



State of Illinois
TRAIL Enrollment Form Instructions
For Plan Year 2016 (January 1 through December 31, 2016)



IMPORTANT

State annuitants and survivors newly-eligible for the TRAIL Medicare Advantage Program **MUST** complete the Medicare Advantage TRAIL enrollment form in order to continue health, prescription drug and EyeMed vision coverage after December 31, 2015.

Current Medicare Advantage TRAIL members should only complete and return the enrollment form if they wish to **change** their current coverage elections.

Once completed, return the form to the retirement system listed on the front of the TRAIL Enrollment Form.

Section 1: Member Information (page 1 of enrollment form)

- Complete the 'Medicare Health Insurance' box exactly as you see the information on your red, white and blue Medicare card. Make sure to put information on every line.
- Enter your personal information including your date of birth, gender, email, Social Security Number and contact phone numbers.
- Check the box to indicate whether or not you have End-Stage Renal Disease (people who need to mark this box are typically those undergoing dialysis treatment).

Section 2: Residential Address (page 1 of enrollment form)

- Complete the 'Residential Address' box if your physical street address is different than the address preprinted at the top of the first page of the enrollment form. **This address must be a physical street location and cannot be a P.O. Box or a General Delivery address.**
- If you reside in a nursing home or assisted living facility, check the box indicating that is your residence. The address of the nursing home or assisted living facility must be entered in the 'Residential Address' box.
- If the mailing address preprinted at the top of the first page of the enrollment form is incorrect, write the correct mailing address on the lines provided.

Section 3: Coverage Elections for 2016 (page 2 of enrollment form)

- Complete the 'Health Plan Election' section if you are a new TRAIL member for 2016 or if you are currently enrolled in an TRAIL but wish to change your health plan election.
 - If electing the PPO, mark the 'UnitedHealthcare PPO' box.
 - If electing an HMO, mark the box for your health plan choice and write your, and your dependent's, primary care physician's (PCP) name on the line. If electing Coventry Advantra or Health Alliance MAPD HMO, enter the physician's **10-digit National Provider Identifier (NPI) number**. If electing Humana, enter the physician's **6-digit PCP number**. The NPI and PCP numbers can be found on the plan's website or by calling the plan.

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TRAIL Enrollment Form Instructions (continued)

Section 3: Coverage Elections for 2016 (page 2 continued)

- If you are enrolling in, or are currently enrolled in, an HMO and are adding a dependent, you must enter the physician's NPI or PCP number for the dependent you are adding.
- If you wish to opt out of the State's coverage, mark the 'Opt Out' box. Dental coverage, if elected, will remain active unless you waive that coverage in the dental section.
- In the 'Dental Election' section, if you are not enrolled in the dental coverage and wish to enroll, mark the first box. If you are currently enrolled in the dental plan and wish to terminate your dental coverage, mark the second box.
- You may change your 'Life Insurance Elections' by contacting your retirement system and requesting a life insurance election form. Underwriting will be required by Minnesota Life if you want to increase or add Member Optional Life coverage, or add Spouse or Child Life coverage.

Section 4: Signature of Plan Participants (page 3 of enrollment form)

- You and your enrolled dependents must read page iii of this Instruction Sheet in its entirety and then sign the 'Signature of Plan Participants' section.
- By signing, you are acknowledging that you have read the 'Authorization, Certification Agreement' on page iii of this Instruction Sheet as required by Medicare. If you are an authorized legal representative of the member, you must sign the 'Signature of Member' line and complete the 'Authorized Legal Representative' section. **If not already on file with the retirement system, legal representatives must provide a copy of the documentation to the member's retirement system giving them the legal authority to assist the member with their health plan election.**

Section 5: Dependent Coverage (page 4 of enrollment form)

- Complete this section if you wish to drop a dependent or add a Medicare dependent. If adding a non-Medicare dependent, contact your retirement system for the appropriate form.
- When dropping a dependent, mark the appropriate 'Spouse,' 'Civil Union Partner' or 'Child' box. If you are terminating a child's coverage, write the child's first name on the line.
- When adding a Medicare dependent, mark the appropriate 'Relationship' box and complete the Medicare and personal information section entirely, including the question regarding End-Stage Renal Disease (ESRD).
- Documentation is required to add a dependent to your State of Illinois coverage. Documentation requirements are listed on page iv of this Instruction Sheet.
- If you are adding a dependent, the dependent must also sign and date page 3 of the TRAIL Enrollment Form in the 'Signature of Plan Participants' section. If a legal representative is making the healthcare election for the dependent, see the instructions above for Section 4.
- You may add a dependent to your coverage by completing page 4 of the form. If you are adding a dependent and are enrolling in a Medicare Advantage HMO, you must also complete the NPI/PCP information in the 'HMO' section on page 2 of the form.

