



# *Benefit Choice Options*



 *Your Benefits  
for Good Health*

## *State of Illinois*

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

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

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

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# Important Changes For Plan Year 2008

(July 1, 2007 through June 30, 2008)

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

The information below presents changes to the State of Illinois benefit plans. Please carefully review all the information in this Benefit Choice Options booklet. Members should review this publication to be aware of benefit changes. Benefit Choice is May 1 - 31, 2007. All selections made during Benefit Choice will be effective July 1, 2007.

**New! Disease Management Program** – A disease management program, **Well Aware for Better Health®** administered through CIGNA by **Healthways**, is now available to QCHP members and dependents that have been identified with **diabetes or cardiac health conditions**. Eligible QCHP members and dependents may receive an invitation to participate in one or both of these disease management support programs. See page 29 for more information.

**Benefits Handbook Amendment** – Effective this year, the Benefits Handbook will be updated via an amendment contained within the annual Benefit Choice Options booklet. Please tear out pages 3-8 of this booklet and keep with your current Benefits Handbook (dated 2004).

**MCAP Grace Period** – Employees enrolled in the Medical Care Assistance Plan (MCAP) may now incur eligible medical, vision and dental expenses through September 15th of each year and have them reimbursed from their previous plan year MCAP account balance. The “grace period” does not apply to DCAP. See page 28 for more information.

## **Managed Care Plan (HMO/OAP) Changes**

- Outpatient surgery co-payment increases to \$150
- Employee and dependent health contributions have increased

## **Quality Care Health Plan (QCHP) Changes**

- General out-of-pocket maximum (individual) increases to \$1,100
- General out-of-pocket maximum (family) increases to \$2,750
- Non-QCHP hospital out-of-pocket maximum (individual) increases to \$4,400
- Non-QCHP hospital out-of-pocket maximum (family) increases to \$8,800
- Prescription co-payments increase to \$11/\$22/\$44
- Employee and dependent health contributions and deductibles have increased
- Emergency room visit co-payment increases to \$400

## **Quality Care Dental Plan (QCDP) Changes**

- Coverage now includes dental implants, inlays, onlays and adult sealants

## **Optional Life Coverage Changes**

- Contributions have decreased for the 40-44 and 50 and above age brackets

# Benefits Handbook Amendment

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

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

1. **Alternative Retirement Cancellation Payment (ARCP)**
2. **Domestic Partner Coverage**
3. **Qualifying Change in Status for Leave of Absence**
4. **Employees Off Payroll**
5. **Insurance Coverage While on a Leave of Absence**
6. **Termination of Member Coverage**
7. **Termination of Dependent Coverage**
8. **Open Access Plan (OAP)**
9. **QCHP Notification Requirements-General**
10. **QCHP Notification Requirements-Outpatient Surgery Procedures**
11. **QCHP Emergency Services**
12. **QCHP Prescription Drugs**
13. **QCHP Skilled Nursing**
14. **QCHP Urgent Care Services**
15. **QCHP Covered Benefits-Adults**
16. **QCHP Covered Benefits-Children**
17. **QCHP Exclusions and Limitations**
18. **QCDP Prosthodontic Limitations**
19. **Age 65 & Over-Medicare Eligible**
20. **Under Age 65-Medicare Due to Disability**
21. **End Stage Renal Disease (ESRD)**
22. **Medicare Part B Reduction**

## **AMENDMENT TO THE STATE OF ILLINOIS GROUP INSURANCE PROGRAM**

The following is an amendment to the 2004 State of Illinois Benefits Handbook for State employees, retirees and survivors. Please review this document carefully and keep it with your Benefits Handbook for future reference.

1. *On pages 15 and 16 under Special Provisions, the following replaces the first sentence:*

### **ARCP**

Employees vested under the State Employees Retirement System who elected the Alternative Retirement Cancellation Payment (ARCP) per Illinois Public Act 93-0839 (between August 16, 2004 and October 31, 2004), Illinois Public Act 94-0109 (between July 1, 2005 and September 30, 2005), or Illinois Public Act 94-0839 (between June 6, 2006 and August 31, 2006) may be eligible for coverage under the Program.

2. *On page 18 under Eligible as Dependents, the following type of dependent is added:*

### **Domestic Partner**

Effective July 1, 2006, unrelated, same-sex individuals who reside in the same household and have a financial and emotional interdependence, consistent with that of a married couple for a period of not less than one year and continue to maintain such arrangement may be eligible for medical, dental and vision benefits. The minimum age of a domestic partner is 19 years old. Neither the member, nor the domestic partner, may be married at the time of enrollment. If either partner gets married at any time after enrollment, the domestic partner's coverage must be terminated. If both parties are State members, one may not waive coverage as a member to become a dependent of the other member. The Domestic Partnership Affidavit (CMS-510) must be completed and submitted, along with two forms of documentation to prove domestic partnership. Dependent children of the domestic partner cannot be added to the member's coverage unless the member legally adopts or obtains legal guardianship of the children. If an enrolled domestic partner is not considered a tax dependent as defined by the IRS, the value of the domestic partner coverage (the portion the State contributes toward the cost) is reported as imputed income and will be subject to federal and state taxes. The effective date of coverage for an approved domestic partner is the first day of the pay period following the signature date on the Domestic Partner Enrollment Form if enrolling mid year or, July 1st if enrolling during the annual Benefit Choice Period. If the domestic partner becomes ineligible for benefits, it is the member's responsibility to notify their agency Group Insurance Representative.

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3. On page 28 under the Waive Health and Dental Coverage for the Leave of Absence: Member entering non-pay status qualifying event, the member type is changed to the following:

## Member Qualifying Change in Status chart

A 'P' which indicates that this is an eligible change for a part-time employee, and/or a survivor or annuitant required to pay a Member premium.

4. On page 33 under Employees off Payroll, the 3rd paragraph is deleted and replaced with the following:

Failure to submit payment may result in termination of coverage and the filing of an involuntary withholding order to collect the unpaid premium.

5. On page 35 under Insurance Coverage While on a Leave of Absence, the 1st paragraph is deleted and replaced with the following:

Employees may choose, within 60 days of the leave, to drop dependent health coverage and/or optional life coverage. Full-time employees must maintain coverage for themselves unless they are on a leave of absence that requires the employee to pay 100% of the premium. Employees should contact their Group Insurance Representative (GIR) for options.

6. On page 39 under Termination of Member Coverage, the 5th bullet point is deleted and replaced with the following:

- The end of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid or collected through involuntary withholding (COBRA ineligible).

7. On page 39 under Termination of Dependent Coverage, the 5th bullet point is deleted and replaced with the following:

- On the last day of the period for which appropriate premiums were paid when subsequent premiums were the responsibility of the Member and were not paid or collected through involuntary withholding (COBRA ineligible).

Also on page 39 under Termination of Dependent Coverage, add the following bullet:

- On the date a newly acquired dependent was added, if not on the first day of a pay period, if the member is subsequently terminated for non-payment of premium for the next pay period.

8. On page 51 under Open Access Plan (OAP), the following bullet point is added:

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

9. On page 56 under Notification Requirements, the 1st through 5th paragraphs are deleted and replaced with the following:

Notification is the telephone call to the health plan administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility or for an outpatient procedure/therapy/service/supply.

