

# Teachers' Retirement Insurance Program (TRIP) Highlights

July 1, 2010 - June 30, 2011



*Retirement Security for Illinois Educators*

# Listing of current health care plan providers

Please call the toll-free number or visit the Web site listed for plan details.

## MEDCO

(800) 899-2587

[www.medco.com](http://www.medco.com)

## CIGNA

(800) 962-0051

<http://provider.healthcare.cigna.com/soi.html>

## Health Alliance HMO

(800) 851-3379

[www.healthalliance.org](http://www.healthalliance.org)

## Health Alliance Illinois

(800) 851-3379

[www.healthalliance.org](http://www.healthalliance.org)

## HealthLink Open Access Plan

(800) 624-2356

[www.healthlink.com](http://www.healthlink.com)

## HMO Illinois

(800) 868-9520

[www.bcbsil.com/stateofillinois](http://www.bcbsil.com/stateofillinois)

## Humana Benefit Plan of Illinois

(866) 427-7478

<http://stateofil.humana.com>

## PersonalCare

(800) 431-1211

[www.personalcare.org](http://www.personalcare.org)

## Out-of-state managed care

Managed care is available in some counties in Arkansas, Indiana, Iowa, Kentucky and Missouri.

See pages 14 through 16 for more details.

## For specific information on coverage benefits:

Illinois Department of Central Management Services

(217) 782-2548

(800) 442-1300 toll free

(800) 526-0844 TDD

[www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)

## For enrollment information:

Teachers' Retirement System

(800) 877-7896

Attn: Insurance Department

Teachers' Retirement System

2815 West Washington

P.O. Box 19253

Springfield, IL 62794-9253

[trs.illinois.gov](http://trs.illinois.gov)



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# Answers to your questions

## What is TRIP?

The Teachers' Retirement Insurance Program (TRIP) is a comprehensive program of quality health care coverage for retired teachers and their eligible dependents.

## Who administers TRIP?

TRIP is a comprehensive program of quality health-care coverage for retired teachers and their eligible dependents. The Teachers' Retirement System's (TRS) role is to provide members with basic coverage information, enroll them in the program, and collect the appropriate premiums. The state of Illinois determines coverage benefits, establishes premiums, negotiates contracts with the insurance carriers, and resolves coverage and claim issues. The Department of Central Management Services (CMS) is the agency that administers TRIP as set forth in the State Employees Group Insurance Act of 1971.

## What kind of coverage is available under TRIP?

The program offers two types of plans: medical indemnity and managed care. The Teachers' Choice Health Plan (TCHP) is a medical indemnity plan. You may enroll in TCHP regardless of where you live.

You may also enroll in one of several managed care plans. TRIP offers two types of managed care plans: health maintenance organizations (HMOs) and an open access plan. Managed care plans are located throughout Illinois and in some neighboring states. Your place of residence determines which managed care plans are available to you.

## Who can join?

In order to join TRIP, you must be receiving a monthly benefit from TRS under the Illinois Pension Code, Article 16, and:

- have at least eight years of creditable service with TRS *or*
- be the survivor of an annuitant or a benefit recipient who had at least eight years of creditable service.

If you are a disability recipient, you are eligible for enrollment in TRIP regardless of the years of service.

If you enroll in TRIP, you may also enroll the following dependents:

- your spouse;
- your unmarried, dependent children age 19 to under age 26, or your unmarried, dependent, honorably discharged veteran children age 19 to under age 30;
- your unmarried children under age 24 who are enrolled full-time in school, financially dependent on you for at least one-half of their support, and eligible to be claimed on your state income tax return;
- your disabled children of any age as long as they have been continuously disabled from causes originating prior to age 19 or prior to age 23 if enrolled full-time in school, and they are financially dependent on you for at least one-half of their support and eligible to be claimed on your state income tax return; and
- your parents if they are financially dependent on you for at least one-half of their support and eligible to be claimed on your state income tax return.

