STAITE OF ILLINOIS

BENEFIT CHOICE OPTIONS

Plan Year July 1, 2000 through June 30, 2001

Benefit Choice Period
May 1 - June 20, 2000

Illinois Department of
Central Management Services

George H. Ryan, Governor
Michael S. Schwartz, Director
THERE ARE IMPORTANT BENEFIT CHANGES
EFFECTIVE JULY 1!

The information below itemizes significant changes to the benefit plans. To ensure awareness of any and all changes in specific coverages, please review all the information in this Benefit Choice Options booklet.

**American HMO/POS** (carrier codes AA and BL) will no longer be available.

**Community Health Plan of Sarah Bush Lincoln** (carrier code BX) will no longer be available.

If you are enrolled in **American HMO/POS** or **Community Health Plan of Sarah Bush Lincoln**, you will need to enroll in another managed care plan or in the **Quality Care Health Plan (QCHP)**. If you do not make another plan selection before June 20, 2000, you will automatically be enrolled in QCHP effective July 1, 2000.

**OSF Winnebago** (carrier code CE) is now available in Winnebago County.

**Rush Prudential HMO** was purchased by Wellpoint Health Networks and will now operate under the name Unicare HMO. **Prudential HealthCare** was purchased by Aetna U.S. Healthcare and will continue to operate under the Prudential HealthCare name in FY 2001. No substantive changes in plan coverage or provider networks are anticipated as a result of these acquisitions.

For information on plans in your area, please see pages 12 and 13. Marketing information from all plans available to you will be mailed to your home, including changes to plan copayments.

**This year’s PPO hospital network** will include 234 hospitals statewide. New to the network are **RML Specialty Hospital, Hinsdale**, **St. Joseph’s Hospital, Bloomington**, **CGH Medical Center, Sterling** and **Swedish American Hospital, Rockford**. No longer in the network are **St. Joseph’s Hospital, Belvidere**, **Doctor’s Hospital of Hyde Park, Chicago**, **Holy Cross Hospital, Chicago**, and **Compton Heights Hospital, St. Louis**.

There are also changes to deductibles and pharmacy copays. Make sure you check the appropriate sections to see how these changes may affect you.

**Specific to claims filing:** Beginning July 1, 2000, members have the current plan year, plus one additional plan year to file all medical, pharmacy, mental health/substance abuse, vision, and dental claims.

MOVED?
Notify your Group Insurance Representative so you don’t miss important benefit news.
Table of Contents

Health Plan Options
Monthly Premium Information
Dependent Health Plan Premiums

Health Maintenance Organizations
  HMO Benefits
  HMO Plan Design
  Hospital Services
  Professional & Other Services
Point of Service Plans
  POS Benefits
  POS Plan Design
  POS Services Covered
Important Reminders About Managed Care
Managed Care Plans in Illinois Counties (map)
Participating Plans in Bordering States
Plan Administrators (phone numbers)

Accreditation Chart

Plan Design
Pre-Certification Notification/Non-Compliance Penalties
  and Pre-Determination of Benefits
Plan Coverage
  Inpatient Hospital Services
  Outpatient Services
  Professional & Other Services
  Prescription Drugs
  Mental Health & Substance Abuse Treatment
  Preferred Provider Organizations
  Preferred Provider Transplant Facilities
Plan Administrators (addresses & phone numbers)
Quality Care Dental Plan (QCDP)
Managed Care Dental Plan (MCDP)
Monthly Dental Premiums
Dental Benefits

FSA Savings Example

Worksheet

Medicare Crossover Enrollment Form
The Importance of Benefit Choice Period

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

Benefit Choice runs from May 1 through June 20. The plans members select during this period will be in force for the plan year July 1, 2000 through June 30, 2001. It is each member’s responsibility to review the information in this publication in its entirety.

All Benefit Choice changes can be processed through your Group Insurance Representative. If you are unsure who your Group Insurance Representative is, please contact your agency’s personnel office. Only health and dental plan selections can be processed via the Telephone Enrollment System by those members residing in the continental United States (see page 40). Members who do not anticipate making a health plan change should carefully review plan coverages and benefits for possible changes.

Remember: There can be changes in your coverage even if you do not change plans.

Health Plan Options
Two types of healthcare options are available. They include:

- **Managed Care Plans** (Health Maintenance Organizations = HMO, Point of Service Plan = POS)
- **Quality Care Health Plan** (QCHP – a traditional medical indemnity plan)

While the Quality Care Health Plan (QCHP) is available statewide, HMO and POS plans (referred to overall as “managed care plans”) tend to have geographic and provider limitations. Members interested in a managed care plan should carefully review each plan’s benefits, the service area map and county list on pages 12 and 13, and the provider directories available from each managed care plan. Specific questions regarding coverage should be directed to each respective plan.

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

- Differences in the services covered
- Differences in deductibles, copayment levels and out-of-pocket maximums
- Premium costs and possible geographic limitations
- Healthcare provider selection process
- Prescription drug benefits

For information specific to participating managed care plans, contact the individual plans (phone numbers on page 14). For detailed information on the Quality Care Health Plan (QCHP), refer to your State of Illinois Benefits Handbook. It is recommended that you keep your Benefit Choice Options booklet and the Benefits Handbook readily available throughout the plan year for complete reference.
**Monthly Premium Information**

**Employee Health Contributions:** While the state covers most of the cost of employee health insurance, employees also make monthly salary-based contributions for healthcare coverage. Contribution amounts are based on the employee’s salary; the higher their salary, the higher their contribution. Contributions remain in effect until June 30, 2001, unless the member retires, accepts a voluntary salary reduction, or returns to state employment at a different salary. (This does not apply to members returning to work from a leave of absence.) Employees who enroll in a managed care plan will pay a lower monthly contribution. Employees who reside in Illinois who do not have managed care available in their county should contact the CMS Group Insurance Division (see page 29).

<table>
<thead>
<tr>
<th>Employee Annual Salary</th>
<th>Employee Monthly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$24,800 &amp; below</td>
<td>Managed Care: $21.00</td>
</tr>
<tr>
<td>$25,401 – $38,300</td>
<td>Quality Care: $27.00</td>
</tr>
<tr>
<td>$38,301 – $51,000</td>
<td>Managed Care: $26.00</td>
</tr>
<tr>
<td>$51,001– $63,800</td>
<td>Quality Care: $32.00</td>
</tr>
<tr>
<td>$63,801 &amp; above</td>
<td>Managed Care: $25.00</td>
</tr>
<tr>
<td></td>
<td>Quality Care: $27.00</td>
</tr>
</tbody>
</table>

* If you became a SRS/SURS annuitant/survivor on or after 1/1/98, or a TRS annuitant/survivor on or after 7/1/98, and have less than 20 years creditable service, call your retirement system for applicable premiums. SRS: 217/785-7150; 217/785-7218 (TDD/TTY), SURS: 217/378-8800 and 800/275-7877, 800/526-0844 (TDD/TTY), TRS: 800/877-7896, 217/753-0329 (TDD/TTY).

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**Monthly Employee Health Contribution:** $_______

**Monthly Dependent Health Premium**

(Member & 1 Dependent) $_______

(Member & 2+ Dependents) $_______

**Monthly Dental Premium**

(Code D7) $_______

(Code D6) $_______

**My Total Monthly Health/Dental Premiums:** $___

Optional Term Life premiums are in addition to health & dental costs!
**Dependent Health Plan Premiums**

Monthly dependent premiums are in addition to member contributions. Dependents must be enrolled in the same plan as the member under whom they are enrolled. **Medicare dependent premiums apply only if Medicare is PRIMARY for both Parts A and B.** If you are actively working, and you or your dependents are enrolled in Medicare, questions regarding whether Medicare is primary payer should be directed to your agency Group Insurance Representative. Employees who reside in Illinois who do not have managed care available and enroll dependents, should contact CMS Group Insurance Division (see page 29).