If using a QCHP network provider (formerly PPO provider), the medical provider is responsible for contacting the Notification Administrator on behalf of the Plan Participant.

If using a non-QCHP provider (formerly non-PPO provider), the Plan Participant must direct their non-QCHP medical Provider to contact the Notification Administrator to provide specific

# Benefits Handbook Amendment

medical information, setting and anticipated length of stay to determine medical appropriateness.

Failure to contact the Notification Administrator prior to having a service performed may result in a **financial penalty** and risk incurring non-covered charges deemed not medically necessary. **Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare.**

10. *On page 57 under Notification is required for the following, the 1st bullet point is deleted and replaced with the following:*

## **Outpatient Surgery, Procedures, Therapies & Supplies/Equipment**

– Outpatient surgery and procedures including, but not limited to, items such as imaging (MRI, PET, SPECT and CAT Scan), physical, occupational or speech therapy, foot orthotics, DME supplies, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, breast reduction/enlargement, select injectable drugs, treatment for varicose veins, etc). Services must be authorized before being performed. Contact the Notification Administrator for the most up-to-date list of procedures requiring Notification.

11. *On page 64 under Urgent Care or Similar Facility, the bullet is deleted and replaced with the following:*

– 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of Emergency Services as presented in the 2004 Benefits Handbook. The benefit applies to professional fees only. Facility charges are not covered when services are performed in a physician's office or an Urgent Care Center. Non-emergency medically necessary services are considered at 80% of U&C.

12. *On page 69 under Prescription Drugs, the following bullets replace the last bullet in this section:*

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

13. *On page 70 under Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home, the last bullet is deleted and replaced with the following:*

- Prescription Drug charges must be submitted to the Health Plan Administrator.

14. *On page 72 under Urgent Care Services, the last paragraph is deleted and replaced with the following:*

Urgent care is treatment for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a Physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. Facility charges are not covered when services are performed in a physician's office or urgent care centers.

15. *On page 73 under Covered Benefits – Adults, the following is added:*

- Human Papillomavirus (HPV) Vaccine:
  - For female adults through age 26.
  - 80% of U&C for vaccine, up to the maximum benefit.
  - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

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16. On page 74 under Covered Benefits – Children, the following is added:

- Human Papillomavirus (HPV) Vaccine:
  - For eligible female dependents age 9–26.
  - 90% of U&C for vaccine.
  - Only the first office visit in conjunction with first HPV injection is covered at 80%, no deductible applies.

17. On page 87 under QCHP – Exclusions and Limitations, the following points are added:

40. For legal fees.
41. For treatment and services rendered in a setting other than direct patient-provider contact.

18. On page 92 under Prosthodontics, the 4th bullet point is deleted.

19. On page 103 under Medicare Eligible, the entire section is deleted and replaced with the following:

## Age 65 & Over - Medicare Eligible

Plan Participants must contact their local Social Security Administration office upon turning age 65 in order to determine if they are eligible for premium-free Medicare Part A benefits based on their own or their spouse's work history. All Plan Participants are eligible for Medicare Part B benefits upon turning age 65. All **retired** Plan Participants eligible for premium-free Medicare Part A, as well as Plan Participants actively employed with an employer other than the State of Illinois and without other large group health plan coverage or Plan Participants without Current Employment Status (CES), **must** enroll in Medicare Part A and Part B when first eligible.

Plan Participants with CES with other large group health plan coverage may delay enrolling in Medicare Part B until loss of CES, loss of

their large group health insurance through their current employer or retirement (whichever is first). Upon this event, a Plan Participant must enroll in Medicare Part B in order to avoid a reduction in benefits. See 'Medicare Part B Reduction' in this section for more information.

If Medicare Part B is not purchased at age 65 when the Plan Participant is either retired or no longer in CES, Medicare will impose a 10% penalty for each year without the purchase of Medicare Part B. The annual Medicare general enrollment period is January, February and March; however, coverage is not effective until July 1.

20. On pages 103-104 under Under Age 65 - Medicare Due to Disability, the entire section is deleted and replaced with the following:

## Under Age 65 - Medicare Due to Disability

In order to apply for Medicare disability coverage, a Plan Participant must contact their local Social Security Administration office. Plan Participants under the age of 65 who are receiving Social Security disability benefits or Railroad Retirement Board disability benefits, will automatically be enrolled in Medicare Parts A and B when determined eligible by the Social Security Administration. If a Plan Participant is retired or without Current Employment Status (CES) and is receiving Medicare benefits, the Plan Participant must remain enrolled in Medicare Part B. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

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21. *On page 104 under End Stage Renal Disease (ESRD), the entire section is deleted and replaced with the following:*

## **End Stage Renal Disease (ESRD)**

Plan Participants of any age may qualify for premium-free Medicare Part A on the basis of End Stage Renal Disease (ESRD) if certain criteria are met. In order to apply for Medicare ESRD coverage, a Plan Participant must contact their local Social Security Administration Office. Plan Participants who are receiving regular dialysis treatments or who have had a kidney transplant, must make application for Medicare benefits on the basis of ESRD. If it is determined that the Plan Participant is eligible for premium-free Medicare Part A, the Plan Participant must accept the Medicare Part A coverage and notify the Central Management Services Medicare COB Unit in order to establish the coordination of benefit period and to determine the date of Medicare primacy.

When Medicare becomes the primary payer, the purchase of Medicare Part B is required. If the Plan Participant does not enroll or remain enrolled in Medicare Part B when Medicare is determined to be the primary payer, the Plan will pay as if the Plan Participant has Medicare Part B benefits and the Part B benefit reduction applies. See 'Medicare Part B Reduction' in this section for more information.

22. *On page 104 after the End Stage Renal Disease (ESRD) section, add the following new section:*

## **Medicare Part B Reduction**

If Medicare Part B is not purchased, the Plan Participant's health plan (either QCHP or the Plan Participant's Managed Care health plan) will process claims as if Medicare Part B was the primary payer. When Medicare is the primary payer, the standard Medicare Part B plan pays 80% of all Medicare approved amounts. The QCHP pays up to the 20% coinsurance that remains after Medicare Part B pays. If a Plan

Participant does not enroll in Medicare Part B when Medicare is primary, the QCHP **will not pay** the initial 80% of the eligible charges. The QCHP will only pay up to 20% of the eligible charges of the claim. Plan Participants enrolled in a managed care health plan should refer to the managed care plan's Certificate of Coverage for reduction information. This reduction of benefits will remain in place until the date that Medicare Part B becomes effective. Plan Participants that terminate Medicare Part B coverage will be subject to claim adjustments by the claims administrator for any claims paid at the incorrect benefit level.

# NOTICE OF CREDITABLE COVERAGE

## Prescription Drug Information for State of Illinois Medicare Eligible Plan Participants

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

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop your entire group coverage through the State Employees Group Insurance Program and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D Plan later.**

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

**REMEMBER: KEEP THIS NOTICE**

## OPT OUT OPTIONS

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

Members who wish to Opt Out must complete the Opt Out Election Certificate, attach proof of other insurance coverage (such as a copy of an insurance card from another health plan that names you as being insured) and return to the Group Insurance Representative no later than May 31, 2007.

