contribution: $_____

NOTE: An interactive Premium Calculation Worksheet is available online at www.benefitschoice.il.gov

Dependent Monthly Health Contributions, Member Plan Year Deductibles and Family Plan Year Deductible Caps

Monthly dependent health contributions 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 contributions 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 or become eligible for Medicare Part A and/or Medicare Part B, or have questions regarding whether Medicare is primary payer, contact CMS Medicare COB Unit. See pages 21 and 22 for Plan Administrator information.

Dependent Monthly Health Plan Contributions				
Health Plan Name and Code	**One Dependent**	**Two or More Dependents**	**One Medicare A and B Primary Dependent**	**Two or More Medicare A and B Primary Dependents**
Unicare HMO (Code: CC)	$ 62	$ 93	$ 57	$ 93
HMO Illinois (Code: BY)	$ 63	$ 96	$ 59	$ 96
PersonalCare (Code: AS)	$ 72	$ 110	$ 68	$ 110
OSF Health Plan (Code: CA)	$ 72	$ 110	$ 69	$ 110
Health Alliance HMO (Code: AH)	$ 74	$ 113	$ 69	$ 113
Health Alliance Illinois (Code: BS)	$ 83	$125	$ 80	$125
HealthLink OAP (Code: CF)	$ 85	$129	$ 82	$129
OSF Winnebago (Code: CE)	$ 87	$132	$ 84	$132
Quality Care Health Plan (Code: D3)	$162	$192	$ 108	$169

Employees who reside in Illinois who enroll dependents, but are not accessible to managed care providers, should contact CMS Group Insurance Division for contribution amounts. See pages 21 and 22 for Plan Administrator information.

Quality Care Health Plan (QCHP)		
Employee's Annual Salary (Based on each employee's annual salary as of April 1st)	**Member Plan Year Deductible**	**Family Plan Year Deductible Cap**
$55,900 or less	$250	$625
$55,901 - $70,000	$350	$875
$70,001 and above	$400	$1000
Retiree/Annuitant/Survivor	$250	$625
Dependents	$250	NA

Prescription Drug Plan for Quality Care Health Plan (QCHP), Managed Care Health Plans - Health Alliance Illinois, HealthLink OAP and OSF Winnebago Managed Care Plans

Medco Health Solutions is the new Prescription Benefit Manager (PBM) for participants enrolled in the above-named plans. If you are not enrolled in one of the above mentioned health plans, contact your Managed Care Plan for prescription information. The coverage provides both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or a dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription. When a brand drug is dispensed 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.

The prescription benefit includes a Preferred Drug List. This list is available by calling Medco at 1-800-899-2587, or at www.benefitschoice.il.gov . The Preferred Drug List is subject to change at any time during the plan year. If you are currently taking a medication that is not on Medco's Preferred Drug List, you will receive a letter informing you of the Medco preferred alternative drug. Please review this letter with your physician to determine if a change in your prescription is appropriate.

The prescription benefit also includes a Maintenance Medication Program (MMP). Maintenance medications are medications taken for conditions such as high blood pressure and high cholesterol. The MMP is a way to save money on your maintenance medication. The maintenance list is also available at www.benefitschoice.il.gov .

Medco is working with Caremark to transfer open mail order prescriptions. Certain prescriptions can not be transferred. Therefore, you may need to obtain a new prescription. If so, you will be notified. The prescription plan offers several options:

Benefit Type Available	Dispensing Facility	Type and Supplies
Retail Pharmacy Network	Retail Pharmacy*	30-day fill of non-maintenance medication and the first two (2) 30-day fills of maintenance medications (one copay each). 3rd fill and any fills thereafter (two copays).
Mail Order Pharmacy	Mail Order Pharmacy	61 to 90-day supply of medication.
Maintenance Medication Program (MMP)	Retail Maintenance Network Pharmacy* **or,** Medco's Mail Order Pharmacy	30-day supply of non-maintenance and maintenance medications, and 61 to 90-day supply of maintenance medications, **or,** 61 to 90-day supply of medication.
Out-of-Network Benefit	All Pharmacies	In most cases, the cost of the prescription drugs will be higher when not using an in-network pharmacy or the mail order pharmacy. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Medco) and your original prescription receipt. However, reimbursement will be at the applicable brand or generic in-network copayment.
***Contact your retail pharmacy to see if it is participating in the Retail Maintenance Network.**		

Retail Pharmacy Network

This network of retail pharmacies contracts with Medco to accept certain copayment amounts. There are no plan year deductibles and no claim forms to file.

