

State of Illinois
Rod R. Blagojevich, Governor

Department of Central Management Services
Bureau of Benefits
Paul J. Campbell, Director



BENEFIT CHOICE OPTIONS

Teachers' Retirement Insurance Program

*Your Benefits
for Good Health*



**Enrollment Period, May 1 – 31, 2006
Effective July 1, 2006 – June 30, 2007**

**Benefit Choice is
May 1 - May 31,
2006**

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Important Changes For Plan Year 2007

(July 1, 2006 through June 30, 2007)

The information below presents changes to the Teachers' Retirement Insurance Program (TRIP). Please carefully review all the information in this Benefit Choice Options booklet. **This annual Benefit Choice Options Booklet contains updates to the Benefits Handbook and should be retained the entire plan year.** Benefit Recipients should review this publication each year to be aware of benefit changes. Benefit Choice is May 1 - 31, 2006. All selections made during Benefit Choice will be effective July 1, 2006.

Teachers' Choice Health Plan (TCHP) Changes

- In-network, out-of-pocket maximum (individual) increases to \$1,200
- Plan participant deductible increases to \$350 per plan year

Medicare Part D - The 2006-2007 Notice of Creditable Coverage is available on page 16. This Notice confirms that existing drug coverage through the TRIP is as good as, or better than, prescription drug coverage through Medicare Part D. Benefit Recipients should not enroll in a Medicare Part D Plan unless they qualify for low-income/extra-assistance under the Social Security Administration. Benefit Recipients with questions regarding the Notice of Creditable Coverage should call the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

YOUR RESPONSIBILITIES

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

Notify the Teachers' Retirement System (TRS) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
 - birth/adoption of a child;
 - marriage, divorce, annulment;
 - death of spouse or dependent;
 - dependent(s) loss of eligibility;
 - a court order results in the gain or loss of an eligible dependent;
 - dependent becomes covered by other health coverage.
- Gain or loss of other group coverage
- Change in Medicare status - if you or your enrolled dependents become eligible for other group insurance coverage including Medicare, or gain other coverage during the plan year, provide a copy of the Medicare card to TRS as soon as possible.

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

- Current health plan information
- Current prescription formulary lists which are subject to change without notice
- Deductions for benefit premiums

To terminate coverage at any time, notify TRS in writing.

The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit Recipients and Dependent Beneficiaries who terminate from TRIP may re-enroll only upon turning age 65 or when coverage is terminated by a former plan.

BENEFIT CHOICE PERIOD IS MAY 1-31, 2006

The Benefit Choice Period is **May 1 through May 31, 2006** for all Benefit Recipients. Elections will be effective July 1, 2006. The Benefit Choice Period is the **only** time of the year, other than when a qualifying change in status occurs, that Benefit Recipients may change health plans. Benefit Recipients who have never been enrolled in TRIP may enroll during the Benefit Choice Period. Any Benefit Recipient or Dependent Beneficiary who was previously covered under TRIP and terminated coverage, may re-enroll only when they or their dependent turns age 65 or when coverage is terminated by a former plan. Before making changes, compare:

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

There are three health benefit coverage options available:

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

See pages 5-13 to review the features for each type of plan.

All Benefit Choice changes should be made on the form provided with this booklet. Benefit Recipients should complete the form **only** if changes are being made. Dependent Beneficiaries must be enrolled in the same plan as the Benefit Recipient. If you or your dependent are enrolling in TRIP for the first time, contact TRS for a TRIP enrollment form.

During the annual Benefit Choice Period, Benefit Recipients may:

- Change health plans
- Add dependent coverage

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

MANAGED CARE PLANS

There are 7 managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.

Health Maintenance Organizations (HMOs)

Benefit Recipients must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs health care services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the Benefit Recipient pays only a co-payment. No annual plan deductibles apply. The minimum level of HMO coverage provided by all plans is described on page 6. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

Open Access Plan (OAP)

The OAP provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with pre-determined co-payments. Tier III (out-of-network) offers Benefit Recipients flexibility in selecting health care providers with higher out-of-pocket costs. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of care providers. Benefit Recipients enrolled in the OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 7.