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

Members opting out of the Program are **not eligible** for the:

- Free influenza immunizations offered annually by the Department of Healthcare and Family Services
- COBRA continuation of coverage
- Smoking Cessation Program

Employees opting out of the Program **are eligible** for the:

- Flexible Spending Account (FSA) Program
- Commuter Savings Program (CSP)
- Paid maternity/paternity benefit
- Either of the two separate Employee Assistance Programs
- Long-Term Care Program
- Adoption Benefit Program

- **In accordance with Public Act 94-0109**, non-Medicare members receiving a retirement annuity from the State Employees' Retirement System (SERS) who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the Health Insurance Program and receive a financial incentive of \$150 per month. Contact the Insurance Section of the SERS at (217) 785-7150 for more information.
- **Individuals who opt out under either Public Act may re-enroll** in the Program only during the annual Benefit Choice period (May 1 - 31 each year), or within 60 days of experiencing an eligible qualifying change in status. Members who re-enroll, and their dependents, are subject to possible health benefit limitations for pre-existing conditions. A Certificate of Creditable Coverage from the previous insurance carrier must be provided to reduce the pre-existing conditions waiting period.

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

The Benefit Choice Period is **May 1 through May 31, 2007** for all members. Elections will be effective July 1, 2007. Members include employees (full-time, part-time employees working 50% or greater, as well as employees on leave of absence), annuitants, survivors and COBRA participants.

The Benefit Choice Period is the **only** time of the year, other than when a qualifying change in status occurs, that members may change their coverage elections. Before making benefit changes, compare:

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

There are three health benefit coverage options available:

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

See pages 14-19 to review the features for each type of plan.

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form (located in the back of this booklet or online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)).

Members should complete the form **only** if changes are being made. The agency/university Group Insurance Representative (GIR) will process the changes based upon the information indicated on the form. Members can access GIR names and locations by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

### **During the annual Benefit Choice Period, members may:**

- Change health plans
- Add or drop dependent coverage
- Increase or decrease member Optional Life insurance coverage
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage
- Enroll unrelated same-sex Domestic Partner (complete Domestic Partner Enrollment Packet available online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov))
- Elect to opt out of health, dental and vision coverage (full-time employees and annuitants only)
- Elect to waive health, dental and vision coverage (part-time employees 50% or greater, annuitants and survivors required to pay a portion of premiums only)
- Elect to waive health, dental and vision coverage and become a dependent of a State-covered spouse (annuitants only)

- Re-enroll in the program if previously opted out (full-time employees or annuitants)
- Re-enroll in the program if previously waived (part-time employees 50% or greater, annuitants and survivors required to pay a portion of the premium)
- Re-enroll in the program if currently terminated due to non-payment of premium while on leave of absence (employees only) **Note:** Survivors and annuitants are not eligible to re-enroll.
- Elect to participate or not participate in the dental plan. **Once elected, this selection will remain in effect the entire plan year and cannot be changed until the next Benefit Choice Period. This dental election cannot be changed even if the member experiences a qualifying change in status.**
- Enroll or re-enroll in the Flexible Spending Accounts (FSA) Program (additional enrollment form required)

### Documentation Requirements

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

## IMPORTANT REMINDERS

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

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

**COBRA Participants:** During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage. COBRA health and dental rates for plan year 2008 will be available on or after May 1, 2007.

## MEMBER MONTHLY HEALTH, DENTAL AND OPTIONAL LIFE PLAN CONTRIBUTIONS

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. Salary-based contributions remain in effect until June 30, 2008, unless the employee retires, accepts a voluntary salary reduction or returns to State employment at a different salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this does not apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions	
\$29,500 & below	Managed Care: \$35.00	Quality Care: \$60.00
\$29,501 - \$44,600	Managed Care: \$40.00	Quality Care: \$65.00
\$44,601 - \$59,300	Managed Care: \$42.50	Quality Care: \$67.50
\$59,301 - \$74,300	Managed Care: \$45.00	Quality Care: \$70.00
\$74,301 & above	Managed Care: \$47.50	Quality Care: \$72.50

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

Retiree, Annuitant and Survivor Monthly Health Plan Contribution	
20 years or more of creditable service	\$0.00
Less than 20 years of creditable service and, <ul style="list-style-type: none"> <li>• SERS/SURS annuitant/survivor on or after 1/1/98,</li> <li style="text-align: center;"><b>or</b></li> <li>• TRS annuitant/survivor on or after 7/1/99</li> </ul>	Required to pay a percentage of the cost of the basic coverage.
Call the appropriate retirement system for applicable premiums. <b>SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896</b>	

Monthly Optional Term Life Plan Contributions			
Member by Age	Monthly Rate Per \$1,000	Member by Age	Monthly Rate Per \$1,000
Under 30	\$0.06	Ages 75 - 79	\$3.52
Ages 30 - 34	0.08	Ages 80 - 84	4.20
Ages 35 - 44	0.10	Ages 85 - 89	5.20
Ages 45 - 49	0.16	Ages 90 and above	6.50
Ages 50 - 54	0.24	Accidental Death & Dismemberment	0.02
Ages 55 - 59	0.48		
Ages 60 - 64	0.72	Spouse (for \$10,000 coverage)	7.14
Ages 65 - 69	1.38	Dependent Children (for \$10,000 coverage)	0.56
Ages 70 - 74	2.52		

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

### Contribution Calculation Worksheet

**Member Monthly Health Contribution:** \$ \_\_\_\_\_  
(see chart on page 12)

**Dependent Monthly Health Contribution:** \$ \_\_\_\_\_  
(if insuring dependents, see chart below)

**Monthly Dental Contribution:** \$ \_\_\_\_\_  
(see chart to left)

**Monthly Optional Term Life Contribution:** \$ \_\_\_\_\_  
(see chart on page 12)

**My Total Monthly Contribution:** \$ \_\_\_\_\_

**Note:** An interactive Premium Calculation Worksheet is available for full-time employees online at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

## DEPENDENT MONTHLY HEALTH PLAN CONTRIBUTION

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

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

Dependent Monthly Health Plan Contributions				
Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
Unicare HMO (Code: CC)	\$ 70	\$101	\$ 65	\$101
HMO Illinois (Code: BY)	\$ 71	\$104	\$ 67	\$104
PersonalCare (Code: AS)	\$ 80	\$118	\$ 76	\$118
OSF HealthPlans (Code: CA)	\$ 80	\$118	\$ 77	\$118
Health Alliance HMO (Code: AH)	\$ 82	\$121	\$ 77	\$121
Health Alliance Illinois (Code: BS)	\$ 91	\$133	\$ 88	\$133
HealthLink OAP (Code: CF)	\$ 93	\$137	\$ 90	\$137
OSF Winnebago (Code: CE)	\$ 95	\$140	\$ 92	\$140
Quality Care Health Plan (Code: D3)	\$184	\$214	\$130	\$191

## MANAGED CARE PLANS

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

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

### Health Maintenance Organizations (HMOs)

Members must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs health care services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the member pays only a co-payment. No annual plan deductibles apply. The minimum level of HMO coverage provided by all plans is described on page 16. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

### Open Access Plan (OAP)

The OAP provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with pre-determined co-payments. Tier III (out-of-network) offers members flexibility in selecting health care providers with higher out-of-pocket costs. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of care providers. Members enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 17.

## IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

**Primary Care Physician (PCP) Leaving a Network:** If a member's PCP leaves the managed care plan's network, the member has three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Quality Care Health Plan. The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

**Provider Network Changes:** Managed care plan provider networks are subject to change. Members should always call the respective plan to verify participation of specific providers, even if the information is printed in the plan's directory.