**STOP****Please Read This Important Information**

Authorization, Certification Agreement

Read this section carefully.

I authorize premiums to be deducted from my pension check for those plans I have selected, in accordance with the rates established in the "Your Retiree Healthcare Decision Guide" for plan year 2016. I understand that if my pension check is insufficient, I will be direct billed. I certify that the information contained in the TRAIL Enrollment Form is complete and true. I agree to abide by all State Employees Group Insurance Program rules. I agree to furnish additional information requested for enrollment and administration of the plan I have elected. I understand it is my responsibility to review my pension check and verify that the amounts of any insurance deductions are accurate. I understand that if my deductions are not correct I must immediately contact my retirement system.

I certify that to the best of my knowledge, the information provided on the TRAIL Enrollment Form is true and accurate and that any dependents listed are eligible for coverage under the criteria described on page iv of this Instruction Sheet. I understand that if I intentionally provide false information, I may be disenrolled from the plan. I understand that I must notify my retirement system within 60 days of the date any dependent ceases to be eligible for coverage. If I fail to do so, the State of Illinois, Department of Central Management Services (CMS) may impose a financial penalty, including, but not limited to, repayment of all premiums the Program made on behalf of the enrolled individuals, as well as expenses incurred by the Program.

By completing this enrollment application, I agree to the following:

- The Medicare Advantage plans with prescription drugs (MAPD plans) have contracts with the federal government. I understand I must continue to be enrolled in Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health and prescription drug plan. Once I enroll, I may leave this plan or make changes only at certain times of the year or under certain special circumstances. I understand that disenrollment from this plan will terminate my coverage through the State Employees Group Insurance Program.
- The MAPD HMO networks serve specific areas. If I move out of that service area, I need to notify my retirement system so I can disenroll and find a new plan in my new area.
- Once I am a member of an MAPD plan, I have the right to appeal plan decisions about payment or service if I disagree. I will read the Evidence of Coverage document from the plan I have chosen when I get it to know which rules I must follow to get coverage with this MAPD plan. I understand that people with Original Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements.
- I understand that, if electing an MAPD HMO plan, beginning on the date the MAPD HMO plan coverage begins, I can only use network providers, except for emergency or urgently needed services or out-of-area dialysis services. I also understand that I will have to pay more for services that I receive from non-network providers. Services authorized by the plan and other services contained in my Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE MAPD PLAN WILL PAY FOR THE SERVICES.**
- I understand that the providers in the networks are independent contractors in private practice and are neither employees nor agents of MAPD plans or their affiliates.

Release of Information: By joining an MAPD health plan, I acknowledge that they will release my information to Medicare and other plans as is necessary for treatment, payment of claims and healthcare operations. Medicare may also use this information for research and other reasons which they can do under federal law.

Dependent Documentation Requirements



If you are adding a **MEDICARE DEPENDENT** to your coverage, you must provide a copy of the appropriate documentation as indicated in the chart below. Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member. Additional documentation may be required for a dependent spouse, civil union partner or child whose coverage was previously terminated.

Relationship of Dependent to You	Eligibility Criteria and Documentation Required
Spouse or Civil Union Partner	<p>Eligibility Criteria Same sex or opposite sex spouse or civil union partner. Does not include ex-spouse, common-law spouse, person not legally married or the new spouse of a survivor.</p> <p>Documentation Required Marriage certificate or civil union partnership certificate.</p>
Disabled Child	<p>Eligibility Criteria Child age 26 or older who is continuously disabled from a cause originating prior to age 26. For tax years in which the child is age 27 or above, they must be eligible to be claimed as a dependent for income tax purposes by the annuitant or survivor.</p> <p>Documentation Required Birth certificate, Statement from the Social Security Administration with the Social Security disability determination and a copy of the member's most recent tax return for dependents 26 and older.</p>

If you wish to add a **NON-MEDICARE DEPENDENT** (i.e., someone who is not enrolled in Medicare Parts A and B) you will need to be enrolled in a non-MAPD plan until that dependent either becomes eligible for, and enrolls in Medicare Parts A and B, or until the dependent is dropped from your coverage. If added, the effective date of the dependent's coverage will be January 1, 2016. To add a non-Medicare dependent to your coverage, you must contact your retirement system and request the appropriate enrollment form.