Non-maintenance medication (1-30 day supply), and the first two 30 day fills of maintenance medication:

Generic	$ 9.00
Preferred Brand	$18.00
Non-preferred Brand	$36.00

Maintenance medication (1-30 day supply) after the first two 30 day fills:

Generic	$18.00
Preferred Brand	$36.00
Non-preferred Brand	$72.00

Maximum days supply at one fill is 60 days. However, two copayments will be charged for any prescription exceeding 30-days.

Medco Mail Order Pharmacy

The mail service program provides up to a 90 day supply of medication for two copays. There are no plan year deductibles.

61 to 90-day supply:

Generic	$18.00
Preferred Brand	$36.00
Non-Preferred Brand	$72.00

Maintenance Medication Program (MMP)

The MMP, which consists of a Retail Network Pharmacies participating in the Retail Maintenance Network and Medco's mail order pharmacy, allows you to obtain a 61 to 90-day supply of maintenance medication for two retail copayments. A listing of maintenance medications can be found at www.benefitschoice.il.gov. Maintenance medication purchased at a retail pharmacy not participating in the Retail Maintenance Network will, after the initial two fills, be available at the above copayments. A list of the pharmacies participating in the Retail Maintenance Network is available at www.benefitschoice.il.gov .

It is NOT necessary to obtain two 30-day fills of maintenance medication before obtaining a 61 to 90-day supply of maintenance medication. The 61 to 90-day supply may be filled at Medco's mail order pharmacy or a participating Retail Maintenance Network pharmacy without first obtaining two 30-day supplies at retail.

Retail Maintenance Pharmacy Network—no plan year deductibles; no claim forms to file.

Non-maintenance medication (1-30-day supply) and the first two fills of maintenance medication:

Generic	$ 9.00
Preferred Brand	$18.00
Non-Preferred Brand	$36.00

Note: Non-maintenance medications are available at all pharmacies.

Maintenance medication (61-90 day supply) and maintenance medications after the second 30 day fill:

Generic	$18.00
Preferred Brand	$36.00
Non-Preferred Brand	$72.00

Mail Order Pharmacy - see above for maintenance medication copayments.

To receive a discounted 61 to 90-day supply of maintenance medication, obtain an original prescription from the attending physician written for a 61 to 90-day supply plus up to three (3) 90-day refills, totaling one year of medication. If ordering through Medco's mail order pharmacy, complete the mail order form. The original prescription must be attached to the order form and mailed to the mail order pharmacy. Medication should be delivered within 11 days from the time mail order pharmacy receives the order. **Remember:** If utilizing a MMP network pharmacy, simply take the prescription to the pharmacy counter.

Out-of-Network Benefit

Prescription drugs may be purchased at out-of-network pharmacies. 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 in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Medco) and the original prescription receipt.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans; the appropriate copayment will be applied for each prescription filled.

Exclusions

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

Behavioral Health Services

QCHP

Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are administered through the QCHP Behavioral Health Administrator listed on page 22. Calling the Behavioral Health Administrator begins the authorization process for services with all levels of care to avoid penalties or non-authorization of benefits. All behavioral health services are subject to medical necessity. Eligible charges are for those services deemed medically necessary by the Behavioral Health Administrator. Services determined not medically necessary will not be eligible for coverage. For further information regarding benefit coverage, coordination of benefits and authorization requirements, refer to the Benefits Handbook.

Managed Care Health Plans

Managed care plans determine the maximum number of inpatient days and outpatient visits for mental health and/or 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. For further information, contact the respective Managed Care Health Plan Administrator listed on page 21 .

Employee Assistance Program (EAP)

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

Who is eligible to participate?

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

What number do I call for services?

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

- Active employees *not* represented by the collective bargaining agreement between the State and AFSCME must contact the EAP Behavioral Health Administrator. Getting help is easy, convenient and available 24 hours a day, seven days a week. See page 22 for Plan Administrator and website information.
- Bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME must access EAP services through the Personal Support Program. See page 22 for Plan Administrator and website information.