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

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



# HMO BENEFITS

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

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

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

# OPEN ACCESS PLAN (OAP) BENEFITS

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

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Annual Out-of-Pocket Maximum Per Individual Enrollee Per Family	Not Applicable	\$600 \$1,200	\$1,500 \$3,500
Annual Plan Deductible (must be satisfied for all services)	\$0	\$200 per enrollee*	\$300 per enrollee*
<b>Hospital Services</b>			
Inpatient	Full coverage after \$250 co-payment per admission	90% of network charges for covered services after \$300 co-payment per admission	80% of U&C for covered services after \$400 co-payment per admission
Inpatient Psychiatric	Benefits available for care received by providers under Tier II and Tier III	Full coverage after \$250 co-payment per admission, up to 30 days per plan year	90% of U&C for covered services after \$250 co-payment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after \$250 co-payment per admission, up to 10 days rehabilitation per plan year	90% of U&C for covered services after \$250 co-payment per admission, up to 10 days rehabilitation per plan year
Emergency Room	Full coverage after \$200 co-payment per visit	90% of network charges for covered services after \$200 co-payment per visit	80% of U&C for covered services after lesser of \$200 co-payment per visit, or 50% of U&C
Outpatient Surgery	Full coverage after \$150 co-payment per admission	90% of network charges for covered services after \$150 co-payment	80% of U&C for covered services after \$150 co-payment
Outpatient Psychiatric and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after \$15 co-payment, up to 30 visits per plan year	90% of U&C for covered charges after \$15 co-payment, up to 30 visits per plan year
Diagnostic Lab and X-ray	Full coverage	90% of network charges for covered services	80% of U&C for covered services
<b>Physician and Other Professional Services</b>			
Physician Office Visits	Full coverage after \$15 co-payment	90% of network charges for covered services	80% of U&C for covered services
Preventive Services, Including Immunizations	Full coverage after \$15 co-payment	90% of network charges for covered services	Covered in-network only
Well Baby Care	Full coverage	90% of network charges for covered services	Covered in-network only
<b>Other Services</b>			
Prescription Drugs – Covered through State of Illinois administered plan, Medco			
	Generic \$10	Preferred Brand \$20	Non-Preferred Brand \$40
Durable Medical Equipment	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Skilled Nursing Facility	Full coverage	90% of network charges for covered services	Covered in-network only
Transplant Coverage	Full coverage	90% of network charges for covered services	Covered in-network only
Home Health Care	Full coverage after \$20 co-payment	90% of network charges for covered services	Covered in-network only

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

# THE QUALITY CARE HEALTH PLAN (QCHP)

QCHP is the State's medical plan that offers a comprehensive range of benefits. Under the QCHP, plan participants can choose any physician or hospital for medical services and any pharmacy for prescription drugs. Plan participants receive enhanced benefits resulting in lower out-of-pocket amounts when receiving services from a QCHP network provider. The **nationwide QCHP network (formerly the PPO network)** consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail and maintenance pharmacy network) and behavioral health services (Magellan behavioral health network). Notification to Intracorp, the QCHP notification administrator, is required for certain medical services in order to avoid penalties. Refer to pages 56-58 of the Benefits Handbook (and the amendment in this book), or contact Intracorp at (800) 962-0051, for direction.

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

Plan Year Maximums and Deductibles	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	The plan year deductible is based upon each employee's annual salary (see chart below for current plan year information)
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit \$400 Non-QCHP hospital admission \$200 Transplant deductible \$100 <b>Note: There is no additional deductible for admission to a QCHP network hospital</b>

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
\$59,300 or less	\$300	\$750
\$59,301 - \$74,300	\$400	\$1,000
\$74,301 and above	\$450	\$1,125
Retiree/Annuitant/Survivor	\$300	\$750
Dependents	\$300	NA

## Out-of-Pocket Maximums

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

<b>General:</b> <b>\$1,100 per individual</b> <b>\$2,750 per family per plan year</b>	<b>Non-QCHP Hospital:</b> <b>\$4,400 per individual</b> <b>\$8,800 per family per plan year</b>
<b>The following do not apply toward out-of-pocket maximums:</b> <ul style="list-style-type: none"> <li>• Prescription Drug benefits or co-payments.</li> <li>• Behavioral Health benefits, coinsurance or co-payments.</li> <li>• Notification penalties.</li> <li>• Ineligible charges (amounts over Usual and Customary (U &amp; C) and charges for non-covered services).</li> <li>• The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay.</li> </ul>	

# QCHP - MEDICAL PLAN COVERAGE

Hospital Services	
QCHP Network Hospitals (formerly PPO Network Hospitals)	90% after annual plan deductible. No admission deductible.
Non-QCHP Hospitals (formerly Non-PPO Hospitals)	<ul style="list-style-type: none"> <li>• \$200 per admission deductible.</li> <li>• If the member resides in Illinois or within 25 miles of a QCHP network hospital and the member chooses to use a non-QCHP hospital and/or voluntarily travels in excess of 25 miles when a QCHP network hospital is available within the same travel distance, the plan pays 65% after the annual plan deductible.</li> <li>• If the member resides in Illinois and has no QCHP network hospital available within 25 miles and voluntarily chooses to travel further than the nearest QCHP network hospital, the plan pays 65% after the annual plan deductible.</li> <li>• If the member does not reside in Illinois or within 25 miles of a QCHP network hospital, the plan pays 80% after the annual plan deductible.</li> </ul>
Outpatient Services	
Lab/X-ray	90% of Usual & Customary (U&C) after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible.
Licensed Ambulatory Surgical Treatment Centers	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Professional and Other Services	
QCHP Physician Network (formerly the PPO Network)	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in QCHP's Network	80% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services (limit of 30 visits per plan year)	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after \$100 transplant deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
Behavioral Health Services	
Magellan administers the QCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see page 81 of the Benefits Handbook or call Magellan at (800) 513-2611.	

**QCHP network providers are subject to change throughout the plan year. Always call the plan administrator to verify participation of a specific provider.**

## PRESCRIPTION DRUG BENEFIT

Plan participants enrolled in all State health plans have prescription drug coverage available. All prescription medications are compiled on a preferred list (“formulary list”) maintained by each managed care plan or Medco. Formulary lists categorize brand drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount.

PRESCRIPTION DRUG CO-PAYS		
	PRESCRIPTION PLAN	
	QCHP	All Other Plans
Generic	\$11	\$10
Preferred Brand (Formulary Brand)	\$22	\$20
Non-Preferred Brand	\$44	\$40

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

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

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

## MANAGED CARE PLAN PRESCRIPTION DRUG BENEFIT

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

# MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT

The following information provides a brief overview of Medco benefits. See the Benefits Handbook or the Benefits website for more information.

**Health Alliance Illinois, HealthLink OAP, OSF Winnebago and the Quality Care Health Plan (QCHP)** have prescription benefits administered through the Prescription Benefit Manager (PBM), Medco. Prescription drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. In order to receive the best value, plan participants enrolled in one of the Medco-administered health plans should carefully review the various prescription networks outlined below. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Participants receiving a drug costing less than the co-payment will only be charged the cost of the drug.