<table>
<thead>
<tr>
<th>Plan Name &amp; Code</th>
<th>One Dependent</th>
<th>Two or More Dependents</th>
<th>One Medicare A &amp; B Primary Dependent</th>
<th>Two or More Medicare A &amp; B Primary Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care Health Plan (Code: D3)</td>
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<td>$150</td>
<td>$66</td>
<td>$127</td>
</tr>
<tr>
<td>Aetna US Healthcare HMO (Code: CD)</td>
<td>$45</td>
<td>$77</td>
<td>$42</td>
<td>$77</td>
</tr>
<tr>
<td>Health Alliance HMO (Code: AH)</td>
<td>$54</td>
<td>$93</td>
<td>$51</td>
<td>$93</td>
</tr>
<tr>
<td>Health Alliance Illinois (Code: BS)</td>
<td>$64</td>
<td>$110</td>
<td>$61</td>
<td>$110</td>
</tr>
<tr>
<td>HMO Illinois (Code: BY)</td>
<td>$46</td>
<td>$79</td>
<td>$43</td>
<td>$79</td>
</tr>
<tr>
<td>Humana Premier HMO (Code: AK)</td>
<td>$47</td>
<td>$81</td>
<td>$44</td>
<td>$81</td>
</tr>
<tr>
<td>OSF Health Plan (Code: CA)</td>
<td>$54</td>
<td>$93</td>
<td>$51</td>
<td>$93</td>
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<tr>
<td>OSF Winnebago (Code: CE)</td>
<td>$66</td>
<td>$114</td>
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<tr>
<td>PersonalCare (Code: AS)</td>
<td>$51</td>
<td>$88</td>
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<td>$88</td>
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<tr>
<td>Prudential HealthCare HMO (Code: BO)</td>
<td>$48</td>
<td>$83</td>
<td>$45</td>
<td>$83</td>
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<tr>
<td>Unicare HMO (formerly Rush Prudential HMO) (Code: CC)</td>
<td>$45</td>
<td>$77</td>
<td>$42</td>
<td>$77</td>
</tr>
<tr>
<td>Humana POS (Code: BZ)</td>
<td>$57</td>
<td>$98</td>
<td>$50</td>
<td>$98</td>
</tr>
<tr>
<td>Prudential HealthCare POS (Code: CB)</td>
<td>$64</td>
<td>$110</td>
<td>$56</td>
<td>$110</td>
</tr>
</tbody>
</table>
Managed Care Plans

There are 12 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and Point of Service (POS) plans. All offer extensive benefit coverage.

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

Health Maintenance Organizations (HMOs)

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

Point of Service Plans (POS)

POS plans are similar to HMOs in that you choose a PCP from the plan’s network, but they offer a special option - services are available from out-of-network providers without authorization from your PCP. These services are covered at a lesser out-of-network benefit level and require deductibles. For example:

Tom’s PCP determines that Tom needs surgery. He refers Tom to a surgeon in the POS network. The surgery is performed by the network surgeon in a network hospital and Tom pays a predetermined copayment.

If Tom decided to have the surgery performed by a surgeon or at a hospital outside the POS network, the services would still be covered, but Tom’s out-of-pocket expenses would be higher.

The minimum levels of coverage POS plans are required to provide are described on page 10. All out-of-network services are subject to Usual & Customary (U&C) limitations. This can significantly affect your out-of-pocket costs. Make sure you compare the POS in-network and out-of-network benefit levels.
HMO Benefits
The benefits described below represent the minimum level of coverage the HMO is required to provide. Benefits are subject to the limitations outlined in the plan’s Certificate of Coverage. Contact each respective plan directly to obtain a copy.

Plan Year Maximum Benefit…………………………..Unlimited
Lifetime Maximum Benefit…………………………..Unlimited

Inpatient hospitalization………………………………100% after $150 copay

Alcohol/substance abuse*…………………………100% after $150 copay per admission
(maximum number of days determined by the plan)

Psychiatric admission*…………………………100% after $150 copay per admission
(maximum number of days determined by the plan)

Outpatient surgery……………………………………100%

Diagnostic lab & X-ray…………………………100%

Emergency room hospital services………………100% after $100 or 50% copay, whichever is less

Physician visits
(including physical exams & immunizations)…………100%, $10 copay may apply

Well Baby Care……………………………………100%

Psychiatric care*…………………………………100%
(maximum number of days determined by the plan)

Alcohol & substance abuse care*…………………………100% after $20 or 20% copay per visit
(maximum number of days determined by the plan)

Prescription drugs…………………………………$5 copay, generic incentive and formulary restrictions may apply

Durable medical equipment………………………80%

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

A Certificate of Coverage is a description of benefits in a plan. This is available upon request from the plan. If you have questions about specific benefits not addressed above, you should request a Certificate of Coverage before making a decision to choose a particular plan.
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<table>
<thead>
<tr>
<th>POS Services Covered</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS Plan Design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-Of-Pocket</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per individual:</td>
<td>Annual out-of-pocket varies from plan to plan. Contact individual plans for details.</td>
<td>$1,500 $3,500</td>
</tr>
<tr>
<td>Per family:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Services Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Plan Design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% after $150 copay</td>
<td>80% of covered charges after $300 copay</td>
</tr>
<tr>
<td></td>
<td>100% after $150 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $150 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after lesser of $100 copay or 50% of U&amp;C</td>
<td>80% after lesser of $100 copay or 50% of U&amp;C</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>80% of U&amp;C after plan deductible</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>80% of U&amp;C after plan deductible</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after lesser of $100 copay or 50% of U&amp;C</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
<tr>
<td></td>
<td>100% after $10 copay</td>
<td>No out-of-network benefit, covered in-network only</td>
</tr>
</tbody>
</table>

A Certificate of Coverage is a description of benefits in a plan. This is available upon request from the plan. If you have questions about specific benefits addressed above, you should request a Certificate of Coverage before making a decision to choose a particular plan.
Important Reminders About Managed Care

**Managed care plan provider networks are subject to change.** Always call the respective plan to verify particular providers and/or receive specific coverage information - even if the information is printed in the plan’s directory.

**If your PCP leaves the managed care plan’s network you have three options:** 1) choose another PCP with that plan; 2) change managed care plans; or 3) enroll in the Quality Care Health Plan. The opportunity to change plans applies to **Primary Care Physicians**. It does not apply to specialists or women’s healthcare providers who are not designated Primary Care Physicians.

**Members residing outside counties where managed care plans have PCPs that the member would like to utilize, should contact the plan to check if they are eligible to enroll.**

**Eligible dependents who are full-time students in accredited schools and live apart from the member’s residence of record for any part of a plan year may be subject to limited service coverage when living away.** If you have such a dependent, it is critical to contact the managed care plan you are enrolled in - or considering enrolling in - to understand the plan’s guidelines on this type of coverage.

**If you change health plans, and are hospitalized in June, it is recommended you contact both your current plan/ PCP and future plan/ PCP well in advance of June 30/ July 1.**

**Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/ substance abuse treatment. Plan benefits may vary, but a minimum of 10 inpatient days and 20 outpatient visits are required. These are in addition to detoxification benefits which include diagnosis and treatment of medical complications.**

**Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. Contact your respective managed care plan for specific information.**

**For detailed information on HMO/ POS service coverage, exclusions, limitations, and other information, contact each respective plan (see page 14 for phone numbers). You do not need to be enrolled in a managed care plan to request this important information.**
STATE
Managed Care Plans
For FY 2001

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

HMO and POS Codes:

AH = HEALTH ALLIANCE HMO
AK = HUMANA PREMIER HMO
AS = PERSONALCARE
BO = PRUDENTIAL HEALTHCARE HMO
BS = HEALTH ALLIANCE ILLINOIS
BY = HMO ILLINOIS
BZ = HUMANA POS
CA = OSF HEALTHPLAN
CB = PRUDENTIAL HEALTHCARE POS
CC = UNICARE HMO (formerly Rush Prudential HMO)
CD = AETNA US HEALTHCARE HMO
CE = OSF WINNEBAGO
## Participating Managed Care Plans in Bordering States

The state contracts with leading managed care plans located in states with counties immediately bordering Illinois.

**Remember:** Verify Primary Care Physician availability prior to enrollment.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna US Healthcare HMO (Code: CD)</td>
<td>Lake &amp; Porter</td>
</tr>
<tr>
<td>Health Alliance HMO (Code: AH)</td>
<td>Scott</td>
</tr>
<tr>
<td>HMO Illinois (Code: BY)</td>
<td>Lake</td>
</tr>
<tr>
<td>Humana Premier HMO (Code: AK)</td>
<td>Lake &amp; Porter</td>
</tr>
<tr>
<td>OSF Health Plan (Code: CA)</td>
<td></td>
</tr>
<tr>
<td>PersonalCare HMO (Code: AS)</td>
<td>Clay, Fountain, Parke, Vermillion &amp; Vigo</td>
</tr>
<tr>
<td>Prudential HealthCare HMO (Code: BO)</td>
<td>Audrain, Boone, Crawford, Franklin, Jefferson, Lincoln, Monroe, Montgomery, St. Charles, St. Louis &amp; Warren</td>
</tr>
<tr>
<td>Prudential HealthCare POS (Code: CB)</td>
<td>Audrain, Boone, Crawford, Franklin, Jefferson, Lincoln, Macon, Monroe, Montgomery, St. Charles, St. Louis &amp; Warren</td>
</tr>
<tr>
<td>Unicare HMO (formerly Rush Prudential HMO) (Code: CC)</td>
<td>Lake</td>
</tr>
</tbody>
</table>
Plan Administrators

The most accurate source of information regarding a managed care plan is the plan’s administrator. Contact the administrator with specific questions or for a “Certificate of Coverage” which provides information on benefits, excluded services, and other important details. You do not need to be enrolled in a managed care plan to request information.

- Personally verify facilities and providers prior to enrolling.