NOTICE OF PRIVACY PRACTICES

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

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

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act. These plans include the Quality Care Health Plan and the Quality Care Dental Plan. The term "we" in this Notice means the Bureau 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 the 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. Medco Health Solutions is the Prescription Drug Plan Administrator. Magellan Behavioral Health is the Behavioral Health Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a notice from the HMO regarding its privacy practices.

How We May Use or Disclose Your PHI:

Treatment: We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party. We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.
Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.
Health Care Operations: We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.
Appointment Reminders: Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

Legal Requirements:

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

Public Health: We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.
Health Oversight Activities: We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.
Judicial and Administrative Proceedings: We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.
Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.
Avert a Serious Threat to Health or Safety: We may use or disclose PHI to stop you or someone else from getting hurt.
Work-Related Injuries: We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.
Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.
Organ Procurement: We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.
Release of Information to Family Members: In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.
Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.
National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.
Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.
Research: You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.
Fundraising and Marketing: We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

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

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

Your Rights:

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

For the Medical Plan Administrator and Notification/Medical Case Management:

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

For Pharmacy Benefits:

Medco Health Solutions, Privacy Services Unit
P.O. Box 800
Franklin Lakes, NJ 07417
800-987-5237

For Behavioral Health Benefits:
Magellan Behavioral Health, Privacy Officer
1301 E. Collins Blvd.
Suite 100
Richardson, TX 75081
800-513-2611

For Dental Plan Benefits:
CompBenefits, Privacy Officer
100 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 "http://www.state.il.us/cms/2_servicese_ben/privpracs.htm".

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

EFFECTIVE DATE: July 1, 2005

The Flexible Spending Account (FSA) Program

The FSA Program is an optional benefit that allows eligible employees to set aside up to $5,000 tax-free to one or both of the plans for a combined maximum of $10,000. The amount designated is payroll deducted and deposited into the account(s) prior to federal, state and Social Security tax withholdings, thereby lowering taxable income and increasing your spendable income. Fringe Benefit Management Company (FBMC) is the Plan Administrator for the FSA Program.

The Plans are as follows:

- **Dependent Care Assistance Plan (DCAP)** - allows you to pay eligible child and/or adult day care expenses incurred during the plan year. For eligibility information contact your GIR or the FSA Unit.
- **Medical Care Assistance Plan (MCAP)** - allows you to pay eligible out-of-pocket medical and dental expenses incurred during the plan year. For eligibility information contact your GIR or the FSA Unit.

The **EZ Reimburse MasterCard Program** is available for MCAP participants. This Program makes MCAP participation virtually paperless. The $20 annual EZ Reimburse Mastercard fee will be deducted from your annual enrolled amount. For more information, visit www.fbmc-benefits.com (select Products and Services).

The EZ Reimburse Card electronically debits funds from your MCAP account when an eligible, uninsured medical expense is incurred.

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

About 50% of all MCAP medical claims are for prescription drugs. FBMC and its partners developed a system enabling online, real-time, adjudication of prescription drug claims. When you present the EZ Reimburse Card at **any FBMC participating pharmacies** to buy a prescription drug or to pay the prescription co-payment, your MCAP account is automatically debited.

You may use the EZ Reimburse Card for:

- co-payments at doctor/dentist/ophthalmologist/optometrist offices
- deductibles
- prescription co-payments or
- co-payments, prescriptions and other health-related expenses (excludes over-the-counter items)

If you were enrolled in the EZ Reimburse Mastercard Program last plan year, and wish to enroll in the Program this plan year, be sure to check the appropriate box on the enrollment/re-enrollment form and you will be issued a new card for this plan year.

Health Plan Options

Review the features below to help make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

There are three (3) types of medical plans from which to choose:

Plan	Type	Features
Health Maintenance Organizations (HMO)	Managed Care	•Selection of primary care physician (PCP) •Referrals to specialists often controlled by PCP •Lower out-of-pocket costs
Open Access Plan (OAP)	Managed Care	•Selection of PCP with self-referral to specialists •Out-of-network physician and hospital access •Slightly higher out-of-pocket costs
Quality Care Health Plan (QCHP)	Indemnity Plan	•Access to any physician •Higher out-of-pocket costs

Managed Care Health Plans

There are 8 managed care plans. Plans include HMOs and an 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. If you are considering a managed care plan, explore and research the various plans available. Benefits are subject to the limitations outlined in each plan's Summary Plan Document. Contact the managed care plan administrator for detailed information concerning the various levels of coverage provided. See page 21 for Plan Administrator information.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Plan participants select a Primary Care Physician (PCP) from the network of participating providers. In conjunction with the health plan, the PCP directs all healthcare services for the plan participant, including visits to specialists and hospitalizations. When medical services are coordinated through the PCP, the plan participant pays only a predetermined copayment. There are no annual plan deductibles for HMO plans.