HMO BENEFITS

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

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

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

Some HMOs may have benefit limitations on a calendar year.

MANAGED CARE PLANS IN ILLINOIS COUNTIES

TRIP MANAGED CARE HEALTH PLANS FOR FISCAL YEAR 2007

- Managed Care Available
- No Managed Care Available
- Managed Care Partially Available

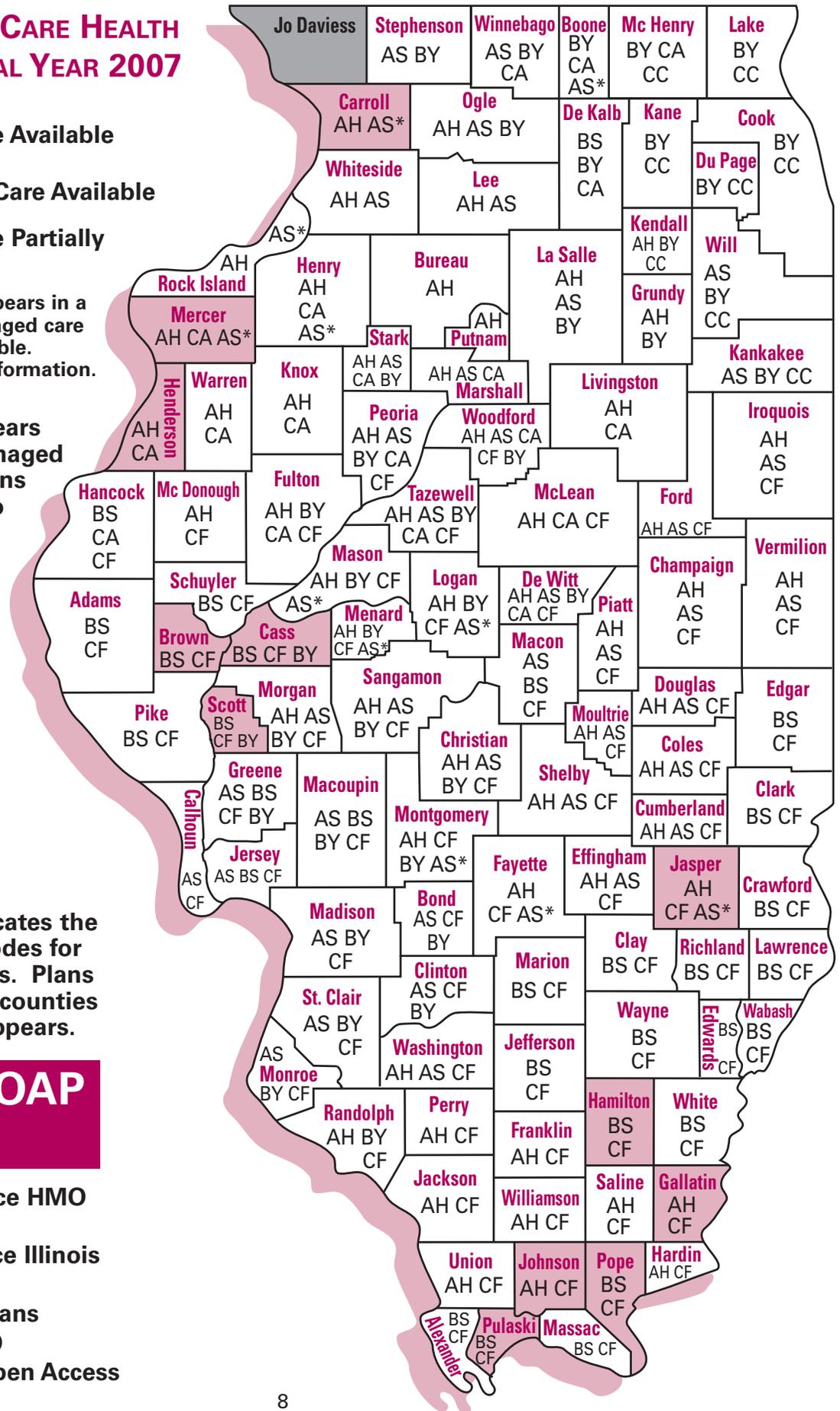
If a two-letter code appears in a shaded county, a managed care provider may be available. Contact the plan for information.