## Non-Maintenance Medication

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

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

## Maintenance Medication

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

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

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

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

## VISION PLAN

All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Co-payments are required. For more information regarding the vision plan, see pages 97-98 of the Benefits Handbook or contact the plan administrator, EyeMed Vision Care at (866) 723-0512, (800) 526-0844 (TTD/TTY) or by visiting their website and logging in as a member at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com).

## LIFE INSURANCE PLAN

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

Optional life insurance coverage is available to members at their own expense. Changes to life insurance must be indicated on the Benefit Choice Election Form (see back of this booklet). For more information regarding the life plan, see pages 99-100 of the Benefits Handbook or contact the plan administrator, Minnesota Life at (888) 202-5525, (800) 526-0844 (TTD/TTY) or by visiting their website at [www.lifebenefits.com](http://www.lifebenefits.com). Optional life coverages available are listed below:

- **Member Optional Life**
- **Member Accidental Death and Dismemberment (AD&D)**
- **Spouse/Child Life**

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

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

## EMPLOYEE ASSISTANCE PROGRAM

There are two separate programs for active employees and their dependents that provide valuable resources for support and information during difficult times, the Employee Assistance Program (EAP) and the Personal Support Program (PSP). See page 33 for plan administrator and website information.

- Active employees **not** represented by the collective bargaining agreement between the State and AFSCME must contact the EAP administered by Magellan Behavioral Health.
- 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 AFSCME Personal Support Program.

# DENTAL OPTIONS

During the Benefit Choice Period, members have the option to participate in the Quality Care Dental Plan (QCDP) or they may elect not to participate in the dental plan. The election not to participate in the dental plan will remain in effect the entire plan year, without exception. The annual Benefit Choice Period is the only time members may enroll or re-enroll in the dental plan. All members and dependents have the same dental benefits available regardless of the health plan selected.

**The maximum benefit per plan participant per plan year for all dental services, including orthodontic and periodontic, is \$2,000 after the plan year deductible.** Each plan participant is subject to an annual \$100 plan deductible for all services, other than those listed as preventive or diagnostic in the Schedule of Benefits. If services span more than one plan year, a deductible applies to each plan year. The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations. For more information, see pages 91-95 of the Benefits Handbook or contact the Dental Plan Administrator, CompBenefits, at (800) 999-1669 or (312) 829-1298 (TDD/TTY).

## FY08 DENTAL SCHEDULE OF BENEFITS

The QCDP reimburses only those services that are listed on the Dental Schedule of Benefits. Listed services are reimbursed at a pre-determined maximum scheduled amount. Members are responsible for all charges over the scheduled amount and/or the annual maximum benefit.

DIAGNOSTIC SERVICES	Maximum Benefit	Code
Periodic Oral Examination .....	\$ 31	D0120
Limited Oral Evaluation (specific oral health problem) .....	\$ 52	D0140
Comprehensive Oral Examination- new or established patient .....	\$ 54	D0150
<b>Radiographs/Diagnostic Imaging</b>		
Intraoral Complete Series (once in a period of three plan years, including bitewings) .....	\$ 97	D0210
Intraoral - Periapical First Film .....	\$ 18	D0220
Intraoral - Periapical Each Additional Film .....	\$ 15	D0230
Bitewing Single Film .....	\$ 20	D0270
Bitewing Two Films .....	\$ 30	D0272
Bitewing Four Films .....	\$ 42	D0274
Panoramic Film, (once in a period of three plan years) .....	\$ 84	D0330
<b>PREVENTIVE SERVICES</b>		
Prophylaxis Adult - Twice each plan year .....	\$ 66	D1110
Prophylaxis Child - Twice each plan year .....	\$ 45	D1120
Topical Application of Fluoride - Child (including prophylaxis) (once each plan year, covered through age 18 only) .....	\$ 67	D1201
Topical Application of Fluoride - Child (not including prophylaxis) (once each plan year, covered through age 18 only) .....	\$ 27	D1203
Sealant - per tooth .....	\$ 39	D1351*
<b>Space Maintainers (Passive Appliances)</b>		
Fixed Unilateral .....	\$248	D1510
Fixed Bilateral .....	\$327	D1515
Removable Unilateral .....	\$307	D1520
Removable Bilateral .....	\$421	D1525
<b>RESTORATIVE SERVICES</b>		
<b>Amalgam Restorations</b>		
Amalgam One Surface, Primary or Permanent .....	\$ 86	D2140
Amalgam Two Surfaces, Primary or Permanent .....	\$112	D2150
Amalgam Three Surfaces, Primary or Permanent .....	\$135	D2160
Amalgam Four or More Surfaces, Primary or Permanent .....	\$165	D2161
<b>Resin-Based Composite Restorations</b>		
One Surface, Anterior .....	\$102	D2330
Two Surfaces, Anterior .....	\$130	D2331
Three Surfaces, Anterior .....	\$159	D2332
Four or More Surfaces or involving incisal angle (anterior) .....	\$188	D2335
One Surface Posterior .....	\$119	D2391

\*Adult sealants covered effective July 1, 2007

# FY08 DENTAL SCHEDULE OF BENEFITS CONTINUED

	Maximum Benefit	Code
<b>Resin-Based Composite Restorations Continued</b>		
Two Surface Posterior .....	\$156	D2392
Three Surface Posterior .....	\$193	D2393
Four or More Surfaces, Posterior .....	\$237	D2394
<b>Inlay/Onlay Restorations*</b>		
Inlay - metallic - one surface.....	\$260	D2510*
Inlay - metallic - two surfaces.....	\$295	D2520*
Inlay - metallic - three or more surfaces.....	\$341	D2530*
Onlay - metallic - three surfaces.....	\$349	D2543*
Onlay - metallic - four or more surfaces.....	\$363	D2544*
Inlay - porcelain/ceramic - one surface .....	\$306	D2610*
Inlay - porcelain/ceramic - two surfaces .....	\$324	D2620*
Inlay - porcelain/ceramic - three or more surfaces .....	\$345	D2630*
Onlay - porcelain/ceramic - two surfaces.....	\$335	D2642*
Onlay - porcelain/ceramic - three surfaces .....	\$361	D2643*
Onlay - porcelain/ceramic - four or more surfaces .....	\$383	D2644*
Inlay - resin-based composite - one surface.....	\$201	D2650*
Inlay - resin-based composite - two surfaces.....	\$240	D2651*
Inlay - resin-based composite - three or more surfaces.....	\$252	D2652*
Onlay - resin-based composite - two surfaces.....	\$219	D2662*
Onlay - resin-based composite - three surfaces.....	\$257	D2663*
Onlay - resin-based composite - four or more surfaces.....	\$276	D2664*
<b>Crowns/Single Restorations Only</b>		
Crown-Resin (indirect) .....	\$268	D2710
Crown-Resin with high noble metal .....	\$660	D2720
Crown-Resin predominantly base metal .....	\$618	D2721
Crown-Resin with noble metal .....	\$632	D2722
Crown-Porcelain/Ceramic Substrate .....	\$677	D2740
Crown-Porcelain fused to high noble metal .....	\$668	D2750
Crown-Porcelain fused to predominantly base metal .....	\$622	D2751
Crown-Porcelain fused to noble metal .....	\$637	D2752
Crown-3/4 cast predominately base metal .....	\$603	D2781
Crown-Full cast high noble metal .....	\$645	D2790
Crown-Full cast predominantly base metal .....	\$611	D2791
Crown-Full cast noble metal .....	\$622	D2792
<b>Other Restorative Services</b>		
Recement Inlay .....	\$ 71	D2910
Recement Crown .....	\$ 74	D2920
Prefabricated stainless steel Crown (primary tooth) .....	\$201	D2930
Prefabricated stainless steel Crown (permanent tooth) .....	\$227	D2931
Prefabricated Resin Crown .....	\$247	D2932
<b>ENDODONTICS</b>		
<b>Pulp Capping</b>		
Pulp Cap - Direct (excluding final restoration) .....	\$ 51	D3110
Pulp Cap - Indirect (excluding final restoration) .....	\$ 40	D3120
Pulpotomy - Therapeutic (excluding final restoration) .....	\$120	D3220
<b>Root Canal Therapy (include intra-operative radiographs)</b>		
Anterior (excludes final restoration) .....	\$509	D3310
Bicuspid (excludes final restoration) .....	\$621	D3320
Molar (excludes final restoration) .....	\$802	D3330
<b>Retreatment of Previous Root Canal Therapy</b>		
Anterior .....	\$685	D3346
Bicuspid .....	\$807	D3347
Molar .....	\$970	D3348
<b>PERIODONTICS</b>		
<b>Gingivectomy/Gingivoplasty</b>		
Per quadrant .....	\$315	D4210
1 - 3 Teeth per quadrant .....	\$135	D4211