Open Access Plan (OAP)

The plan is unique because it offers three benefit levels:

Tier I - HMO level of benefits - often paying 100% after a copayment (using a Tier I network provider).
Tier II - self-referral PPO benefits generally paying at 90%, after you pay a deductible (using a Tier II network provider).
Tier III - open access to out-of-network providers where benefits are generally paid at 80% of the usual and customary charges (after a deductible).

Your benefit level is determined by the provider you choose. The plan provider directory contains separate listings of participating providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive.

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, you choose any physician or hospital for general or specialty medical services, and receive higher levels of benefits by using a QCHP Preferred Provider Organization (PPO) hospital or the CIGNA Healthcare PPO Network of providers and facilities. Intracorp is the QCHP Notification Administrator/Medical Case Management Administrator. In addition to the State's PPO hospital network, QCHP non-Medicare members also have access to CIGNA's nationwide network of PPO hospitals and medical providers. An enhanced 90% benefit for hospital services, facility services, and professional fees is available by using a network provider. The network providers are reimbursed on the basis of a negotiated rate and usual and customary limits are not applied to the enrollee. To receive the enhanced PPO network benefit, always present your State of Illinois QCHP identification card with the CIGNA logo at the time of service. Magellan Behavioral Health is the QCHP Behavioral Health Administrator for mental health/substance abuse services. Contact Magellan for a listing of network providers and facilities. Medco Health Solutions is the Prescription Drug Plan Administrator. See pages 21 and 22 for Plan Administrator information.