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

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

HMO AND OAP CODES:

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



IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

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

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

Out-of-County Managed Care Plans: Benefit Recipients interested in enrolling in a managed care plan that is not available in their county of residence should contact the plan directly to determine if an exception can be made that would allow the Benefit Recipient to participate in the managed care plan.

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

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

Psychiatric/Substance Abuse Treatment: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Plans are required to cover a minimum of 10 inpatient days and 20 outpatient visits. These visits are in addition to detoxification benefits that include diagnosis and treatment of medical complications.

Transplant Services: Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. Plan participants should contact the respective managed care plan for specific information at the first indication that a transplant may be needed.

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

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

THE TEACHERS' CHOICE HEALTH PLAN (TCHP)

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

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

Plan Year Maximums and Deductibles	
Plan Year Maximum	\$2,000,000
Lifetime Maximum	\$2,000,000
Plan Year Deductible	\$350 TCHP Primary Participant (Non-Medicare) \$350 Medicare Primary Participant
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit \$250 Non-PPO hospital admission \$250 Note: There is no additional deductible for admission to a PPO hospital

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

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

TCHP - MEDICAL PLAN COVERAGE

Hospital Services	
Preferred Provider Organization (PPO) Hospitals	80% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (Non-PPO) Hospitals	<ul style="list-style-type: none"> • \$250 per admission deductible. • If the Benefit Recipient resides in Illinois or within 25 miles of a PPO hospital and they choose to use a non-PPO and/or voluntarily travel in excess of 25 miles when a PPO hospital is available within the same travel distance, the plan pays 60% after the annual plan deductible. • If the Benefit Recipient resides in Illinois and has no PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest PPO hospital, the plan pays 60% after the annual plan deductible. • If the Benefit Recipient does not reside in Illinois or within 25 miles of a PPO hospital, the plan pays 70% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	80% 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	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Professional and Other Services	
CIGNA Healthcare Physician PPO Network	80% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in CIGNA's PPO Network	60% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services - medical necessity required (limit of \$1,000 per plan year)	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.

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

TCHP - NOTIFICATION AND PENALTIES

Health Plan Notification Requirements

Notification is the telephone call to the health plan notification administrator, **Intracorp**, informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for an outpatient procedure/therapy. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits. Notification is required for all plan participants including those who may have benefits available from other primary payer insurance or Medicare. Intracorp can be reached by calling (800) 962-0051.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information and evaluate the procedure, the setting and the anticipated initial length of stay for medical appropriateness. Failure to contact Intracorp within the required time limits will result in a \$1,000 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

A "reference number" will be assigned and should be maintained by the plan participant should there be any questions regarding notification; however, it is not a guarantee of benefits. For benefit confirmation, Intracorp, the Notification Administrator, can transfer the plan participant to CIGNA for assistance.

Notification is required for the following:

- **Elective Inpatient Surgery or Non-Emergency Admission** - The plan participant must contact Intracorp at least seven days prior to the admission.
- **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable Intracorp to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. **Notification of a maternity admission is not automatic enrollment of the newborn.** Contact TRS to enroll the newborn within 60 days of birth.
- **Skilled Nursing** - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home - The plan participant must contact Intracorp at least seven days prior to the admission. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission** - The plan participant or physician must contact Intracorp within two business days after the admission.
- **Notification for Outpatient Surgery or Procedures/Therapies** - The plan participant must contact Intracorp prior to receiving services such as, but not limited to, speech, physical and occupational therapies and imaging (MRI, PET, SPECT and CAT Scan). **Failure to notify Intracorp of outpatient surgery or procedures may result in a reduction of benefits.**
- **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should contact Intracorp at the first indication that a transplant may be necessary. Benefits are available only if authorized by Intracorp.