\*New benefit effective July 1, 2007

# FY08 DENTAL SCHEDULE OF BENEFITS CONTINUED

PERIODONTICS CONTINUED	Maximum Benefit	Code
<b>Gingival Flap Procedure</b>		
Per quadrant - includes root planing .....	\$371	D4240
Gingival Flap - including root planing, 1-3 teeth per quadrant .....	\$191	D4241
<b>Osseous Surgery (including flap entry and closure)</b>		
4 or More contiguous teeth or bounded teeth spaces per quadrant .....	\$598	D4260
1-3 contiguous teeth or bounded teeth spaces per quadrant .....	\$312	D4261
<b>Bone Replacement Graft</b>		
First site in quadrant .....	\$181	D4263
Each additional site in quadrant .....	\$ 90	D4264
<b>Pedicle Soft Tissue Graft</b> .....	\$442	D4270
<b>Free Soft Tissue Graft</b> .....	\$455	D4271
<b>Provisional Splinting</b>		
Intracoronaral .....	\$168	D4320
Extracoronaral .....	\$147	D4321
<b>Periodontal Scaling and Root Planing</b>		
4 or More contiguous teeth or bounded teeth spaces per quadrant .....	\$ 91	D4341
1-3 contiguous teeth or bounded teeth spaces per quadrant .....	\$ 46	D4342
<b>Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis</b> .....		
<b>Periodontal Maintenance Procedure</b>	\$ 61	D4355
Following active therapy .....	\$ 55	D4910
Unscheduled Dressing Change .....	\$ 47	D4920
<b>PROSTHODONTICS</b>		
<b>Removable Prosthetics</b>		
Complete Denture - Maxillary .....	\$789	D5110
Complete Denture - Mandibular .....	\$789	D5120
Immediate Denture - Maxillary .....	\$860	D5130
Immediate Denture - Mandibular .....	\$860	D5140
<b>Partial Dentures (removable)</b>		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth) .....	\$666	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth) .....	\$774	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth) .....	\$872	D5213
Mandibular Partial Denture - cast metal framework, resin base (convention clasps, rests and teeth) .....	\$872	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth) .....	\$508	D5281
<b>Adjustments to Dentures</b>		
Adjust complete denture - Maxillary .....	\$ 43	D5410
Adjust complete denture - Mandibular .....	\$ 43	D5411
Adjust partial denture - Maxillary .....	\$ 43	D5421
Adjust partial denture - Mandibular .....	\$ 43	D5422
<b>Repairs to Complete Dentures</b>		
Repair broken complete denture base .....	\$ 86	D5510
Replace missing or broken teeth - complete denture (each tooth) .....	\$ 72	D5520
<b>Repairs to Partial Dentures</b>		
Repair resin denture base .....	\$ 94	D5610
Repair cast framework .....	\$101	D5620
Repair or replace broken clasp .....	\$122	D5630
Replace broken teeth - per tooth .....	\$ 79	D5640
Add tooth to existing partial denture .....	\$108	D5650
Add clasp to existing partial denture .....	\$130	D5660
<b>Denture Rebase Procedure</b>		
Rebase complete maxillary denture .....	\$320	D5710
Rebase complete mandibular denture .....	\$306	D5711
Rebase maxillary partial denture .....	\$302	D5720
Rebase mandibular partial denture .....	\$302	D5721

# FY08 DENTAL SCHEDULE OF BENEFITS CONTINUED

	Maximum Benefit	Code
<b>Denture Reline Procedure</b>		
Reline complete maxillary denture (chairside) .....	\$181	D5730
Reline complete mandibular denture (chairside) .....	\$181	D5731
Reline maxillary partial denture (chairside) .....	\$166	D5740
Reline mandibular partial denture (chairside) .....	\$166	D5741
Reline complete maxillary denture (laboratory) .....	\$241	D5750
Reline complete mandibular denture (laboratory) .....	\$241	D5751
Reline maxillary partial denture (laboratory) .....	\$238	D5760
Reline mandibular partial denture (laboratory) .....	\$238	D5761
<b>Implant Services*</b>		
Surgical placement of implant body: endosteal implant .....	\$2,000	D6010*
Surgical placement: eposteal implant .....	\$2,000	D6040*
Surgical placement: transosteal implant .....	\$2,000	D6050*
Implant/abutment supported removable denture for completely edentulous arch .....	\$1,528	D6053*
Implant/abutment supported removable denture for partially edentulous arch .....	\$1,528	D6054*
Dental implant supported connecting bar .....	\$520	D6055*
Prefabricated abutment – includes placement .....	\$363	D6056*
Custom abutment – includes placement .....	\$475	D6057*
Abutment supported porcelain/ceramic crown .....	\$1,178	D6058*
Abutment supported porcelain fused to metal crown (high noble metal) ..	\$1,162	D6059*
Abutment supported porcelain fused to metal crown (predominantly base metal) .....	\$1,098	D6060*
Abutment supported porcelain fused to metal crown (noble metal) .....	\$1,121	D6061*
Abutment supported cast metal crown (high noble metal) .....	\$1,116	D6062*
Abutment supported cast metal crown (predominantly base metal) .....	\$959	D6063*
Abutment supported cast metal crown (noble metal) .....	\$1,016	D6064*
Implant supported porcelain/ceramic crown .....	\$1,159	D6065*
Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) .....	\$1,129	D6066*
Implant supported metal crown (titanium, titanium alloy, high noble metal) .....	\$1,095	D6067*
Abutment supported retainer for porcelain/ceramic FPD .....	\$1,178	D6068*
Abutment supported retainer for porcelain fused to metal FPD (high noble metal) .....	\$1,162	D6069*
Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) .....	\$1,098	D6070*
Abutment supported retainer for porcelain fused to metal FPD (noble metal) .....	\$1,121	D6071*
Abutment supported retainer for cast metal FPD (high noble metal) .....	\$1,144	D6072*
Abutment supported retainer for cast metal FPD (predominantly base metal) .....	\$1,036	D6073*
Abutment supported retainer for cast metal FPD (noble metal) .....	\$1,116	D6074*
Implant supported retainer for ceramic FPD .....	\$1,159	D6075*
Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) .....	\$1,129	D6076*
Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) .....	\$1,095	D6077*
Implant maintenance procedures, including removal of prosthesis, cleaning of prosthesis and abutments and reinsertion of prosthesis .....	\$106	D6080*
Abutment supported crown – (titanium) .....	\$922	D6094*
Radiographic/surgical implant index, by report .....	\$196	D6190*
Abutment supported retainer crown for FPD – (titanium) .....	\$950	D6194*
<b>Fixed Partial Denture Pontics</b>		
(Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal .....	\$441	D6210
Pontic-Cast predominantly base metal .....	\$414	D6211
Pontic-Cast noble metal .....	\$430	D6212
Pontic-Porcelain fused to high noble metal .....	\$436	D6240
Pontic-Porcelain fused to predominantly base metal .....	\$402	D6241
Pontic-Porcelain fused to noble metal .....	\$425	D6242
Pontic-Resin with high noble metal .....	\$430	D6250