<table>
<thead>
<tr>
<th>Healthcare Plan Name/Administrator</th>
<th>Toll-free Phone 1</th>
<th>Toll-free Phone 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna US Healthcare HMO</td>
<td>800/444-6066</td>
<td>800/628-3323</td>
</tr>
<tr>
<td>Health Alliance HMO</td>
<td>800/851-3379</td>
<td>217/337-8137</td>
</tr>
<tr>
<td>Health Alliance Illinois</td>
<td>800/851-3379</td>
<td>217/337-8137</td>
</tr>
<tr>
<td>HMO Illinois</td>
<td>800/868-9520</td>
<td>800/888-7114</td>
</tr>
<tr>
<td>Humana Premier HMO &amp; Humana POS</td>
<td>800/486-2621</td>
<td>800/526-0844</td>
</tr>
<tr>
<td>OSF Health Plan</td>
<td>888/716-9138</td>
<td>888/817-0139</td>
</tr>
<tr>
<td>OSF Winnebago</td>
<td>888/716-9138</td>
<td>888/817-0139</td>
</tr>
<tr>
<td>PersonalCare</td>
<td>800/431-1211</td>
<td>217/366-5551</td>
</tr>
<tr>
<td>Prudential HealthCare HMO &amp; POS</td>
<td>800/298-7625</td>
<td>888/870-4452</td>
</tr>
<tr>
<td>Unicare HMO (formerly Rush Prudential HMO)</td>
<td>888/234-7747</td>
<td>312/234-7770</td>
</tr>
<tr>
<td>CompDent of Illinois (Managed Care &amp; Quality Care Dental Plan)</td>
<td>800/999-1669</td>
<td>312/829-1298</td>
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<tr>
<td>Vision Service Plan</td>
<td>800/877-7195</td>
<td>800/428-4833</td>
</tr>
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</table>
Accreditation of Managed Care Health Plans

One way managed care consumers can judge plan quality is through accreditation by an outside agency. The National Committee for Quality Assurance (NCQA) is a leader in accrediting managed care plans. With a staff made up of managed care experts including employers, consumer and labor representatives, health plan representatives, physicians, quality experts and policy makers, the not-for-profit NCQA prides itself on providing purchasers and consumers of managed care with comparative data on plan quality and value.

NCQA evaluates managed care plans in a number of areas, including:

- How well the plan encourages the use of preventive healthcare services
- How the plan assesses physician qualifications and credentials
- How well the plan informs members of their rights and responds to concerns
- Whether the plan has high standards for medical record quality
- Whether the plan's medical management standards are consistent and reasonable
- Whether the plan continually makes improvements in its healthcare and services

NCQA levels of accreditation are assigned subsequent to an analysis of information each plan is required to submit. The plan must also undergo an on-site evaluation of its practices and standards. Plans must pay a fee to be reviewed and are not eligible for consideration until they have been in operation for at least two years.

Please note that the accreditation levels have changed from previous years. All levels of accreditation indicate that a plan has been reviewed by NCQA. The higher the level of the accreditation, the more closely the plan meets NCQA standards. Levels include:

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

**Commendable:** Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. A "Commendable" designation is the equivalent to NCQA's former "Full Accreditation" designation.

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

**Provisional:** Is an indication that a plan's service and clinical quality meet some, but not all, of NCQA's basic requirements.
Indicates the plan did not meet NCQA’s requirements at the time of review.

___ Denotes those plans for which an initial accreditation determination has been made but the determination is under review at the request of the plan.

___________ Denotes those plans NCQA has chosen to review in order to assess the appropriateness of an existing accreditation decision.

Further information regarding NCQA accreditation is available by contacting NCQA directly at 888/275-7585 or at their website (http://www.ncqa.org).
## Current NCQA Managed Care Plan Accreditation

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Not Reviewed</th>
<th>Review Scheduled</th>
<th>Discretionary Review</th>
<th>Under Review</th>
<th>Denied</th>
<th>Provisional</th>
<th>Accredited</th>
<th>Commendable</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna US Healthcare HMO</td>
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<td>Health Alliance HMO</td>
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<td>Humana Premier HMO</td>
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<tr>
<td>Unicare HMO (formerly Rush Prudential HMO)</td>
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The Quality Care Health Plan (QCHP)

QCHP offers members more freedom than managed care plans when it comes to choosing providers, specialists and facilities. Enhanced benefits are paid if members use a Preferred Provider Organization (PPO) hospital, benefits are paid at a lesser amount if a non-PPO hospital is utilized (see page 20). For transplant facilities, please see page 28.

Plan Year Maximum Benefit……..Unlimited
Lifetime Maximum Benefit…….Unlimited

Annual Deductibles:
Based on each employee’s annual salary as of April 1st:

<table>
<thead>
<tr>
<th>Salary Range</th>
<th>Employee Deductible</th>
<th>Family Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$51,000 or less</td>
<td>$200</td>
<td>$300</td>
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<tr>
<td>$51,001 - $63,800</td>
<td>$300</td>
<td>$400</td>
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<tr>
<td>$63,801 or more</td>
<td>$350</td>
<td>$450</td>
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<tr>
<td>Retiree/ Annuitant/ Survivor</td>
<td>$200</td>
<td>$300</td>
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<tr>
<td>Dependents</td>
<td>$200</td>
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Regardless of salary: Non-PPO hospital admission…………………………………………$200
PPPO or non-PPO hospital emergency room visit..............$200

QCHP has both general and non-Preferred Provider Organization (PPO) out-of-pocket maximums. After meeting the maximum amount of out-of-pocket expenses, coinsurance payments cease and the plan pays 100% of eligible charges for the remainder of the plan year. Prescriptions copays, pre-certification penalties, mental health/substance abuse services and ineligible charges such as non-covered services or costs over Usual and Customary (U&C) fee schedule.

<table>
<thead>
<tr>
<th>Deductibles &amp; Coinsurance</th>
<th>Applied to GENERAL Out-of-Pocket Max</th>
<th>Applied to NON-PPO Out-of-Pocket Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Plan Deductibles</td>
<td>($800 per individual, $2,000 per family)</td>
<td>($3,000 per individual, $7,000 per family)</td>
</tr>
<tr>
<td>Professional &amp; Physician Coinsurance</td>
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<tr>
<td>PPO Inpatient/ Outpatient Coinsurance</td>
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<tr>
<td>Standard Hospital Coinsurance* &amp; Admission Deductibles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Emergency Room Deductibles &amp; Coinsurance</td>
<td></td>
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</tbody>
</table>

* Only if pre-certification administrator grants an exception allowing a non-PPO admission.
Pre-Certification Notification/Non-Compliance Penalties and Pre-Determination of Benefits:

Pre-certification is notification to the plan of an upcoming surgery or admission to a facility such as a hospital or extended care facility. Failure to pre-certify with Intracorp (the medical pre-certification administrator) within specific time limits, will result in a $400 non-compliance penalty and no coverage for services not deemed to be medically necessary. Even though pre-certification is required, it is not a guarantee of benefits.

It is the member's responsibility to pre-certify prior to anticipated outpatient surgery or an inpatient hospital admission. In the case of an emergency hospital admission, notification is required within 48 hours of your admission. If you have questions about whether a service needs to be pre-certified, call:

**INTRACORP**
800/ 327-7443
800/ 855-2880 (TDD/ TTY)

Pre-determination of benefits ensures that the surgery or the extended care facility stay will meet medical criteria and be eligible for benefit coverage. If you have questions about whether all or part of a healthcare service will be covered, it is recommended that you contact UNICARE (the medical plan administrator) to obtain a pre-determination of benefits.

**UNICARE**
888/ 209-7950
888/ 209-7953 (TDD/ TTY)

**NOTIFICATION TO INTRACORP IS REQUIRED FOR ALL MEMBERS, INCLUDING THOSE WITH MEDICARE AS PRIMARY PAYER, PRIOR TO:**
- non-emergency hospital admissions
- maternity hospital admission
  (see Benefits Handbook for requirements)
- skilled nursing facility admission
- any elective surgery
  (pre-certification required at least seven days prior)
- potential transplant(s)
  (pre-certification is required upon notification that an evaluation is necessary for you to be considered a candidate for a transplant or transplant covered services, prior to any additional inpatient and outpatient services)
- emergency admission
  (required within 48 hours of an emergency hospital admission)
**INPATIENT HOSPITAL SERVICES:**

Preferred Provider Organization Hospital

90% after annual plan deductible.

No admission deductible.

Non-Preferred Provider Organization Hospital

$200 per admission deductible. The plan pays 65% after annual plan deductible if member voluntarily chooses to use a non-PPO, or voluntarily travels in excess of 25 miles when a PPO hospital is available within the same travel distance. Coverage will be at 80% after annual plan deductible if a PPO hospital within 25 miles of a member’s residence is not medically qualified to perform the required services, if no PPO exists within 25 miles of the member’s residence, or if a member utilizes a non-PPO for emergency services.

**OUTPATIENT SERVICES:**

Diagnostic lab/ X-ray..................100% of Usual & Customary (U&C) after annual plan deductible.

Approved durable medical equipment & prosthetics.............80% of U&C after annual plan deductible. Contact the plan administrator for approval prior to obtaining items.