## When can I join?

If you are eligible, you can enroll yourself and qualifying dependents during the following periods:

- **When you apply for monthly pension benefits.** If you want to enroll at this point, you must return the enrollment form to TRS no later than 30 days after the effective date of the pension benefits. The insurance becomes effective the first day of the first full month of benefits or the first day of the month in which your enrollment application is received, whichever is later. You may delay your effective date of coverage up to four months after the effective date of your pension benefits. However, TRS must receive your enrollment form within 30 days of the effective date of your pension benefits.
- **When you turn 65 or when you become eligible for Medicare.** TRS will mail your enrollment information within 60 days before your 65th birthday. You have six months from the date you become eligible for Medicare to enroll. If you are not eligible for Medicare, you may enroll within 30 days of your 65th birthday. The insurance becomes effective the first day of the month in

which you turn 65 or the first day of the month in which TRS receives the enrollment form, whichever is later.

- **When coverage is terminated by a former plan.** You may continue coverage with another plan rather than enroll in TRIP. If this occurs, you and your eligible dependents may enroll in TRIP when coverage under the other plan is terminated. The termination must be initiated by the plan. You must return the enrollment form, along with a letter from the plan stating the effective date of termination, no later than 30 days after the effective date of termination of the plan's coverage. The insurance becomes effective the first day of the month following cancellation of coverage with the other plan.
- **During the Benefit Choice Period, if you have never been enrolled in TRIP.** You may enroll in TRIP during the Benefit Choice Period (usually May 1 through May 31 each year). The insurance becomes effective on July 1. If you or your dependent were previously covered under TRIP and terminated coverage, you may re-enroll only when you or your dependent turns age 65 or when coverage is terminated by a former plan.

### **When can I enroll dependents?**

You may enroll dependents when you enroll in the program, the dependent turns 65, a change in family status occurs, or coverage is terminated by a former plan. You may also enroll dependents during the annual Benefit Choice Period if they previously have not been enrolled in TRIP.

Your dependent has six months from the date he or she becomes eligible for Medicare to enroll. If your dependent is not eligible for Medicare, he or she may enroll within 30 days of his or her 65th birthday.

You may also enroll a new dependent due to marriage, adoption, or birth. A survivor of a member enrolled in TRIP is not eligible to add newly acquired dependents to his/her TRIP coverage unless the dependent is the natural or adopted child of the deceased member. Your dependent has 31 days following the change in family status to



enroll. If you are already enrolled in TRIP and your dependent's coverage is terminated by another plan, you may enroll your dependent within 30 days of the coverage's termination.

### ***Dependent/child enrollment information***

Effective July 1, 2009, Public Act 95-0958 allows unmarried, dependent children age 19 to under age 26, or unmarried, dependent, honorably discharged veteran children age 19 to under age 30 to be enrolled in TRIP. For additional information, visit the CMS Web site at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov) or contact TRS directly.

### ***What happens to dependent coverage in the event of my death?***

Dependent coverage is terminated at midnight on the day of the member's death. Dependents who are eligible for a monthly survivor benefit may re-enroll in TRIP and coverage will be reinstated retroactively to the date of cancellation.

### **Are benefits coordinated with other coverage?**

Yes. Benefits are coordinated with other insurance carriers and Medicare.

If you have group insurance coverage other than Medicare and have not previously notified TRS, please send in a copy of your insurance card.

### **Is there a pre-existing condition clause?**

No. Coverage begins immediately upon the effective date of enrollment.

### **What is precertification? Does it apply to all plans?**

Precertification is a notification process; it is not a guarantee of benefits. Precertification is **your** responsibility, and there are penalties for noncompliance.

For precertification requirements, contact the specific plan you are interested in joining.

### **When can I change plans?**

You may change plans each year during the annual Benefits Choice period. You will receive information before each Benefits Choice period.

The selection you make will be in effect until the next Benefits Choice period, unless you are enrolled in a managed care plan and your primary care physician leaves that plan. In addition, a change in your permanent residence may change your managed care availability. Contact TRS immediately if either of these situations occur.

**Is dental, vision, and life insurance coverage available under TRIP?**

No. Only health coverage is available under TRIP.