\*New benefit effective July 1, 2007

# FY08 DENTAL SCHEDULE OF BENEFITS CONTINUED

	Maximum Benefit	Code
<b>Fixed Partial Denture Pontics Continued</b>		
Pontic-Resin with predominantly base metal .....	\$397	D6251
Pontic-Resin with noble metal .....	\$410	D6252
<b>Fixed Partial Denture Retainers - Inlays/Onlays*</b>		
Inlay - cast predominantly base metal, two surfaces .....	\$307	D6604*
Inlay - cast predominantly base metal, three or more surfaces .....	\$326	D6605*
Onlay - cast predominantly base metal, two surfaces .....	\$336	D6612*
Onlay - cast predominantly base metal, three or more surfaces .....	\$352	D6613*
<b>Fixed Partial Denture Retainers - Crowns</b>		
Crown-Resin with high noble metal .....	\$486	D6720
Crown-Resin with predominantly base metal .....	\$461	D6721
Crown-Resin with noble metal .....	\$469	D6722
Crown-Porcelain fused to high noble metal .....	\$497	D6750
Crown-Porcelain fused to predominantly base metals .....	\$464	D6751
Crown-Porcelain fused to noble metal .....	\$475	D6752
Crown-3/4 cast high noble metal .....	\$469	D6780
Crown-Full cast high noble metal .....	\$480	D6790
Crown-Full cast predominantly base metal .....	\$455	D6791
Crown-Full cast noble metal .....	\$472	D6792
<b>Other Fixed Partial Denture Services</b>		
Recement Fixed Partial Denture .....	\$ 58	D6930
Fixed Partial Denture Repair, by report .....	\$ 49	D6980
<b>ORAL SURGERY</b>		
<b>Extractions</b>		
Coronal Remnants - Deciduous Tooth .....	\$ 83	D7111
Extraction, Erupted Tooth or Exposed Root (elevation and/ or forceps removal) .....	\$110	D7140
<b>Surgical Extraction</b> (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 .....	\$109	D7210
Removal of impacted tooth - soft tissue .....	\$136	D7220
Removal of impacted tooth - partially bony .....	\$181	D7230
Removal of impacted tooth - completely bony .....	\$213	D7240
Removal of impacted tooth - completely bony with unusual surgical complications .....	\$267	D7241
Surgical removal of residual tooth roots (cutting procedure) .....	\$115	D7250
<b>Other Surgical Procedures</b>		
Biopsy of oral tissue - hard (bone/tooth) .....	\$453	D7285
Biopsy of soft tissue - soft (all others) .....	\$186	D7286
Alveoloplasty in conjunction with extractions, per quadrant .....	\$127	D7310
Alveoloplasty in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant .....	\$127	D7311
Alveoloplasty not in conjunction with extractions, per quadrant .....	\$565	D7320
Alveoloplasty not in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant .....	\$565	D7321
Frenulectomy - separate procedure .....	\$266	D7960
<b>ADJUNCTIVE GENERAL SERVICES</b>		
<b>Surgical Incision</b>		
Palliative (emergency) treatment of dental pain (minor procedure) .....	\$ 88	D9110
<b>Anesthesia</b>		
<b>General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.</b>		
General anesthesia - first 30 minutes .....	\$365	D9220
General anesthesia - each additional 15 minutes .....	\$149	D9221
Intravenous sedation/analgesia - first 30 minutes .....	\$280	D9241
Intravenous sedation/analgesia - each additional 15 minutes .....	\$117	D9242
<b>Miscellaneous Services</b>		
Occlusal guards, by report .....	\$230	D9940
Occlusal adjustment, limited .....	\$112	D9951
Occlusal adjustment, complete .....	\$634	D9952

\*New benefit effective July 1, 2007

## THE FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

The FSA Program is an optional tax-free benefit that consists of two plans: the Medical Care Assistance Plan (MCAP), which allows members to pay eligible out-of-pocket medical, dental and vision expenses, and the Dependent Care Assistance Plan (DCAP), which allows members to pay eligible child and/or adult day care expenses. Eligible employees may set aside up to \$5000 tax free to one or both of the plans for a combined maximum of \$10,000. **Employees must enroll during the annual Benefit Choice Period to take advantage of this benefit, even if they are currently enrolled in the program.** After the Benefit Choice Period, employees may only enroll upon experiencing an eligible qualifying change in status event. Claims for reimbursement of eligible MCAP and DCAP expenses incurred during the plan year or the corresponding “grace period,” must be submitted to FBMC by September 30th following the end of the plan year.

### Eligible MCAP expenses include:

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

### Eligible DCAP expenses include:

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

**MCAP Grace Period** – Employees enrolled in the Medical Care Assistance Plan (MCAP) may now incur eligible medical, vision and dental expenses through September 15th of each year and have them reimbursed from their previous plan year MCAP account balance. Claims incurred during this “grace period” must be submitted for reimbursement no later than September 30th of the same year. Participants who have a balance in their previous plan year MCAP account and use their EZ REIMBURSE® MasterCard® card will have those transactions paid from that account before the current plan year’s account will be utilized for payment. The “grace period” does not apply to DCAP. See the 2007-2008 FSA Booklet for more detailed information about the plans.

## EZ REIMBURSE® MASTERCARD® CARD PROGRAM

MCAP participants have the option to have their MCAP account automatically debited when an eligible, uninsured medical expense is incurred. There is a non-refundable \$20 annual fee for the EZ Reimburse® MasterCard®. The fee will be automatically deducted from the MCAP account at the beginning of the plan year. Like other debit cards, there is no risk of overspending or exceeding account limits. If funds are not available because the annualized amount has been spent down, the transaction will be denied. Because no credit is being extended, cards are available to anyone who signs up for MCAP.

All health, dental and vision services, as well as prescription drugs, can be purchased with the EZ Reimburse® MasterCard® card with no out-of-pocket expenses to the participant. Expenses for services, prescription drugs and over-the-counter items will be automatically paid out of the employee’s MCAP account in accordance with the IRS Code. Expenses that have a known co-payment amount (such as the \$15 HMO physician visit co-pay) do not require follow-up documentation; however, if the card is used for an expense that is not a set co-payment (such as a dental procedure), the employee will need to provide the follow-up documentation (i.e., receipts, EOBs) to the plan administrator, FBMC, within two monthly statement cycles in order to avoid suspension of the card.