Surgical facility charges...............90% after annual plan deductible for PPOs and licensed, freestanding surgical facilities. (Outpatient facility charges will be covered at 65% after annual plan deductible if member voluntarily chooses to use a non-PPO, or voluntarily travels in excess of 25 miles when a PPO hospital is available within the same travel distance. Coverage will be at 80% after annual plan deductible if a PPO hospital within 25 miles of a member’s residence is not medically qualified to perform the required services, if no PPO exists within 25 miles of the member’s residence, or if a member utilizes a non-PPO for emergency services.)

Physician & Surgeon Services.........80% of U&C after annual plan deductible for inpatient, outpatient & office visits.

Preventive Services....................Well Baby Care (through age 6), pap smears (includes office visit), mammograms, prostate screening, routine adult physcals & school health exams (grades 5-9) are covered per the applicable coverages listed in the Benefits Handbook. No deductibles apply.

**PRESCRIPTION DRUGS:**

In-Network Pharmacy

Prescription Drugs................7 generic, $14 formulary brand, $28 non-formulary brand, copays for 30-day supply (see following page for additional details).

Out-of-Network Pharmacy

Prescription Drugs................Reimbursement limited to network price minus copay.

When a generic is available and the pharmacy dispenses a brand name drug for any reason, you will pay the generic copay as well as the cost difference between the brand name and generic product.
Important things to remember about QCHP prescription drug benefits

- The maximum supply available at one fill is 60-days medication. Copays double for any prescription exceeding 30-days. Copays do not apply toward medical plan deductibles or out-of-pocket maximums.

- Insulin pumps and related supplies: These items are not covered under the pharmacy plan. Coverage is available through the medical plan. For more information, contact the Medical Case Management Administrator, Intracorp, at 800/327-7443, 800/855-2880 (TDD/TTY).

- Pre-packaged Prescriptions: Since some products are pre-packaged in amounts greater or less than what is needed to meet a 30-day prescription, there may be instances where more than one copay is required. For example, if a prescription is written for 90 lancets to be used over a 30-day period, but lancets only come in boxes of 100, then an additional copayment is required to cover the surplus amount. Similarly, manufacturers commonly pre-package inhalers or tubes of ointment. Since the packaged medication may not be a 30-day supply, more than one package/unit may be required, therefore two copays would be required to obtain the correct amount.

- Medicare: Medicare Part B provides coverage for lancets, test strips, and glucose monitors for both Type I and Type II diabetics. Persons who are Medicare primary must pay for these items at time of purchase and submit a claim directly to Medicare for reimbursement. The Explanation of Medicare Benefits should then be filed with the Pharmacy Program Administrator for any secondary benefits. In order to receive the maximum reimbursement for secondary benefits, supplies should be purchased at network pharmacies.

- Exclusions: The Pharmacy Program Administrator reserves the right to exclude or limit coverage of specific prescription drugs or supplies. The following drugs are not covered by the pharmacy plan: oral contraceptives prescribed for birth control, Rogaine, and any item, including vitamins, that can be purchased over-the-counter without a prescription (with the exception of insulin). Other limitations may be placed on other prescriptions in accordance with U.S. Food and Drug Administration guidelines.
QCHP offers coverage for mental health and substance abuse services through the Member Assistance Program (MAP). The plan administrator is Magellan. To obtain the highest benefit possible (the in-network benefit), services must be pre-certified by the Member Assistance Program (MAP) by calling 800/513-2611. Coverage is as follows:

**In-Network (Enhanced Benefit):**

**Outpatient:** 100% coverage after $15 copay per visit.

**Inpatient:** $50 per day copay up to a max of $275 per admission, 100% coverage of additional facility charges, and 100% coverage of physician charges after $15 per day copay. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.

**Alternative Treatment:** Intensive outpatient, partial hospitalization and other treatments are covered with a $25 per day copay up to a max of $125 per admission, 100% coverage of additional facility charges, and 100% coverage of physician charges after $15 per day copay. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.

**Out-of-Network Benefit:**

**Outpatient:** 50% coverage up to $35 per visit with 50 visit max per plan year.

**Inpatient:** $50 per day copay up to a max of $250 per admission, 60% coverage of additional facility charges. Physician charges reimbursed at the applicable in or out-of-network level. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.

**Alternative Treatment:** Intensive outpatient, partial hospitalization and other treatments are covered with a $25 per day copay up to a max of $125 per admission, 60% coverage of additional facility charges. Physician charges reimbursed at the applicable in or out-of-network level. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.

**If you do not live within 25 miles of an in-network facility, the following benefits apply:**

**Outpatient:** Applicable in or out-of-network benefit as listed above.

**Inpatient:** $50 per day copay up to a max of $250 per admission, 80% coverage of additional facility charges, maximum out-of-pocket expenses of $1,500 per plan year. Physician charges reimbursed at the applicable in or out-of-network level. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.

**Alternative Treatment:** Intensive outpatient, partial hospitalization and other treatments are covered with a $25 per day copay up to a max of $125 per admission, 80% coverage of additional facility charges, maximum out-of-pocket expenses of $1,500 per plan year. Physician charges reimbursed at the applicable in or out-of-network level. Out-of-network physician charges are covered at 50% up to $35 per day. 50 visit max per plan year.
Important things to remember about QCHP mental health/substance abuse benefits

Medical Necessity: All mental health and substance abuse services are subject to medical necessity. Services determined not medically necessary will not be reimbursed.

Pre-Certification: Psychological testing must be pre-certified with MAP in order to receive the enhanced or standard benefit.

Medicare Primary Members: If you receive treatment from a provider who is not Medicare-approved, you must pre-certify with MAP in order to obtain enhanced benefits.

Provider Credentials: All outpatient services received at the out-of-network benefit level must be provided by a licensed clinical social worker (LCSW), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), licensed psychologist (Ph.D.) or a licensed psychiatrist (MD) to be eligible for coverage.
QCHP Preferred Provider Organizations

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

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

E
Edgewater Medical Center, Chicago
Edward Hospital, Naperville
Elmhurst Memorial Hospital, Elmhurst
 Evanston Hospital, Evanston

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

H
Highland Park Hospital, Highland Park
Hinsdale Hospital, Hinsdale
Holy Family Medical Center, Des Plaines

I
Illinois Masonic Medical Center, Chicago
Ingalls Memorial Hospital, Harvey

J
Jackson Park Hospital, Chicago

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

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

N
Northwest Community Hospital, Arlington Hts.
Northwestern Memorial Hospital, Chicago
Norwegian American Hospital, Chicago
Oak Forest Hospital of Cook County, Oak Forest
Oak Park Hospital, Oak Park
Olympia Fields Osteopathic Hosp., Olympia Fields
Our Lady of the Resurrection Med. Center, Chicago
Provena St. Therese Medical Center, Waukegan
Provident Hospital of Cook County, Chicago

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

S
Sacred Heart Hospital, Chicago
Schwab Rehabilitation Hospital, Chicago
South Shore Hospital, Chicago
St. Alexius Medical Center, Hoffman Estates
St. Anthony Hospital, Chicago
St. Bernard Hospital & Health Care Center, Chicago
St. Elizabeth Hospital, Chicago
St. Francis Hospital, Evanston
St. Francis Hospital & Health Center, Blue Island
St. James Hospital & Health Center, Chicago Hts.
St. Joseph Hospital, Chicago
St. Margaret Mercy Healthcare Ctr., Hammond, IN
St. Margaret Mercy Healthcare Center, Dyer, IN
St. Mary of Nazareth Hospital Center, Chicago
Swedish Covenant Hospital, Chicago

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

U
University of Chicago Hospital, Chicago
University of Illinois Hospital, Chicago