Health Plan Comparison

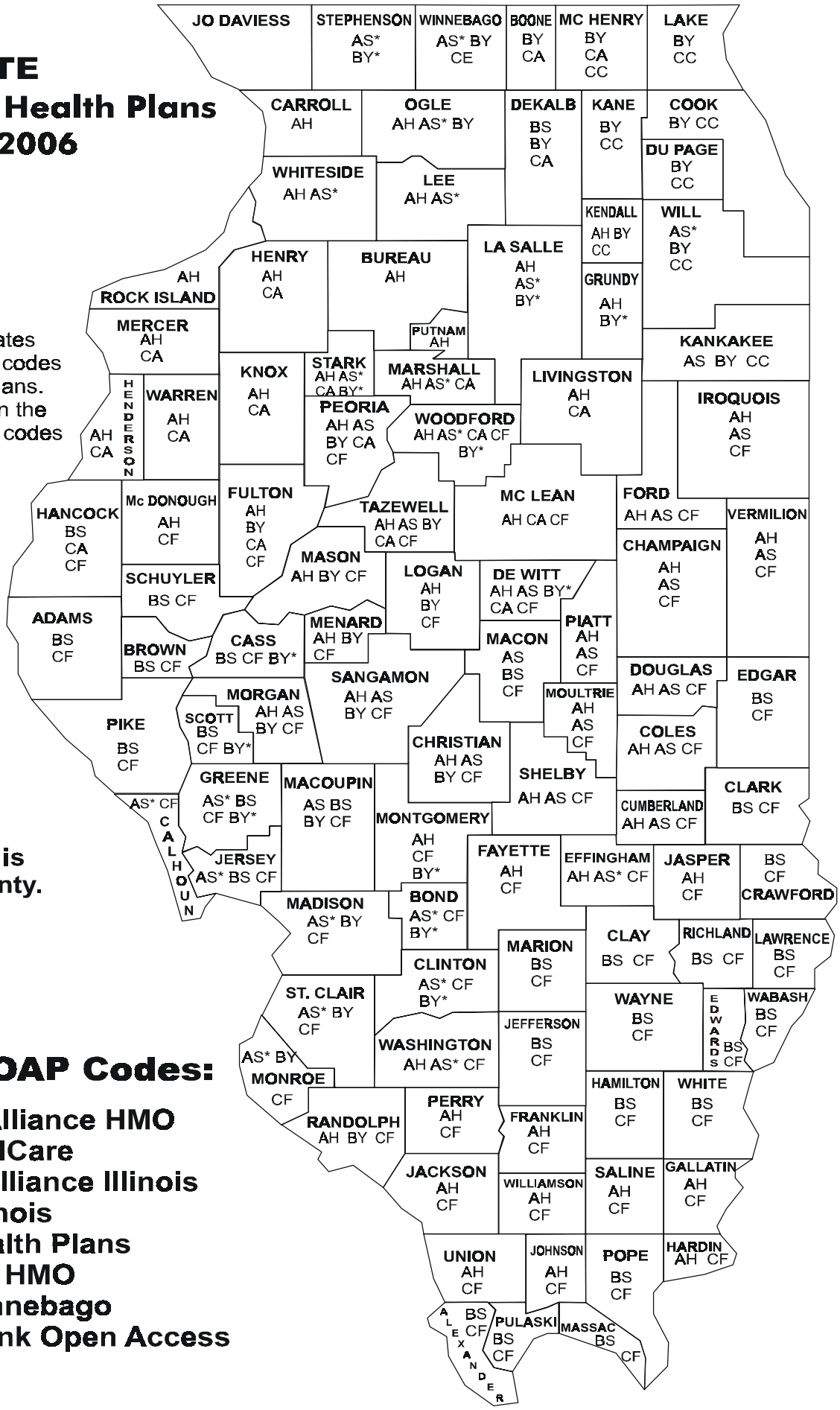
Benefit	HMO	OAP Tier I	OAP Tier II	OAP Tier III (Out-of-Network)	QCHP
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000,000	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000,000	Unlimited
Patient Responsibilities					
Annual Out-of-Pocket Maximum • Per Enrollee • Per Family	$1,500 $3,000	Not Applicable	$600 $1,200	$1,500 $3,500	General: $900 per enrollee $2,250 per family/plan year Non-PPO Hospital: $3,800 per enrollee $7,600 per family/plan year
Other Deductibles/Copayments: Emergency Room Non-PPO/Out-of-Network Hospital Admission	$150 No Coverage	$150 Not Applicable - See Tier III for benefit level	$150 + 10% Network Charges** Not Applicable - See Tier III for benefit level	$150 + 20% Network Charges** $300 + 20% of U&C*	$300 $200
Annual Plan Deductible Must be satisfied for all services	$0	$0	$200 Per Enrollee	$300 Per Enrollee	$250 - $400 (salary based premium)
Plan Benefit Levels Comparison					
Inpatient	$200 copayment	$200 copayment	90% of network charges** after $250 copayment	80% of U&C* after $350 copayment	90% - PPO 80% or 65% - Non-PPO
Outpatient Surgery	$100 copayment	$100 copayment	90% of network charges** after $100 copayment	80% of U&C* after $100 copayment	90% for PPO Network Provider
Diagnostic Lab & X-ray	100%	100%	90% of network charges**	80% of U&C*	90% of U&C*
Durable Medical Equipment	80%	100%	90% of network charges**	80% of U&C*	80% of U&C*
Physician Office Visit	$10 copayment	$10 copayment	90% of network charges** for covered services	80% of U&C*for covered services	90% PPO 80% of U&C* Non-PPO
Preventive Services	$10 copayment	$10 copayment	90% of network charges** for covered services	Covered In-Network only	80% or 100% for specific services
Home Health Care (skilled care visits)	$15 copayment	$15 copayment	90% of network charges** for covered services	Covered In-Network only	80% of U&C*
Hearing Exams and Aids (covered by all health plans)	Up to a maximum of $100 for audiologist fees and $500 for hearing aids - benefit available once every three years				

* Usual & Customary (U & C) is an amount determined by the health plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment, or supplies for a similar medical condition.
** Network Charges are the amount the plan determines is the appropriate charge for a covered service.