**How much of the premium will be subsidized?**

The subsidy amount of the premium will be based on the type of coverage you select.

You will receive a **75 percent** subsidy (based on your permanent residence):

- if a managed care plan is available to you and you enroll in it.
- if no managed care plan is available to you and you enroll in TCHP.
- if a managed care plan is only partially available in your county of residence and you enroll in it or TCHP (see table beginning on page 13).

You will receive a **50 percent** subsidy (based on your permanent residence) if a managed care plan is available to you and you choose to enroll in TCHP.

**What is Medicare Part D?**

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 should call the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

**The Teachers' Choice Health Plan (TCHP)**

TCHP (administered by CIGNA) is the medical plan that offers a comprehensive range of benefits. Under

the TCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a TCHP network provider.

The TCHP has a nationwide network [Open Access Plan (OAP)] that consists of physicians, hospitals, and ancillary providers. Notification to Intracorp, the TCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. Note: The TCHP and the HealthLink OAP are separate health plans with a separate plan design.

TCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits.

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

<b>TCHP Plan Year Maximums and Deductibles</b>	
<b>Lifetime Maximum</b>	\$2,000,000
<b>Plan Year Deductible</b>	\$500 TCHP Primary Participant (Non-Medicare) \$500 Medicare Primary Participant
<b>Additional Deductibles</b> <i>These are in addition to the plan year deductible.</i>	Each emergency room visit \$400 TCHP hospital admission \$200 Non-TCHP hospital admission \$400

## **Out-of-Pocket Maximums**

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: In-Network and Out-of-Network.

Coinsurance and deductibles apply to one or the other, but not both. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100 percent of eligible charges for the remainder of the plan year.

<b>In-network:</b> \$1,200 per individual \$2,750 per family per plan year	<b>Out-of-network:</b> \$4,400 per individual \$8,800 per family per plan year
<p><b>The following do not apply toward out-of-pocket maximums:</b></p> <ul style="list-style-type: none"> <li>• Prescription Drug benefits, coinsurance, or copayments.</li> <li>• Notification penalties.</li> <li>• Ineligible charges [amounts over Usual and Customary (U &amp; C), charges for non-covered services, and charges for services deemed not to be medically necessary].</li> <li>• The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay.</li> </ul>	

## **TCHP - Medical Plan Coverage**

<b>Hospital Services</b>	
TCHP Network Hospitals	80% after annual plan deductible. \$200 deductible per hospital admission.
Non-TCHP Hospitals	60% after annual plan deductible. \$400 deductible per hospital admission.
<b>Outpatient Services</b>	
Lab/X-ray	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Licensed Ambulatory Surgical Treatment Centers	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
<b>Professional and Other Services</b>	
Provider services included in the TCHP Network	80% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Provider services not included in the TCHP Network	60% of U&C after the annual plan deductible for inpatient, outpatient, and office visits.
Chiropractic Services - medical necessity required (limit of 30 visits per plan year)	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
<b>Transplant Services</b>	
Organ and Tissue Transplants	80% of negotiated fee after inpatient deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
<b>Behavioral Health Services</b>	
Magellan administers the TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see CMS's <i>Teachers' Retirement Insurance Program Benefits Handbook</i> or call Magellan at (800) 513-2611.	

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

## Disease Management Program For TCHP Plan Participants

Disease Management Programs are utilized by CIGNA and the managed care health plans as a way to improve plan participants' health. You may be contacted by your plan to participate in these programs.

## Prescription Drug Benefit

Plan participants enrolled in any TRIP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred drug list ("formulary list") maintained by each health plan's Prescription Benefit Manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand, and non-preferred brand. Each level has a different copayment amount. Please note that 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 generic copayment. This cost difference does not apply toward the annual prescription out-of-pocket maximum. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for Coordination of Benefits (COB) information. TCHP has 20 percent coinsurance with minimum and maximum copayments. TCHP plan participants can receive a 90-day supply of maintenance medication through the Mail Order Program for two copayments and applicable coinsurance.