V
Victory Memorial Hospital, Waukegan

W
West Suburban Hospital Medical Center, Oak Park
Westlake Community Hospital, Melrose Park
CGH Medical Center, Sterling
Copley Medical Center, Aurora
Delnor Community Hospital, Geneva
DeWitt Community Hospital, DeWitt, IA
Freeport Memorial Hospital, Freeport
Genesys Medical Center East, Davenport, IA
Genesys Medical Center West, Davenport, IA
Hammond-Henry District Hospital, Geneseo
Harvard Memorial Hospital, Inc., Harvard
Illini Hospital, Silvis
Katherine Shaw Bethea Hospital, Dixon
Kenosha Hospital, Kenosha, WI
Kishwaukee Community Hospital, DeKalb
Memorial Medical Center, Woodstock
Mendota Community Hospital, Mendota
Mercer County Hospital, Aledo
Mercy Medical Center, Clinton, IA
Morris Hospital, Morris
Northern Illinois Medical Center, McHenry
Provena Mercy Center, Aurora
Provena St. Joseph Hospital, Elgin
Provena St. Joseph Medical Center, Joliet
Provena St. Mary's Hospital, Kankakee
Riverside Medical Center, Kankakee
Rochelle Community Hospital, Rochelle
Rockford Memorial Hospital, Rockford
Sherman Hospital, Elgin
Silver Cross Hospital, Joliet
St. Anthony Medical Center, Rockford
St. Catherine's Hospital, Kenosha, WI
Swedish American Hospital, Rockford
The Monroe Clinic, Monroe, WI
Trinity Med. Ctr., North Campus, Davenport, IA
Trinity Medical Center, 7th St., Moline
Trinity Medical Ctr., West Campus, Rock Island
Univ. of Wisconsin Hospital, Madison, WI
Valley West Community Hospital, Sandwich
Abraham Lincoln Memorial Hospital, Lincoln
Blessing Hospital, Quincy
BroMenn Regional Medical Center, Bloomington
Carle Foundation Hospital, Urbana
Carlinville Area Hospital, Carlinville
Community Hospital of Ottawa, Ottawa
Comm. Med. Ctr. of Western Illinois, Monmouth
Community Memorial Hospital, Staunton
Decatur Memorial Hospital, Decatur
Doctors Hospital, Springfield
Dr. John Warner Hospital, Clinton
Eureka Community Hospital, Eureka
Galesburg Cottage Hospital, Galesburg
Gibson Community Hospital, Gibson City
Graham Hospital, Canton
Hannibal Regional Hospital, Hannibal, MO
Hillsboro Area Hospital, Hillsboro
Hoopeston Comm. Memorial Hosp., Hoopeston
Illini Community Hospital, Pittsfield
Illinois Valley Community Hospital, Peru
Iroquois Memorial Hospital, Watseka
Jersey Community Hospital, Jerseyville
Julia R. Perry Memorial Hospital, Princeton
Mason District Hospital, Havana
McDonough District Hospital, Macomb
Memorial Hospital Association, Carthage
Memorial Medical Center, Springfield
Methodist Medical Center of Illinois, Peoria
Pana Community Hospital, Pana
Paris Community Hospital, Paris
Passavant Memorial Area Hospital, Jacksonville
Pekin Hospital, Pekin
Proctor Hospital, Peoria
Provena Covenant Medical Center, Urbana
Provena United Samaritans Med. Ctr., Danville
Sarah Bush Lincoln Health Center, Mattoon
Sarah D. Culbertson Mem. Hosp., Rushville
Shelby Memorial Hospital, Shelbyville
St. Francis Hospital, Litchfield
St. Francis Medical Center, Peoria
St. James Hospital, Pontiac
St. John’s Hospital, Springfield
St. Joseph Medical Center, Bloomington
St. Margaret’s Hospital, Spring Valley
St. Mary Medical Center, Galesburg
St. Mary’s Hospital, Decatur
St. Mary’s Hospital, Streator
St. Vincent Memorial Hospital, Taylorville
The John & Mary E. Kirby Hospital, Monticello
Thomas H. Boyd Memorial Hospital, Carrollton
Alexian Brothers Hospital, St. Louis
Alton Memorial Hospital, Alton
Anderson Hospital, Maryville
Barnes-Jewish Hospital, St. Louis
Barnes-Jewish St. Peter’s Hospital, St. Peters, MO
Barnes-Jewish West County Hospital, Creve Coeur
Bethesda General Hospital, St. Louis
Cardinal Glennon Children’s Hospital, St. Louis
Carmi Township Hospital, Carmi
Christian Hospital, NE, St. Louis
Christian Hospital, NW, Florissant
Clay County Hospital, Flora
Crawford Memorial Hospital, Robinson
Crossroads Comm. Hospital, Mt. Vernon
Deaconess Hospital, Evansville, IN
DePaul Health Center, Bridgeton, MO
Des Peres Hospital, St. Louis
Edward A. Utlaut Hospital, Greenville
Fairfield Memorial Hospital, Fairfield
Fayette County Hospital, Vandalia
Ferrell Hospital, Inc., Eldorado
Forest Park Hospital, St. Louis
Franklin Hospital, Benton
Good Samaritan Hospital, Vincennes, IN
Good Samaritan R.H.C., Mt. Vernon
Hamilton Memorial Hospital, McLeansboro
Hardin County General Hospital, Rosiclare
Harrisburg Medical Center, Harrisburg
Herrin Hospital, Herrin
Lawrence County Memorial Hospital, Lawrenceville
Lourdes Hospital, Paducah, KY
Marion Memorial Hospital, Marion
Marshall Browning Hospital, DuQuoin
Massac Memorial Hospital, Metropolis
Memorial Hospital, Belleville
Memorial Hospital, Chester
Memorial Hospital of Carbondale, Carbondale
Missouri Baptist Medical Center, St. Louis
Pinckneyville Community Hosp., Pinckneyville
Richland Memorial Hospital, Olney
Salem Township Hospital, Salem
South Pointe Hospital, St. Louis
Southeast Missouri Hospital, Cape Girardeau
Sparta Community Hospital, Sparta
SSM Rehabilitation Institute, St. Louis (all sites)
St. Anthony’s Health Center, Alton
St. Anthony’s Medical Center, St. Louis
St. Anthony’s Memorial Hospital, Effingham
St. Clare’s Hospital, Alton
St. Elizabeth Medical Center, Granite City
St. Elizabeth’s Hospital, Belleville
St. John’s Mercy Medical Center, St. Louis
St. Joseph’s Hospital, Highland
St. Joseph’s Hospital, Breese
St. Joseph Memorial Hospital, Murphysboro
St. Louis Children’s Hospital, St. Louis
St. Louis University Hospital, St. Louis
St. Luke’s Hospital, Chesterfield
St. Mary’s Health Center, Richmond Heights
St. Mary’s Hospital, Centralia
St. Mary’s Hospital of E. St. Louis, E. St. Louis
Touchette Regional Hospital, Centerville
UMW of A Union Hospital, West Frankfort
Union County Hospital District, Anna
Unity-St. Clement Health Services, Red Bud
Wabash General Hospital, Mt. Carmel
Washington County Hospital, Nashville
Wood River Township Hospital, Wood River
QCHP provides coverage for organ and tissue transplants. Transplant evaluations as well as the procedures themselves must take place at one of the PPO facilities listed below. Asterisks indicate the transplants performed at each facility. For more information, see your Benefits Handbook or contact the Precertification Administrator.

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<th>Heart/Lung</th>
<th>Kidney</th>
<th>Kidney/Pancreas</th>
<th>Liver</th>
<th>Lung</th>
<th>Pancreas</th>
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<td>Mayo Clinic</td>
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<td>Peoria, Illinois</td>
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<tr>
<td>St. John’s Hospital</td>
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<td>Springfield, Illinois</td>
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<td>St. Louis Children’s Hospital</td>
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<td>St. Louis, Missouri</td>
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<td>St. Louis U. Medical Center</td>
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<td>Swedish American Hospital</td>
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<td>Rockford, Illinois</td>
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<tr>
<td>U. of Chicago Medical Center</td>
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<td>Chicago, Illinois</td>
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<tr>
<td>U. of Illinois Medical Center</td>
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<tr>
<td>U. of Iowa Medical Center</td>
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<tr>
<td>Iowa City, Iowa</td>
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<tr>
<td>U. of Wis. Hospital &amp; Clinic</td>
<td>*</td>
<td>*</td>
<td>*</td>
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<tr>
<td>Madison, Wisconsin</td>
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</tr>
</tbody>
</table>
Plan Administrators

CMS contracts with specific benefit administrators to manage the plan’s components. Claim forms can be obtained and should be filed with the benefit administrators listed below. Specific coverage questions or concerns should also be directed there. Only general plan questions should be directed to the CMS Group Insurance Division or your Group Insurance Representative.