STATE
Managed Care Health Plans For FY 2006

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

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



HMO and OAP Codes:

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

Life Insurance Coverage

Member Optional:

- Active members and eligible annuitants under age 60 may elect optional life 1– 8 times the basic coverage amount with a maximum of $3,000,000 when combined with basic coverage. Survivors (prior to Sept. 22, 1979) may elect 1– 4 times their basic coverage amount.
- Optional life coverage in excess of 4 times the basic coverage amount will terminate when an annuitant turns age 60.
- Members may add/drop/increase or decrease optional life coverage during Benefit Choice by completing Section E of the Benefit Choice Election Form.
- Adding or increasing optional life coverage is subject to prior approval by Minnesota Life Insurance Company. Members must complete and submit a Statement of Health form to Minnesota Life Insurance Company for review. Contact your agency GIR to obtain a Statement of Health form or visit the Benefit Choice website at www.benefitschoice.il.gov . The effective date for adding or increasing optional life coverage will be July 1, 2005, or the pay period following the Statement of Health approval date, whichever is later.

Accidental Death and Dismemberment (AD&D):

- The maximum AD&D coverage an employee may elect is 5 times their basic coverage amount (basic plus 4 times optional coverage).
- Members may add or drop coverage during Benefit Choice by completing Section E of the Benefit Choice Election Form.
- A Statement of Health is not required to obtain AD&D coverage.

Spouse/Child Life:

- Members may add or drop coverage during Benefit Choice by completing Section F of the Benefit Choice Election Form.
- Adding spouse and/or child life coverage is subject to prior approval by Minnesota Life Insurance Company. Members must complete and submit a Statement of Health form to Minnesota Life Insurance Company for review. Contact your agency GIR to obtain a Statement of Health form or visit the Benefit Choice website at www.benefitschoice.il.gov . The effective date for adding spouse and/or child life coverage will be July 1, 2005, or the pay period following the Statement of Health approval date, whichever is later.
- Spouse life coverage will reduce to $5,000 when an eligible annuitant turns age 60. Child life coverage remains $10,000 for both active Members and eligible annuitants.

Long-Term Care Insurance

The State Employees Group Insurance Program offers an optional group long-term care insurance plan through MetLife. Premiums for the plan are paid entirely by the Member directly to MetLife. Members may enroll or disenroll at any time.

Most medical plans are designed to cover acute care and skilled care, but rarely cover care of a custodial or long-term nature. A person may need this level of care due to various factors such as age, illness, or accidental injury. The plan has coverage options that range from in-home care through services provided in a residential facility.

Members may request an enrollment kit from MetLife by calling 1-800-438-6388. Please say “State of Illinois” when asked for your company name. Members will be sent, at no obligation, plan information and options, premium rates, and a personalized enrollment kit.

Commuter Savings Program (CSP)

formerly known as Qualified Transportation Benefit (QTB) Program

Pay for your commute tax-free and save money!
The Commuter Savings Program (CSP) can save you money on your commuting costs. By enrolling in the CSP, you can pay for your commute to work tax-free. You save because you won't pay any federal taxes on your commuting costs through the CSP. That means the CSP will not only reduce your transportation costs, but will lower your taxable income, too. You'll have more money to spend on your other needs. WageWorks is the plan administrator for the Program. To enroll in the program call 1-877-924-3967 or visit www.wageworks.com .

Use it for Public Transportation
If you take public transportation to work, you can have up to $105 per month deducted to pay for bus or train passes. Your monthly pass will be mailed directly to your home before the beginning of the month.

Use it for Parking
If you drive to work, you can have up to $200 per month deducted to pay for work-related parking expenses. WageWorks can pay your parking provider directly or you may be reimbursed by submitting a simple claim form and a receipt, or by completing an online claim form.

Use it for Van Pools
If you take a vanpool to work, you can have up to $105 per month deducted to pay for your ride to work.

How does the CSP work?
When you enroll, you choose how much money you want deducted from your paycheck. WageWorks will then notify your payroll office of the amount you selected and that amount will be deducted from your paycheck before any federal or Social Security taxes are withheld – that's how you save! See page 21 for Plan Administrator information.

When should I enroll?
You can enroll, cancel or change the deduction amount at any time. You must enroll, cancel or make any changes by the 10th of the month in order for the transaction to be effective the next month. For example, a selection made on or before May 10th would begin in June.