Behavioral Health Services Notification and Authorization Requirements

Contacting the Behavioral Health Plan Administrator, **Magellan**, begins the authorization process for services at all levels of care to avoid penalties or non-authorization of benefits. In an emergency or life-threatening situation, call 911, or go to the nearest hospital emergency room. Contact Magellan within 48 hours to avoid a financial penalty.

A licensed behavioral health professional will conduct a review to determine if treatment meets medical necessity criteria and appropriate level of care. If treatment is authorized, services are eligible for benefit coverage. Services determined not medically necessary will not be eligible for coverage.

For authorization procedures for behavioral health services, see the Behavioral Health Services section of the Benefits Handbook or call Magellan at (800) 513-2611.

MONTHLY HEALTH PREMIUMS

The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
	Under Age 23	Age 23-64	Age 65 and Above	All Ages
Benefit Recipient enrolled in any managed care plan	\$51.22	\$159.06	\$216.70	\$62.86
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	\$132.90	\$375.09	\$564.11	\$163.66
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	\$66.45	\$187.55	\$282.05	\$81.83
Dependent Beneficiary enrolled in any managed care plan	\$204.89	\$636.22	\$866.81	\$228.65**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	\$265.80	\$750.17	\$1,128.21	\$327.33
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	\$265.80	\$750.17	\$1,128.21	\$245.50**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See page 19 for contact information.

** Medicare Primary Dependent Beneficiaries enrolled in a managed care plan, or in the TCHP when no managed care plan is available, receive a premium subsidy.

PRESCRIPTION DRUG BENEFIT

Plan participants enrolled in TRIP have prescription drug coverage available. All prescription medications are compiled on a preferred list (“formulary list”) maintained by each managed care plan or Medco. Formulary lists categorize brand drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount. TCHP has separate minimum and maximum co-payments/coinsurance amounts that apply.

PRESCRIPTION DRUG CO-PAYS FOR ALL MANAGED CARE PLANS

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

PRESCRIPTION DRUG CO-PAYS/COINSURANCE FOR TCHP

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

- Annual prescription drug out-of-pocket maximum of \$1250 applies.
- Out-of-Network claims do not count toward this annual out-of-pocket maximum.
- 20% coinsurance with minimum and maximum co-payments (1-30 day supply).
- After meeting the \$1250 out-of-pocket maximum, prescriptions are covered at 100%.
- Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums.

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

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

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

MANAGED CARE PLAN PRESCRIPTION DRUG BENEFIT

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

MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT

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

Note for TCHP: Prescription drug benefits of plan participant's enrolled in the Teachers' Choice Health Plan (TCHP) are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums. A separate annual prescription in-network out-of-pocket maximum of \$1,250 applies. After meeting the \$1,250 out-of-pocket maximum, in-network prescriptions are covered at 100%. When a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the appropriate co-payment/coinsurance amount. The cost difference does not apply to the \$1,250 annual out-of-pocket maximum.

In-Network Pharmacy

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

Out-of-Network Pharmacy

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

Mail Order Pharmacy

The Mail Order Pharmacy provides participants the opportunity to receive medications directly from Medco at a discounted price. 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. Plan participants will be charged two co-payments/coinsurance amounts for a 61-90 day supply. 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. Order forms are also available on the Benefits website at www.benefitschoice.il.gov.

NOTICE OF CREDITABLE COVERAGE

Prescription Drug Information for Teachers' Retirement Insurance Program (TRIP) Medicare Eligible Plan Participants

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

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop your entire group coverage through the TRIP and do not enroll in a Medicare Part D Plan after your existing group coverage ends, 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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

How We May Use or Disclose Your PHI:

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

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

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

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

Legal Requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights:

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

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

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

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

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

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

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

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

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

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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

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

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

DISCLAIMER

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

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

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