<table>
<thead>
<tr>
<th>Specific Plan Component</th>
<th>Contact For:</th>
<th>Administrator’s Name &amp; Address</th>
<th>Customer Service Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care Medical Care &amp; Services</td>
<td>Medical service information, claim forms and filing, claim resolution, and predetermination of benefits.</td>
<td>UNICARE Group Number 28455 State of Illinois P.O. Box 5025 Bolingbrook, IL 60440-5025</td>
<td>888/ 209-7950 (nationwide) 888/ 209-7953 (TDD/ TTY)</td>
</tr>
<tr>
<td>Quality Care Medical Pre-certification &amp; Case Management</td>
<td>Pre-certification prior to hospital services. Non-compliance penalty of $400 applies. See page 19 for more information.</td>
<td>Intracorp, Inc. (no address required)</td>
<td>800/ 327-7443 (nationwide) For access when outside the United States, dial the AT&amp;T Direct Access code of the country you are calling from and then the above number. 800/ 855-2880 (TDD/ TTY)</td>
</tr>
<tr>
<td>Quality Care Pharmacy Benefits</td>
<td>Information on prescription drug coverage, pharmacy network, claim forms and filing.</td>
<td>National Prescription Administrators (NPA) Group Number 1400 711 Ridgedale Avenue East Hanover, NJ 07936</td>
<td>800/ 250-9594 (nationwide) 888/ 269-5304 (TDD/ TTY)</td>
</tr>
<tr>
<td>Quality Care Mental Health &amp; Substance Abuse Services</td>
<td>Pre-certification and authorization for any and all related services.</td>
<td>Magellan Behavioral Health Group Number 28455 P.O. Box 909782 Chicago, IL 60690</td>
<td>800/ 513-2611 (nationwide) 800/ 526-0844 (TDD/ TTY)</td>
</tr>
<tr>
<td>Quality Care Dental Plan</td>
<td>Dental services, claim forms and filing. Copies of the managed care dental brochure.</td>
<td>CompDent, Inc. Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677</td>
<td>800/ 999-1669 800/ 526-0844 312/ 829-1298 (TDD/ TTY)</td>
</tr>
<tr>
<td>Vision Plan</td>
<td>Vision services and benefits, network providers, claim forms and filing.</td>
<td>Vision Service Plan 222 South Riverside Plaza Suite 2210 Chicago, IL 60606</td>
<td>800/ 877-7195 800/ 428-4833 (TDD/ TTY) email: <a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Flexible Spending Account Program (MCAP &amp; DCAP)</td>
<td>Information on setting aside pre-tax dollars for medical and dependent care expenses.</td>
<td>Fringe Benefits Management Company P.O. Box 1800 Tallahassee, FL 32302-1800</td>
<td>800/342-8017 800/955-8771 (TDD/TTY)</td>
</tr>
<tr>
<td>State Health Plans, COBRA, Life Insurance &amp; Adoption Benefits</td>
<td>General information on the state health plans or other benefits.</td>
<td>CMS Group Insurance Division 600 Stratton Building Springfield, IL 62706</td>
<td>217/ 782-2548 800/ 442-1300 800/ 526-0844 (TDD/ TTY)</td>
</tr>
</tbody>
</table>
Lack of regular preventive dental care can lead to significant health problems. Members have the option of enrolling in a traditional indemnity or managed care dental plan, regardless of the type of health plan they choose. Both plans are administered by CompDent, Inc. and are designed to offer good oral care while keeping out-of-pocket expenses in check. Dental plan questions should be directed to 800/999-1669, 800/526-0844, or 312/829-1298 (TDD/TTY).

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

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

**Monthly Dental Premiums:**

There can be significant out-of-pocket expenses for this service. Orthodontic expenses are eligible under MCAP and significant savings can be achieved by enrolling in the program during the Benefit Choice Period. For more information on MCAP, see page 36.

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Employee Only</th>
<th>Employee + 1 Dependent</th>
<th>Employee + 2 or more Dependents</th>
<th>Retirees, Annuitants, Survivors + 1 Dependent</th>
<th>Retirees, Annuitants, Survivors + 2 or more Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care</td>
<td>$7.50</td>
<td>$12.50</td>
<td>$15.00</td>
<td>$5.00</td>
<td>$7.50</td>
</tr>
<tr>
<td>Managed Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Plan Design</td>
<td>Managed Care</td>
<td>Dental Plan</td>
<td>Quality Care</td>
<td>Dental Plan</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Premium</td>
<td>None</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>None</td>
<td>$50 individual plan deductible for dental services other than those listed as “preventive or diagnostic” on the Schedule of Benefits in the Benefits Handbook.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit Limit</td>
<td>No lifetime limitation</td>
<td>$1,200 per person per plan year after plan deductible. $2,000 combined maximum, after deductible, on prosthetic, periodontic, surgical extraction and general anesthesia services accumulated every five years as of July 1, 1994, in accordance with benefit implementation.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Maximum Benefit Level for Child Orthodontics (under age 19)</td>
<td>No lifetime limitation but member copay is required</td>
<td>$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above. <strong>Contact CompDent for treatment explanation.</strong></td>
<td></td>
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</tr>
<tr>
<td>Claim forms</td>
<td>None</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist selection</td>
<td>Participating providers only</td>
<td>Member’s choice of provider</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Preventive/Diagnostic</th>
<th>Pediatric Sealants</th>
<th>Restorations</th>
<th>Crowns</th>
<th>Bridges</th>
<th>Child Orthodontics</th>
<th>Periodontics (gum disease)</th>
<th>Endodontics (root canals)</th>
<th>Full Dentures</th>
<th>Partial Dentures</th>
<th>Simple Extractions</th>
<th>Complex Surgical Extractions</th>
<th>General Anesthesia (including intravenous sedation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No charge</td>
<td>No charge</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Copayment required</td>
<td>Covered only if medically necessary for certain medical conditions</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Scheduled amount</td>
<td>Scheduled amount</td>
<td>Scheduled amount</td>
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<td>Scheduled amount</td>
<td>Scheduled amount</td>
<td>Scheduled amount</td>
<td>Scheduled amount</td>
<td>Scheduled amount</td>
<td>Covered only if medically necessary for certain medical conditions</td>
</tr>
</tbody>
</table>

31
All members and their dependents are enrolled in the same vision plan regardless of the health plan in which they are enrolled. All other benefits remain available once every 24 months from the last time used. Copays are still required. For more information regarding the vision plan, contact the administrator, Vision Service Plan (VSP) at 800/877-7195 or 800/428-4883 (TDD/TTY). VSP is also available on the Internet (www.vsp.com).

### Service/Eyewear Covered

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefit</th>
<th>Out-of-Network Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>100% after $10 copay</td>
<td>$30</td>
</tr>
<tr>
<td>Frames</td>
<td>100% after $10 copay for frames in the benefit selection</td>
<td>$50</td>
</tr>
<tr>
<td>Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single lenses</td>
<td>100% after $10 copay</td>
<td>$40</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>100% after $10 copay</td>
<td>$60</td>
</tr>
<tr>
<td>Trifocal lenses</td>
<td>100% after $10 copay</td>
<td>$60</td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized lenses</td>
<td>100% after $20 copay</td>
<td>$100</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Hard or soft daily wear</td>
<td>100% coverage after $50 copay</td>
<td>$100</td>
</tr>
<tr>
<td>Gas Permeable</td>
<td>100% coverage after $50 copay</td>
<td>$100</td>
</tr>
<tr>
<td>Others</td>
<td>$100 benefit after $10 copay</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Lenses:** Available from in-network doctors with copay. Out-of-network benefit applies. Optional lens enhancements extra.

**Frames:** Frames outside the benefit selection are discounted by network providers. Out-of-network benefit applies. Additional charges are paid by member or dependent.

**Specialized Contact Lenses:** Provider must obtain prior approval from the Vision Plan Administrator for contact lenses prescribed due to specific medical situations such as cataract surgery, extreme visual acuity problems not corrected by spectacle lenses, certain conditions of Anisometropia and/or certain situations involving Keratoconus.

**Elective Contact Lenses:** Elective or medically necessary contacts may be chosen instead of glasses. The benefit listed above applies. Professional fees for fitting and evaluation of contact lenses are not covered and are the member’s responsibility.
Established under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the program permits eligible State of Illinois employees, their spouses, and dependent children enrolled in a CMS-administered group health plan to purchase continued health and dental coverage if their state group health coverage terminates for specific reasons called “eligible qualifying events.” COBRA members are responsible for the entire cost of their coverage, with an additional two percent administrative fee as allowed by federal guidelines, and is available only after a “qualifying event” has occurred.

Who is eligible for COBRA?
Eligible individuals are those covered under the state's group health plan the day before a qualifying event takes place. This includes the employee as well as an enrolled spouse and/or dependents (all such individuals are referred to as “qualified beneficiaries”). A child who is born to the covered employee or who is placed for adoption with the covered employee during a period of COBRA coverage also has continuation rights. Newly acquired dependents such as a spouse, newborn or adopted child, stepchild, or a child for whom the member has legal guardianship may be added to their COBRA plan within 60 days of an eligible change in status or during Benefit Choice.

What is a “Qualifying Event?”
A qualifying event is one that causes a loss of insurance coverage or ineligibility under the group health insurance plan. Certain qualifying events enable the member to be eligible for COBRA for different lengths of time.

A qualifying event resulting in a maximum of 18 months of COBRA coverage may include:

♦ termination

A qualifying event resulting in a maximum of 36 months of COBRA coverage may include:

♦ death
♦ legal separation and/or divorce
♦ dependent losing eligibility

The voluntary termination of a dependent is not a qualifying event and COBRA is not offered to these individuals.

According to federal law, the affected employee or a family member must notify the current/former employing agency when a qualifying event has taken place and within:

♦ 60 days
Enrolling in COBRA:
Upon notification that a qualified beneficiary has experienced a COBRA qualifying event, the Group Insurance Representative of the current/former employing agency will notify the Group Insurance Division. Within 14 days, a COBRA rights letter, an enrollment form, and rate information sheet will be mailed to the qualified beneficiary’s address of record.

The qualified beneficiary has 60 days from the date of the notification letter to elect COBRA coverage. The qualified beneficiary has an additional 45 days to pay all retroactive premiums. Upon payment of the entire COBRA premium, coverage becomes effective retroactive to the date of the qualifying event. The qualified beneficiary’s group health coverage remains terminated until they complete and return the COBRA enrollment forms and pay the appropriate premium.

The COBRA Administration Unit serves as Group Insurance Representative for COBRA enrollees. It is incumbent upon COBRA enrollees to notify the Unit of any address change, additional qualifying events, or major life changes that might effect COBRA coverage.