To enroll in the program call 1-877-924-3967 or visit www.wageworks.com . When calling, be sure to have your Social Security number and your zip code available. Before you enroll, you can estimate your savings using the Commuter Savings Calculator at www.wageworks.com . (WageWorks administers the CSP for the State of Illinois).

Who is eligible?
Full-time and part-time state employees who work at least 50% time and who have their payroll checks processed through the Office of the Comptroller.

Deferred Compensation Program

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

Benefits from Participation in the Deferred Compensation Program

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

- **Reduce taxable income**
  The amount contributed to a deferred compensation account reduces taxable income which allows more savings, less taxes and more 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 in this Program.

Enrollment

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

Contribution Limitations

Contribution amounts may be as little as $20 per month up to $14,000 for tax year 2005 and $15,000 for tax year 2006. Participants age 50 and older will be allowed an additional "catch-up" amount for a total contribution of $18,000 for tax year 2005 and $20,000 for tax year 2006.

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

By State statue, the Plan must be administered so there are no expenses to the State. That is, all costs must be borne by the participants. An administrative fee is charged to participants to cover expenses such as recordkeeping, consultant projects, staff payroll, Plan materials and mailing costs. The annual charge to participants is 0.15% of account balances with a maximum fee of $45 for calendar year 2005.

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 21 for the Deferred Compensation Plan Administrator.

Quality Care Dental Plan (QCDP)

All members are automatically enrolled in QCDP unless you elect not to participate. To terminate your dental coverage during Benefit choice, complete Section D of the Benefit Choice Election Form. Declining participation in the dental plan does not affect your coverage under the medical plan. QCDP is administered by CompBenefits. Under QCDP, you may go to any dentist and receive benefits for an extensive range of services. QCDP reimburses covered services at a pre-determined maximum allowable scheduled amount. Members are responsible for any charges over the scheduled amount. For a detailed description of your dental plan benefits, see the schedule of benefits at www.benefitschoice.il.gov . Dental plan questions should be directed to CompBenefits, at (800) 999-1669, or (312) 829-1298 (TDD/TTY).

Plan Design	Quality Care Dental Plan (QCDP)
Annual Deductible	$100 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefit at www.benefitschoice.il.gov
Maximum Benefit Limit	$2,000 per person per plan year after plan deductible.
Maximum Benefit Level for Child Orthodontics (under age 19)	$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	Required
Dentist selection	Member's choice of provider

Vision Care Benefit Plan

The Vision Care Benefit Plan is designed to assist with the costs of well vision care. Eye examinations can provide early detection of serious health conditions throughout the entire body. The Plan is intended to encourage regular eye examinations and assist with vision care expenses when glasses or contact lenses are needed.

All Members and dependents covered by any of the health plans offered by the State Employees Group Insurance Program are eligible for the Vision Care Benefit Plan. The eye exam benefit is available once a year and materials such as frames, spectacle lenses or contact lenses (in lieu of frames and spectacle lenses) are available once every 24 months.

The new Vision Plan Administrator is EyeMed. Benefits are available from both in-network and non-network providers. Visit www.benefitschoice.il.gov for a link to EyeMed's website for the most up to date listing of network providers. See your Benefits Handbook for benefit details or contact EyeMed at (866) 723-0512.

Service	Network Provider Benefit	Non-Network Provider Benefit	Frequency of Benefit
Eye Exam	$10 copayment	$30 Allowance	Once every 12 months
Spectacle Lenses (single, bifocal and trifocal)	$10 copayment	$40 Allowance for single vision lenses $60 Allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	$10 copayment for frames within the benefit selection	$50 Allowance	Once every 24 months
Contact Lenses All contact lenses are in lieu of standard frames and spectacle lenses.	$100 Allowance	$100 Allowance	Once every 24 months

Who to call for information...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/stateofillinois
OSF Health Plans	(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 and Web Site Address
Vision Plan Administrator	Vision services, benefits, network providers, claim forms and filing.	**EyeMed Vision Care** Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY) www.benefitschoice.il.gov
Life Insurance Plan Administrator	Life insurance coverage and claim information.	**Minnesota Life Insurance Company** 1 N.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** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(800) 442-1300 (800) 526-0844 (TDD/TTY) www.state.il.us/cms/employee/defcom
FSA Plan Administrator	Information on MCAP/DCAP and claim eligibity.	**Fringe Benefits Management Company** P.O. Box 1800 Tallahassee, FL 32302-1800	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax) www.fbmc-benefits.com
Commuter Savings Program (CSP) - *Formerly known as the 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) www.wageworks.com
Health/Dental Plans, Medicare COB Unit, FSA Unit, Special Payment Programs Unit, Life Insurance, Adoption and Smoking Cessation Benefits	General information on the state health plans or other benefits.	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY) www.benefitschoice.il.gov