Prescription Drug Copay for all Managed Care Plans (30-day supply)	
Generic	\$10
Preferred (Formulary) Brand	\$20
Non-Preferred Brand	\$40

Prescription Drug Copay/Coinsurance for TCHP (30-day supply)		
Type	Min.	Max.
Generic	\$7	\$50
Preferred (Formulary) Brand	\$14	\$100
Non-Preferred Brand	\$28	\$150

Copay for TCHP:

- Annual prescription drug out-of-pocket maximum of \$1,500 applies.

- After meeting the \$1,500 out-of-pocket maximum, prescriptions are covered at 100 percent.
- Out-of-network claims do not count toward this annual out-of-pocket maximum.
- 20 percent coinsurance with minimum and maximum copayments.
- The maximum supply at one fill is 60 days.
- 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.
- Prescription plan benefits are included in the lifetime maximum.

Coverage for specific prescription drugs may vary depending upon the health plan. It is important to note that formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the Web site of each health plan they are considering. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

## HMO Benefits

Plan participants must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the plan participant pays only a copayment. No annual plan deductibles apply. The following HMO coverage descriptions represent the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

<b>Hmo plan design</b>	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
<b>Hospital services</b>	
Inpatient hospitalization	100% after \$250 copayment per admission
Alcohol and substance abuse	100% after \$250 copayment per admission
Psychiatric admission	100% after \$250 copayment per admission
Outpatient surgery	100% after \$150 copayment
Diagnostic lab and X-ray	100%
Emergency room hospital services	100% after the lesser of \$200 copayment per visit, or 50% of U&C
<b>Professional and other services</b>	
Physician office visit (including physical exams and immunizations)	100% after \$20 copayment per visit
Specialist office visit	100% after \$20 copayment per visit
Outpatient psychiatric and substance abuse care	100% after \$20 copayment per visit
Prescription drugs (Formulary is subject to change during plan year)	\$10 copayment for generic \$20 copayment for preferred brand \$40 copayment for non-preferred brand
Durable medical equipment	80% of network charges
Home health care	100% after \$15 copayment per visit

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

## **Open Access Plan (OAP) Benefits**

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with copayments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection

of healthcare providers. Members enrolled in the OAP can mix and match providers. The following benefit descriptions represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact HealthLink for a copy of the SPD.

<b>Benefit</b>	<b>Tier I 100% Benefit</b>	<b>Tier II 80% Benefit</b>	<b>Tier III (Out-of-Network) 60% Benefit</b>
Plan Year Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	\$1,000,000
Annual Out-of-pocket Max Per Individual Enrollee Per Family	\$0 \$0	\$700 \$1,400	\$1,700 \$3,600
Annual Plan Deductible (Must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*
<b>Hospital Services</b>			
Inpatient	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Psychiatric	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Emergency Room	100% after \$200 copayment per visit	80% of network charges after \$200 copayment per visit	60% of U&C after lesser of \$200 copayment per visit, or 50% of U&C
Outpatient Surgery	100% after \$150 copayment per visit	80% of network charges after \$150 copayment	60% of U&C after \$150 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C
<b>Physician and Other Professional Services</b>			
Physician Office Visits	100% after \$20 copayment	80% of network charges	60% of U&C
Specialist Office Visits	100% after \$20 copayment	80% of network charges	60% of U&C
Preventive Services, including immunizations, well baby care, allergy testing and treatment	100% after \$20 copayment	80% of network charges	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment	80% of network charges	60% of U&C
<b>Other Services</b>			
Prescription drugs – covered through State of Illinois administered plan, Medco Generic \$10                      Preferred brand \$20                      Non-preferred brand \$40			
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 copayment	80% of network charges	Covered under Tier I and Tier II only