Waiving COBRA Coverage and Revocation of Waiver:
A qualified beneficiary can waive COBRA coverage during the election period by indicating on the enrollment form that coverage is being waived. Be sure to sign and date the form before returning it to the COBRA Administration Unit.

A waiver of COBRA coverage can be revoked by the qualified beneficiary at any time before the end of the 60-day election period. If an individual waives coverage and then changes his or her mind, revoking the waiver, COBRA coverage will not be retroactive to the qualifying event that resulted in the break in coverage. Waivers and revocations are considered effective on the date the election is made. Pre-existing condition limitations will apply unless the revocation of waiver is made within 10 days of the initial waiver.

COBRA and Social Security Disability Benefits:
COBRA enrollees who become disabled under Social Security disability guidelines during the first 60 days of their 18 month COBRA period may extend their continuation coverage for an additional 11 months. To be eligible for the extension, the disability must have existed during the first 60 days of COBRA coverage and a copy of the SSA disability determination letter must be provided to the COBRA Administration Unit within 60 days of the date on the determination letter and before the end of the original 18 month COBRA coverage period. If coverage is extended beyond the initial 18 months, the premium rises an additional fifty percent (administrative fee) for the remaining available 29 months of coverage.
**COBRA and Medicare:**
Individuals entitled to Medicare prior to a COBRA qualifying event may elect COBRA coverage. Individuals who become entitled to receive Medicare after enrolling in COBRA, however, become ineligible for continued coverage.

**COBRA and Other Coverage:**
Anyone who becomes covered under another group health plan that does not exclude or limit services due to pre-existing conditions is not eligible for COBRA.

**COBRA and the Medical Care Assistance Plan (MCAP):**
Individuals who were participating in the Medical Care Assistance Plan (MCAP) while an active state employee may continue participation through direct payments to the Flexible Spending Account (FSA) Unit. Direct payments allow continued access to your MCAP account; there is no tax benefit on these contributions, however.

For further information regarding COBRA or FSA, see your State of Illinois Benefits Handbook or contact the COBRA Administration Unit/FSA Unit at 217/782-2548, 800/442-1300, press #1 and then press #5, or 800/526-0844 (TDD/TTY).
The Flexible Spending Account (FSA) program is an optional benefit that gives State of Illinois employees the opportunity to use tax-free dollars to pay eligible dependent and/or medical care expenses. The FSA program offers two plans:

**The Medical Care Assistance Program (MCAP):** MCAP allows you to use pre-tax dollars to pay eligible, medically necessary expenses that you, your spouse and your dependents incur during the plan year.

**The Dependent Care Assistance Program (DCAP):** DCAP enables you to use pre-tax dollars to pay eligible dependent care expenses you incur during the plan year.

Employees may contribute up to a maximum of $5,000 in pre-tax dollars for each program. Contributions are deducted from your paycheck and deposited into your FSA account before state, federal and Social Security taxes are withheld. This amount does not appear on your W-2 Form as taxable income, so it lowers your taxable income, leaving more money to spend and less taxes to pay.

Savings from participation in the FSA program can vary greatly depending on income, contribution amount, number of dependents, adjustments or itemizations on federal taxes and the total of your medical/dependent care expenses. If you have both medical and dependent care expenses, participating in both plans will provide the maximum savings benefit.

Read the FSA booklet to ensure your expenses meet the IRS/FSA requirements and are eligible for MCAP/DCAP. During the Benefit Choice Period, enroll in MCAP/DCAP by completing the appropriate forms and submitting them to your Group Insurance Representative. New employees, or employees who have an eligible change in status, may enroll within 60 days of their date of hire or change in status. Enrollment and changes in enrollment are not permitted outside Benefit Choice Period unless an employee experiences an eligible change in status. For enrollment forms and FSA booklets contact your Group Insurance Representative or the FSA Unit.

Specific claim eligibility questions should be directed to the claim processor, Fringe Benefits Management Company (FBMC) at 800/342-8017 or the CMS Flexible Spending Account Unit at 217/782-2548, 800/442-1300, press #1 and then press #5, or 800/526-0844 (TDD/TTY).
MCAP/DCAP reimbursement can be made through a check payable to the participating member and mailed to the address of record in the FSA system, or through direct deposit.

FSA direct deposit is fast and easy. To enroll, visit the Illinois Comptroller’s web site at [http://www.ioc.state.il.us](http://www.ioc.state.il.us) or contact the comptroller’s Electric Commerce Unit at 217/557-0930. Once electronic payment has been established, all reimbursements paid to you by the comptroller’s office, with the exception of your payroll check and income tax refund, will be deposited to your bank account directly. For example, if you elect direct deposit for your FSA reimbursement via the comptroller’s web site, your FSA reimbursements, as well as travel reimbursements, workers’ compensation payments, etc., will be made by direct deposit.

If you have questions about how FSA direct deposit works, contact the comptroller’s web site or the Electronic Commerce Unit as listed above.

**Remember:** Annual re-enrollment in FSA is not automatic. If you currently have a Medical Care Assistance Plan and/or Dependent Care Assistance Plan account(s), and wish to continue participating in the program, you must re-enroll during Benefit Choice Period.
The following is an example of how FSA works:

<table>
<thead>
<tr>
<th>Married w/2 dependents</th>
<th>Income &amp; taxes without MCAP</th>
<th>Income &amp; taxes with MCAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual gross income</td>
<td>$60,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Standard deductions and exemptions</td>
<td>$18,200</td>
<td>$18,200</td>
</tr>
<tr>
<td>MCAP contributions for plan year</td>
<td>$0</td>
<td>$5,000</td>
</tr>
<tr>
<td>Taxable income</td>
<td>$41,800</td>
<td>$36,800</td>
</tr>
<tr>
<td>Taxes paid* (state, federal &amp; FICA)</td>
<td>$12,462</td>
<td>$11,180</td>
</tr>
<tr>
<td>After-tax medical expenses</td>
<td>$5,000</td>
<td>$0</td>
</tr>
<tr>
<td>Real disposable income</td>
<td>$42,538</td>
<td>$43,820</td>
</tr>
<tr>
<td>Increased spendable income</td>
<td>$0</td>
<td>$1,282</td>
</tr>
</tbody>
</table>

* Taxes based on 1999 federal tax rates, a 3% state tax & a 7.65% Social Security tax. No child tax credit was applied in this instance.

For more information on the Flexible Spending Program and how it can help defray your medical and dependent care costs, contact your agency Group Insurance Representative or the CMS Group Insurance Division, FSA Unit, at 217/ 782-2548 or 800/ 442-1300, press #1 then press #5, or 800/ 526-0844 (TDD/ TTY).
Life Insurance

Full-time State of Illinois employees and annuitants are provided no-cost term life insurance coverage as a benefit of their employment. As in past years, this coverage is equal to the employee’s annual salary or $5,000 for annuitants age 60 or older.

Employees and immediate annuitants may purchase optional life insurance at low group rates. Optional terms include:

- Member life insurance up to four times the state-provided amount
- Accidental Death and Dismemberment (AD&D)
- $5,000 term life insurance on a spouse
- $5,000 term life insurance per child

To increase member coverage, add spouse life, or to purchase child life for the first time (except for newborns and newly-acquired dependents), evidence of insurability is required. Health Certificate applications are available from your Group Insurance Representative and must be completed and returned during the Benefit Choice Period. Increases to optional term coverage are subject to the approval of the Health Certificate by the life insurance plan. For more information on optional coverage, contact your Group Insurance Representative.

<table>
<thead>
<tr>
<th>Member</th>
<th>Monthly Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.06</td>
</tr>
<tr>
<td>Ages 25-39</td>
<td>0.07</td>
</tr>
<tr>
<td>Ages 40-44</td>
<td>0.15</td>
</tr>
<tr>
<td>Ages 45-49</td>
<td>0.25</td>
</tr>
<tr>
<td>Ages 50-54</td>
<td>0.44</td>
</tr>
<tr>
<td>Ages 55-59</td>
<td>0.72</td>
</tr>
<tr>
<td>Ages 60-64</td>
<td>1.02</td>
</tr>
<tr>
<td>Ages 65-69</td>
<td>1.58</td>
</tr>
<tr>
<td>Ages 70-74</td>
<td>3.34</td>
</tr>
<tr>
<td>Ages 75 &amp; Above</td>
<td>3.74</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (All ages)</td>
<td>0.03</td>
</tr>
</tbody>
</table>
In recent years, members residing in the continental United States have enjoyed the ease of processing health and/or dental carrier changes via touch tone phone. Using telephone enrollment is entirely optional — changes can also be made through your Group Insurance Representative. All changes made will be effective July 1, 2000. To use the system effectively, complete both pages of the worksheet on pages 42 and 43. The worksheet will provide the answers you need to respond to the system’s prompts.

1) When your toll-free call connects to the system it will ask you to enter your Social Security number and date of birth.

2) It will then offer you the option of changing health and/or dental plans. (Remember: only health and dental plan changes can be made by telephone -- all other changes must be made through your agency Group Insurance Representative.)