Who to call for information...Plan Administrators

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution, and pre-determination of benefits.	**CIGNA** Group Number 3181456 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $800 applies.	**Intracorp, Inc.** (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, specialty pharmacy, ID cards and claim filing.	**Medco** Group Number: 1400, 1400BS,1400CE, 1400CF **Paper Claims:** Medco Health Solutions P.O. Box 2080 Lee's Summit, MO 64063 - 2080 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630 - 3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) Prior to July 1, 2005: www.benefitschoice.il.gov After July 1, 2005: www.medco.com
QCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavorial Health Services.	**Magellan Behavioral Health** Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services, ID cards.	**Magellan Behavioral Health** *--- For Non-AFSCME represented employees ---* No Address Required	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Personal Support Program (PSP - AFSCME EAP)	Confidential assessment and assistance services.	**AFSCME Council 31** *--- For AFSCME represented State employees ---* No Address Required	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) www.afscme31.org
Quality Care Dental Plan (QCDP) Administrator	Dental services, claim filing, ID cards.	**CompBenefits** Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits and contributions described in this Benefit Choice Options Booklet. This Booklet is produced annually and is intended to update the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

BENEFIT CHOICE ELECTION FORM

May 1 – 31, 2005 (Changes effective July 1, 2005)

COMPLETE THIS FORM ONLY TO MAKE A CHANGE IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

SSN: — —

Last Name	First Name	Phone Numbers	
		Home:	Work:

SECTION B: OPT OUT / OPT IN

OPT OUT/OPT IN of Health & Dental		
☐ Opt Out	☐ Opt In	**See Section B on the instruction sheet for requirements.**

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

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

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

SECTION D: DENTAL PLAN OPTION

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

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

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

SECTION F: DEPENDENT INFORMATION [1] (dependent must be enrolled in the same plans as the member)

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

Notes: [1] Documentation required to add dependents – see the instruction sheet for specific documentation requirements.

[2] Statement of Health form required when increasing Optional Life or adding Spouse or Child Life (form available at www.benefitschoice.il.gov).

[3] Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

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

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office by May 31, 2005.

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

If you are keeping your current coverage elections, you do not need to complete the Benefit Choice Election Form.

SECTION A – EMPLOYEE INFORMATION (Complete all fields)

SECTION B – OPT OUT / OPT IN
If you wish to opt out or opt in to the State Employees Group Insurance Program you must complete the 'Opt Out/Opt In' portion of Section B and submit an 'Opt Out/Opt In Election Certificate' (CMS-500 - form available at **www.benefitschoice.il.gov** or through your agency Group Insurance Representative). If you elect to opt out, you must also provide proof of comprehensive major medical health coverage (indemnity or managed care) provided by an entity other than the Department of Central Management Services. Proof of coverage may be a certificate of creditable coverage or a copy of the front and back of your health ID card.

SECTION C – HEALTH PLAN ELECTIONS
Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your carrier directly in order to make this change.
If you wish to change your **health** plan, you must check either the Quality Care Health Plan (QCHP) or one of the managed care plan boxes (HMO or OAP). If electing/changing managed care plans, you must enter the managed care plan's two-digit carrier code (see page 16 of the FY2006 Benefit Choice booklet for carrier codes), the plan's name, and the Primary Care Physician (PCP) number or National Provider Identifier (NPI). The PCP or NPI number may be found in the online directory on the individual plan's website (see page 21 of the FY2006 Benefit Choice booklet for Managed Care Health Plan Administrator contact information).

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

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

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

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

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

SIGNATURE
You must sign and date the Benefit Choice Election Form and give to your agency GIR by **May 31, 2005** in order for your elections to be effective July 1, 2005. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period.

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

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

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Printed by the authority of the State of Illinois
(CMS-BEN2002-02-200M-04/05)
Printed on recycled paper