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

# Monthly premiums through June 30, 2011

Type of Plan	Not Medicare Primary Under age 24	Not Medicare Primary Age 24-64	Not Medicare Primary Age 65 & above	Medicare Primary* All ages
<b>Benefit recipient</b> enrolled in any managed care plan	\$59.29	\$184.13	\$250.87	\$72.77
<b>Benefit recipient</b> enrolled in TCHP when a managed care plan is available in their county of residence	\$153.85	\$434.21	\$653.03	\$189.46
<b>Benefit recipient</b> enrolled in TCHP when a managed care plan is not available in their county of residence	\$76.92	\$217.11	\$326.52	\$94.73
<b>Dependent beneficiary</b> enrolled in any managed care plan	\$237.20	\$736.50	\$1,003.45	\$252.09**
<b>Dependent beneficiary</b> enrolled in TCHP when a managed care plan is available in their county of residence	\$307.69	\$868.41	\$1,306.04	\$378.93
<b>Dependent beneficiary</b> enrolled in TCHP when a managed care plan is not available in their county of residence	\$307.69	\$868.41	\$1,306.04	\$284.20**

\* 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 inside front cover 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.

Your monthly premium is based upon the type of coverage you select and your permanent residence on file with TRS. This is why it is extremely important that you notify TRS of any eligibility and/or address changes as soon as possible. **Corrections to eligibility that result in a premium change will only be processed up to six months retroactively. There are no exceptions to this policy.**

It is your responsibility to ensure premium changes are reflected correctly in your monthly benefit.

## **Do dependent beneficiaries receive a premium subsidy?**

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. See premium table previously shown.



## **What if I want to terminate either my or my enrolled dependents' coverage under TRIP?**

Notify TRS in writing of your decision to terminate coverage. Cancellation will be effective the first of the month following receipt of the request. You can only re-enroll yourself or your dependent upon turning 65 or if your coverage is terminated by your existing plan.

## **What should I, or my dependent, do when we turn 65 or become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD)?**

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 become eligible for Medicare due to a medical condition (Medicare disability or Medicare ESRD), CMS will review the Medicare information to determine primacy.

If Medicare is primary, the monthly premium will be adjusted accordingly. If you or your dependent are actively working and eligible for Medicare or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare COB Unit.

If you do not qualify at age 65 for Medicare benefits, documentation from the Social Security Administration must be sent to TRS.

**What is the premium if I enroll in a county with partial managed care available?**

In counties with partial managed care availability, a benefit recipient may enroll in the medical indemnity plan without receiving a reduced premium subsidy. The monthly premiums are the same as those listed for TCHP when a managed care plan is not available.