**Participants who wish to elect the EZ Reimburse® MasterCard® Program card must check the appropriate box on the MCAP Enrollment Form. Current card participants should keep their same card until the card expires. The card will be loaded with the new plan year’s annual election amount and ready for use beginning July 1.**

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

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

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

## **OPTIONAL PROGRAMS**

### **Commuter Savings Program (CSP)**

The CSP can save employees tax dollars on eligible commuting and parking expenses by having those expenses payroll deducted pre-tax. Full-time and part-time employees (working 50% or greater) who have payroll checks processed through the Office of the Comptroller are eligible. Transit passes are mailed directly to the employee's home and parking providers can be paid directly. The current IRS maximum for parking is \$215 per month for work-related parking expenses and \$110 per month for eligible transit expenses. To enroll, change or cancel a deduction, employees should contact the plan administrator at [www.myFBMC.com](http://www.myFBMC.com). See page 117 of the Benefits Handbook for more information.

### **Smoking Cessation Program**

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

### **Adoption Benefit Program**

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

### **Deferred Compensation Program**

The Deferred Compensation Program is one way to save for the future while enjoying tax savings today. This program provides an investment opportunity for state employees by offering a wide variety of investment options, flexibility to make investment changes and convenient services. See pages 113-114 of the Benefits Handbook for more information.

### **Long-Term Care (LTC) Insurance**

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

## NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

#### **How We May Use or Disclose Your PHI:**

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

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

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

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

#### **Legal Requirements:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Your Rights:**

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

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

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

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

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

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

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

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

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

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

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

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

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
<b>Vision Plan</b>	<b>EyeMed</b> Out-of-Network Claims P.O. Box 8504	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com
<b>Life Insurance Plan</b>	<b>Minnesota Life Insurance Company</b> 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
<b>Long-Term Care (LTC) Insurance</b>	<b>MetLife</b>	(800) 438-6388 (800) 638-1004 (TDD/TTY)	
<b>Deferred Compensation Program</b>	<b>CMS Deferred Compensation Division</b> 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
<b>Flexible Spending Accounts (FSA) Program</b>	<b>Fringe Benefits Management Company</b> P.O. Box 1810 Tallahassee, FL 32302-1810	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax)	www.myFBMC.com
<b>Commuter Savings Program (CSP)</b>			
<b>Health/Dental Plans, Medicare COB Unit, FSA Unit, Special Payment Programs Unit, Life Insurance, Adoption and Smoking Cessation Benefits</b>	<b>CMS Group Insurance Division</b> 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

# WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
<b>Quality Care Health Plan (QCHP) Medical Plan Administrator</b>	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits	<b>CIGNA</b> Group Number 3181456 <b>CIGNA HealthCare</b> P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>QCHP Notification and Medical Case Management Administrator</b>	Notification prior to hospital services  Non-compliance penalty of \$800 applies	<b>Intracorp, Inc.</b>	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>Prescription Drug Plan Administrator</b>  QCHP (1400SD3) Health Alliance Illinois (1400SBS) OSF Winnebago (1400SCE) HealthLink OAP (1400SCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	<b>Medco</b> Group Number: 1400SD3, 1400SBS, 1400SCE, 1400SCF <b>Paper Claims:</b> Medco Health Solutions P.O. Box 14711 Lexington, KY 40512  <b>Mail Order Prescriptions:</b> Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide)  (800) 759-1089 (TDD/TTY)  <a href="http://www.medco.com">www.medco.com</a>
<b>QCHP Behavioral Health Administrator</b>	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	<b>Magellan Behavioral Health</b> Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>
<b>Employee Assistance Program (EAP)</b>	Confidential assistance and assessment services, ID cards	<b>Magellan Behavioral Health</b> -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>
<b>Personal Support Program (PSP – AFSCME EAP)</b>	Confidential assessment and assistance services	<b>AFSCME Council 31</b> -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) <a href="http://www.afscme31.org">www.afscme31.org</a>
<b>Quality Care Dental Plan (QCDP) Administrator</b>	Dental services, claim filing and ID cards	<b>CompBenefits</b> Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY) <a href="http://www.compbenefits.com">www.compbenefits.com</a>

## DISCLAIMER

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

## BENEFIT CHOICE ELECTION FORM INSTRUCTION SHEET

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

### SECTION A – EMPLOYEE INFORMATION (Complete all fields)

### SECTION B – OPT OUT / OPT IN

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

### SECTION C – HEALTH PLAN ELECTIONS

*Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan 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 the managed care plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see page 15 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see page 32 for website addresses).

### SECTION D – DENTAL PLAN OPTION

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

### SECTION E – OPTIONAL LIFE INSURANCE

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

### SECTION F – DEPENDENT INFORMATION

Complete this section if you are adding, dropping or changing your dependent health or life<sup>1</sup> coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below:**

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

<sup>1</sup> 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](http://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, 2007** in order for your elections to be effective July 1, 2007. 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-day period, your dependents will not be added.**

# BENEFIT CHOICE ELECTION FORM

May 1 – 31, 2007 (Changes effective July 1, 2007)

**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 on page 34 for requirements

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

Health Plan Election *	If Managed Care is selected <b>you must</b> complete the information below. Go to the health plan's website to find the provider identifier. See the Instruction Sheet on page 34 for more information.
<p><b>Elect One:</b></p> <p>Quality Care Health Plan (QCHP)    <input type="checkbox"/></p> <p style="text-align: center;">~ Or ~</p> <p>Managed Care    <input type="checkbox"/></p>	<p>Provider Identifier _____ (6 or 10 characters)</p> <p>Carrier Code _____ (2 alpha characters – see page 15)</p> <p>Plan Name _____</p>

\* You must complete a Coordination of Benefits Worksheet for yourself and/or any dependent that has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at [www.benefitschoice.il.gov](http://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 <sup>2</sup>	DECREASE	CANCEL	AD&D (Accidental Death & Dismemberment)	
<input type="checkbox"/> 1 x Basic	<input type="checkbox"/> 3 x Basic	<input type="checkbox"/> 5 x Basic	<input type="checkbox"/> 7 x Basic	<input type="checkbox"/> CANCEL AD&D	<input type="checkbox"/> BASIC only (Basic)
<input type="checkbox"/> 2 x Basic	<input type="checkbox"/> 4 x Basic	<input type="checkbox"/> 6 x Basic	<input type="checkbox"/> 8 x Basic		<input type="checkbox"/> COMBINED (Basic + Optional Life)

**SECTION F: DEPENDENT INFORMATION <sup>1</sup> (dependents will be enrolled in the same health plan as the member)**

A (Add) / D (Drop) / C (Change)					Name	SSN	Birth Date	Relationship <sup>3</sup>	Provider Identifier
HEALTH			LIFE <sup>2</sup>						
A	D	C	A	D					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Notes:** <sup>1</sup> Documentation required to add dependents – see specific documentation requirements on the Instruction Sheet.

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

<sup>3</sup> 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, 2007.**

**You must  
return this form  
to your  
Group Insurance  
Representative by  
May 31, 2007**

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

Address Service Requested

**PRSR STD  
U.S. POSTAGE  
PAID  
SPRINGFIELD, IL  
PERMIT NO. 489**