3) If selecting a managed care health and/or dental plan, callers must enter the six-digit Primary Care Provider number which can be found in the managed care plan’s provider directory. If providing coverage for dependents, a Primary Care Physician/dentist provider number must be entered for each dependent or the plan change will not be processed. Note: Designation of a Primary Care Provider via the Telephone Enrollment System does not guarantee availability of that provider. Please contact the managed care plan to receive the most up-to-date Primary Care Provider information.

4) Members with dependent coverage must have any covered dependent’s valid Social Security number on file with CMS so that the system will respond.

5) If you are selecting a managed care plan, the system will ask you to authorize the release of health-related information to both the respective managed care plan and the State of Illinois. This information is kept confidential. If you are unwilling to authorize this release of information, you will not be able to enroll in a managed care plan.

6) After you make a selection, the system will ask to verify what was entered. Once verified, the system will acknowledge the change by saying “Your change/selection has been recorded.” The call should be terminated only after the system makes that statement. If you hang up prior to hearing “Your change/selection has been recorded,” the selection will not be processed.
7) After you have made all your selections and the system has acknowledged your last selection, you are finished.

8) Within two weeks of calling the telephone enrollment system, you will receive a verification form in the mail. A duplicate will be sent to your agency. Please check the form to ensure your changes were recorded accurately. If you do not receive the verification form at the end of two weeks, or if any of the changes you made are inaccurate, contact your Group Insurance Representative immediately.

Once you have decided on a health and dental plan, enter the two-digit number in the corresponding blank on the accompanying telephone enrollment worksheet.

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Dental Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Quality Care Health Plan</td>
<td>21 Quality Care Dental Plan</td>
</tr>
<tr>
<td>03 OSF Winnebago</td>
<td>22 Managed Care Dental Plan</td>
</tr>
<tr>
<td>07 Health Alliance HMO</td>
<td></td>
</tr>
<tr>
<td>08 Health Alliance Illinois</td>
<td></td>
</tr>
<tr>
<td>11 Humana Premier HMO</td>
<td></td>
</tr>
<tr>
<td>14 PersonalCare HMO</td>
<td></td>
</tr>
<tr>
<td>16 Prudential HealthCare HMO</td>
<td></td>
</tr>
<tr>
<td>24 HMO Illinois</td>
<td></td>
</tr>
<tr>
<td>25 Humana POS</td>
<td></td>
</tr>
<tr>
<td>26 OSF Health Plan</td>
<td></td>
</tr>
<tr>
<td>27 Prudential HealthCare POS</td>
<td></td>
</tr>
<tr>
<td>28 Unicare HMO (formerly Rush Prudential HMO)</td>
<td></td>
</tr>
<tr>
<td>29 Aetna USH healthcare HMO</td>
<td></td>
</tr>
</tbody>
</table>
To use telephone enrollment for health and/or dental changes, you must live in the continental United States and be calling from a touch tone phone. Do not end your call until you have made your last change and the system says “Your change/election has been recorded.” Terminating the call prior to receiving system confirmation means your last change will not be processed.

Member’s Social Security Number: ________________

Enter #1 for “state enrollee”: __________________

Member’s eight-digit birthdate (enter month/day/year such as 09/17/1947): ________________

Two-digit health plan number (refer to numbers on previous page): ________________

Six-digit managed care primary care provider number (refer to HMO or POS plan’s directory): ________________

Two-digit dental plan number (refer to dental plan numbers on previous page): ________________

Six-digit managed care primary care dental provider number (refer to the plan’s dental plan provider directory): ________________

If you have no covered dependents on your health or dental plan, you are ready to make your call. The toll-free number is 877/819-5111. TDD/TTY users, please contact the Illinois Relay Service at 800/526-0844.

If you have dependent coverage, please complete the next page prior to calling the toll-free telephone enrollment number.

If you don’t receive verification of your changes within two weeks, it’s your responsibility to call your Group Insurance Representative.
If you have selected a managed care health and/or dental plan, you must select a Primary Care Provider for each covered dependent.

1) ___________________  ___________________  ___________________
2) ___________________  ___________________  ___________________
3) ___________________  ___________________  ___________________
4) ___________________  ___________________  ___________________
5) ___________________  ___________________  ___________________
6) ___________________  ___________________  ___________________
7) ___________________  ___________________  ___________________
8) ___________________  ___________________  ___________________
9) ___________________  ___________________  ___________________
10) ___________________  ___________________  ___________________

Upon completion of your dependent coverage information, you are ready to make your health and/or dental plan changes via the telephone enrollment system.

The toll-free number is ____. TDD/TTY users, please contact the Illinois Relay Service at ____
Medicare Crossover is when Medicare automatically and electronically forwards your processed Part B claims to the QCHP Medical Plan Administrator, UNICARE, for secondary benefit processing. This means you will no longer need to forward your Explanation of Medicare Benefits (EOMB) to UNICARE for payment — it will be done for you automatically. Medicare Crossover is available at no cost to you and is offered as a complementary service of your QCHP coverage.

In order for you to participate in Medicare Crossover, complete and mail the Medicare Crossover enrollment self-mailer on page 47. Or, if you prefer, you can call UNICARE toll-free at 888/659-2273 (Voice/TDD/TTY) to enroll. Once you have notified UNICARE by mail or phone, your Part B claims will begin to automatically “crossover” within approximately 60 days. UNICARE may also enroll Medicare primary members when they can verify the Medicare claim number through submission of a claim.

Below are some frequently asked questions about Medicare Crossover:

Who is eligible to participate in the Medicare Crossover Process?
All QCHP members who are Medicare primary and have Medicare Part B coverage.

How does the process work?
When you have a medical claim submitted to Medicare and Medicare has completed processing the claim, it is then automatically forwarded electronically to UNICARE for the processing of any secondary benefits.

Will Medicare still send me an Explanation of Medicare Benefits (EOMB)?
You will receive an EOMB that will advise you that the claim has been forwarded to your private insurer (UNICARE).

What sort of information must I provide UNICARE?
The information required by UNICARE is very basic. You will need to provide your Medicare claim number that is on your Medicare Health Insurance Card. UNICARE will keep this number strictly confidential, using it only for QCHP claims processing. Remember to provide your Medicare claim number to UNICARE exactly as it appears on your Medicare Health Insurance Card.
Once I mail the form or call to enroll, how long before "Crossover" takes effect?

It will take approximately 60 days for the process to start working. If you have forwarded or given your information to UNICARE and you do not see a remark on your EOMB that your claim has been forwarded for secondary payment, contact UNICARE at 888/659-2273 (Voice/TDD/TTY) to verify your information was received and properly recorded.

What do I do with my claims during the 60-day start-up period?

Continue to submit your Part B claims to UNICARE as you do now. Once you notice the message on your EOMB that the claim has been forwarded electronically to your supplemental insurer, you will know that your claims are being automatically forwarded.

Do I still get "Crossover" if I reside out-of-state?

Yes. Medicare Crossover is available to all plan members who have Medicare primary Part B coverage regardless of where they reside or receive service.

If you have any additional questions about the “Crossover” process, contact UNICARE at 888/659-2273.
Questions, Notes & Computations:
Medicare Crossover Enrollment Form

for

Quality Care Health Plan Members Only

Quality Care Health Plan members who are Medicare primary can have their Medicare Part B claims automatically forwarded to UNICARE, the Medical Plan Administrator, for consideration of secondary benefits. In order to have your Part B claims handled in this fashion you may at any time:

1) Contact UNICARE directly at 888/ 659-2273 (Voice/ TDD/ TTY) or,
2) Fully complete the self-mailer below and return it to:

UNICARE
P.O. Box 5025
Bolingbrook, IL  60440-5025

———fold here upon completion of form, seal and affix stamp to self-mailing side———

QUALITY CARE HEALTH PLAN — ENROLLEE FORM

Member’s Name, Medicare Claim Number (MCN) & Social Security Number (SSN):

Name: ____________________________

SSN #: ____________________________

Medicare Claim Number (MCN): ____________________________

Medicare Effective Date: ____________________________

Dependent’s Name, Medicare Claim Number (MCN) & Social Security Number (SSN):

Name: ____________________________

SSN #: ____________________________

Medicare Claim Number (MCN): ____________________________

Medicare Effective Date: ____________________________

Member’s Signature: ____________________________ Date: ____________________________

Dependent’s Signature: ____________________________ Date: ____________________________
It’s okay to ask for help...

In addition to your other state benefits, the Employee Assistance Program (EAP) is available to assist employees experiencing significant personal difficulties which impact their job performance. Entirely confidential, the EAP Program can assist you in locating resources to help you through your difficult time. The program is voluntary. Participation will not jeopardize your job security, and the service is open to all state employees and their family members.

The EAP also provides Critical Incident Stress Debriefing services. When a critical incident occurs in the workplace (such as an accidental death), contact your EAP coordinator for available resources.

For more information, contact your agency/university personnel office or your Group Insurance Representative. They can direct you to your EAP Referral Coordinator.

Help is out there. Give your EAP Referral Coordinator a call. All services are confidential!