**May my dependent choose a type of coverage different from my own?**

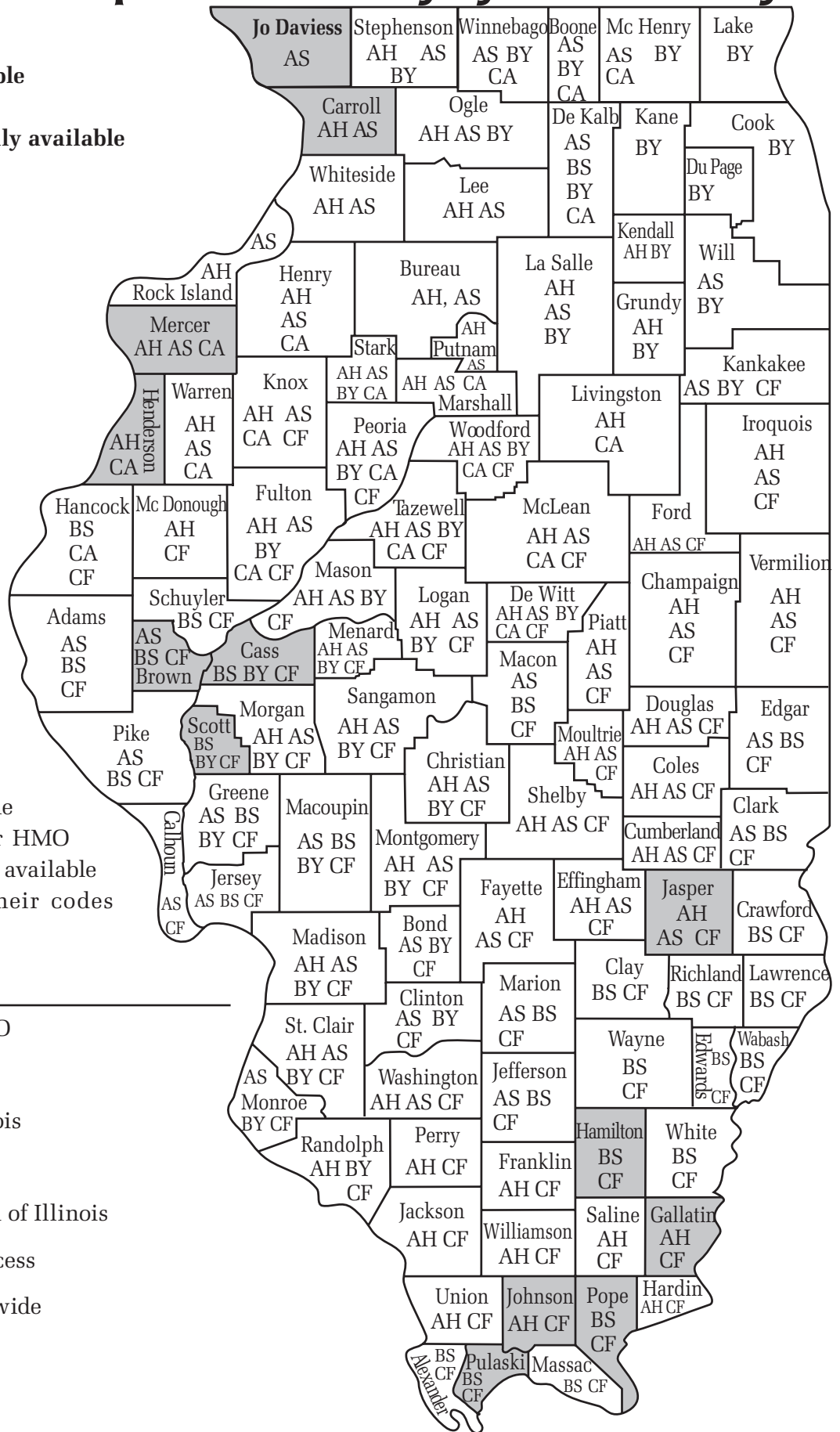
No. Your dependent must be under the same plan.

**What if I decide to drop my Medicare Part B?**

Enrollment in both Medicare Part A and B is required to receive the lower Medicare primary premium. If you drop Medicare Part B coverage, you must notify TRS immediately. The higher non-Medicare primary premium will be charged retroactively from the date of termination.

# TRIP managed care plans availability by Illinois county

- Managed Care available
- Managed Care partially available



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

## HMO and OAP codes

- AH = Health Alliance HMO
- AS = PersonalCare
- BS = Health Alliance Illinois
- BY = HMO Illinois
- CA = Humana Benefit Plan of Illinois
- CF = HealthLink Open Access

Note: TCHP available statewide

# Managed care plans availability by Illinois County

The following counties have a managed care plan available.

Managed Care Codes	
<i>Basic Managed Care</i>	<i>Open Access Plan</i>
AH = Health Alliance HMO	CF = Health Link Open Access Plan
AS = PersonalCare	
BS = Health Alliance Illinois	
BY = HMO Illinois	
CA = Humana Benefit Plan of Illinois	

County	Full	Partial	Managed Care Code
Adams	X		AS, BS, CF
Alexander	X		BS, CF
Bond	X		AS, BY, CF
Boone	X		AS, BY, CA
Brown		X	AS, BS, CF
Bureau	X		AH, AS
Calhoun	X		AS, CF
Carroll		X	AH, AS
Cass		X	BS, BY, CF
Champaign	X		AH, AS, CF
Christian	X		AH, AS, BY, CF
Clark	X		AS, BS, CF
Clay	X		BS, CF
Clinton	X		AS, BY, CF
Coles	X		AH, AS, CF
Cook	X		BY
Crawford	X		BS, CF
Cumberland	X		AH, AS, CF
DeKalb	X		AS, BS, BY, CA
Dewitt	X		AH, AS, BY, CA, CF
Douglas	X		AH, AS, CF
DuPage	X		BY
Edgar	X		AS, BS, CF
Edwards	X		BS, CF
Effingham	X		AH, AS, CF
Fayette	X		AH, AS, CF
Ford	X		AH, AS, CF

County	Full	Partial	Managed Care Code
Franklin	X		AH, CF
Fulton	X		AH, AS, BY, CA, CF
Gallatin		X	AH, CF
Greene	X		AS, BS, BY, CF
Grundy	X		AH, BY
Hamilton		X	BS, CF
Hancock	X		BS, CA, CF
Hardin	X		AH, CF
Henderson		X	AH, CA
Henry	X		AH, AS, CA
Iroquois	X		AH, AS, CF
Jackson	X		AH, CF
Jasper		X	AH, AS, CF
Jefferson	X		AS, BS, CF
Jersey	X		AS, BS, CF
Jo Daviess		X	AS
Johnson		X	AH, CF
Kane	X		BY
Kankakee	X		AS, BY, CF
Kendall	X		AH, BY
Knox	X		AH, AS, CA, CF
Lake	X		BY
LaSalle	X		AH, AS, BY
Lawrence	X		BS, CF
Lee	X		AH, AS
Livingston	X		AH, CA

continued on next page

# Managed care plans availability by Illinois County

The following counties have a managed care plan available.

County	Full	Partial	Managed Care Code
Logan	X		AH, AS, BY, CF
Macon	X		AS, BS, CF
Macoupin	X		AS, BS, BY, CF
Madison	X		AH, AS, BY, CF
Marion	X		AS, BS, CF
Marshall	X		AH, AS, CA
Mason	X		AH, AS, BY, CF
Massac	X		BS, CF
McDonough	X		AH, CF
McHenry	X		AS, BY, CA
McLean	X		AH, AS, CA, CF
Menard	X		AH, AS, BY, CF
Mercer		X	AH, AS, CA
Monroe	X		AS, BY, CF
Montgomery	X		AH, AS, BY, CF
Morgan	X		AH, AS, BY, CF
Moultrie	X		AH, AS, CF
Ogle	X		AH, AS, BY
Peoria	X		AH, AS, BY, CA, CF
Perry	X		AH, CF
Piatt	X		AH, AS, CF
Pike	X		AS, BS, CF
Pope		X	BS, CF
Pulaski		X	BS, CF
Putnam	X		AH, AS

County	Full	Partial	Managed Care Code
Randolph	X		AH, BY, CF
Richland	X		BS, CF
Rock Island	X		AH, AS
Saline	X		AH, CF
Sangamon	X		AH, AS, BY, CF
Schuyler	X		BS, CF
Scott		X	BS, BY, CF
Shelby	X		AH, AS, CF
St. Clair	X		AH, AS, BY, CF
Stark	X		AH, AS, BY, CA
Stephenson	X		AH, AS, BY
Tazewell	X		AH, AS, BY, CA, CF
Union	X		AH, CF
Vermilion	X		AH, AS, CF
Wabash	X		BS, CF
Warren	X		AH, AS, CA
Washington	X		AH, AS, CF
Wayne	X		BS, CF
White	X		BS, CF
Whiteside	X		AH, AS
Will	X		AS, BY
Williamson	X		AH, CF
Winnebago	X		AS, BY, CA
Woodford	X		AH, AS, BY, CA, CF

# Managed care plans availability outside of Illinois

The following states and counties have a managed care plan available as of the date of this printing.

County	Full	Partial	Managed Care Code
<b>Arkansas</b>			
Baxter	X		CF
Benton	X		CF
Carroll	X		CF
Clark	X		CF
Clay	X		CF
Cleburne	X		CF
Conway	X		CF
Craighead	X		CF
Crawford	X		CF
Faulkner	X		CF
Garland	X		CF
Greene	X		CF
Hot Spring	X		CF
Independence	X		CF
Jackson	X		CF
Lawrence	X		CF
Logan	X		CF
Madison	X		CF
Mississippi	X		CF
Ouachita	X		CF
Poinsett	X		CF
Polk	X		CF
Pope	X		CF
Pulaski	X		CF
Randolph	X		CF
Saline	X		CF
Sebastian	X		CF
Sharp	X		CF
Van Buren	X		CF
Washington	X		CF
White	X		CF
Yell	X		CF
<b>Indiana</b>			
Clay		X	CF
Daviess		X	BS
Dubois		X	BS, CF

County	Full	Partial	Managed Care Code
<b>Indiana (continued)</b>			
Gibson	X		BS, CF
Greene		X	CF
Knox	X		BS, CF
Lake	X		BY
Martin		X	BS
Parke		X	CF
Pike		X	BS
Porter		X	BY
Posey		X	BS, CF
Spencer		X	BS, CF
Sullivan	X		CF
Vanderburgh		X	BS, CF
Vermillion	X		CF
Vigo	X		CF
Warrick		X	BS, CF
<b>Iowa</b>			
Clinton	X		AH
Lee	X		BS
Scott	X		AH
<b>Kentucky</b>			
Caldwell		X	CF
Calloway		X	CF
Carlisle		X	CF
Crittenden	X		CF
Fulton		X	CF
Graves		X	CF
Henderson		X	CF
Hickman		X	CF
Hopkins		X	CF
Livingston	X		CF
Lyon		X	CF
Marshall		X	CF
McCracken	X		CF
Trigg		X	CF
Union		X	CF
Webster		X	CF

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Note: Accessibility to managed care plans is subject to change throughout the plan year. Please contact the managed care plan directly to verify participation.

County	Full	Partial	Managed Care Code
Missouri			
Adair		X	CF
Audrain		X	CF
Barry		X	CF
Barton		X	CF
Bollinger		X	CF
Boone		X	CF
Butler		X	CF
Callaway		X	CF
Camden		X	CF
Cape Girardeau		X	CF
Carter		X	CF
Cedar		X	CF
Chariton		X	CF
Christian		X	CF
Clark	X		BS, CF
Cole		X	CF
Cooper		X	CF
Crawford		X	CF
Dade		X	CF
Dallas		X	CF
Dent		X	CF
Douglas		X	CF
Dunklin		X	CF
Franklin		X	CF
Gasconade		X	CF
Greene		X	CF
Hickory		X	CF
Howard		X	CF
Howell		X	CF
Iron		X	CF
Jasper		X	CF
Jefferson		X	CF
Knox		X	CF
Laclede		X	CF
Lawrence		X	CF
Lewis		X	BS
Lincoln		X	CF
Linn		X	CF
Macon		X	CF

County	Full	Partial	Managed Care Code
Missouri (continued)			
Madison		X	CF
Maries		X	CF
Marion		X	CF
McDonald		X	CF
Miller		X	CF
Mississippi		X	CF
Moniteau		X	CF
Monroe		X	CF
Montgomery		X	CF
Morgan		X	CF
New Madrid		X	CF
Newton		X	CF
Oregon		X	CF
Osage		X	CF
Ozark		X	CF
Pemiscot		X	CF
Perry	X		CF
Phelps		X	CF
Pike	X		CF
Polk		X	CF
Pulaski		X	CF
Putnam		X	CF
Ralls	X		CF
Randolph		X	CF
Reynolds		X	CF
Ripley		X	CF
Schuyler		X	CF
Scotland		X	CF
Scott	X		CF
Shannon		X	CF
Shelby		X	CF
St. Charles	X		CF
St. Francois		X	CF
St. Louis	X		CF
St. Louis City	X		CF
Ste. Genevieve	X		CF
Stoddard		X	CF
Stone		X	CF
Sullivan		X	CF

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Note: Accessibility to managed care plans is subject to change throughout the plan year. Please contact the managed care plan directly to verify participation.

County	Full	Partial	Managed Care Code
Missouri (continued)			
Taney		X	CF
Texas		X	CF
Warren		X	CF
Washington		X	CF
Wayne		X	CF
Webster		X	CF
Wright		X	CF

