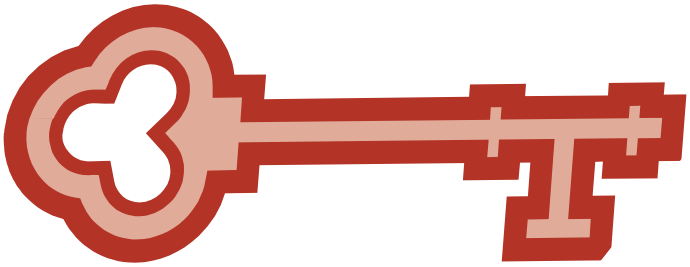
# Benefit Choice Options

## The Key to Understanding Your Benefits



# College Insurance Program

**Department of Central Management Services**
**Bureau of Benefits**

**Effective July 1, 2003 - June 30, 2004**

**Rod R. Blagojevich, Governor**
**Michael M. Rumman, Director**

Benefit Choice is
May 1-31, 2003

# Important Changes For Fiscal Year 2004

The information below presents significant changes to the college insurance benefit plans. Please carefully review all the information in this Benefit Choice Options booklet. **This annual Benefit Choice Options Booklet contains updates to the College Insurance Program Benefits Handbook.** Participants should review this publication each year to be aware of changes in the benefits available. Benefit Choice is May 1-31, 2003. All selections made during Benefit Choice will be effective July 1, 2003.

## Changes that Impact All Plan Participants

**Life Changing Events -** If you have a life changing event such as marriage, divorce, etc. , contact State Universities Retirement System (SURS) to understand how your coverage may be impacted.

**Health Insurance Portability and Accountability Act (HIPAA)** - Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The Department of Central Management Services, Bureau of Benefits contracts with Business Associates (health plan administrators, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavorial health services and prescription drug benefits.

If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective plan administrator. If you are a plan participant in the CCHP, refer to page 24 for the Notice of Privacy Practices.

## Changes specific to Managed Care Plans (HMO/OAP)

**Plans no longer available -** Humana HMO is no longer available. If you are enrolled in this plan, you will need to enroll in another managed care plan or in the College Choice Health Plan (CCHP). **If you do not make another plan selection before May 31, 2003, you will automatically be enrolled in CCHP effective July 1, 2003.** Information on the managed care plans will be mailed to your home. For details on plans in your area, see pages 12 -13.

## Changes specific to the College Choice Health Plan (CCHP)

**The CCHP Hospital Preferred Provider Organizations -** will include 228 hospitals statewide including 3 additions and 6 deletions of providers. Refer to pages 20-23 for a complete listing.

## Changes specific to the College Choice Dental Plan (CCDP)

**CompDent has changed their name to CompBenefits.** The Schedule of Benefits has changed, refer to page 28 for details.

# Table of Contents


**Participant Responsibilities** 4

**Benefit Choice Period is May 1-31, 2003** 5

**Frequently Asked Questions (FAQs) about Benefits** 6

**Monthly Premium Information** 7

**Managed Care Plans** 8
- HMO Benefits 9
- OAP Benefits 10
- Important Reminders About Managed Care Plans 11
- NCQA Accreditation and Managed Care Plans in Bordering States 12
- Managed Care Plans in Illinois Counties 13

**The College Choice Health Plan (CCHP)** 14
- CCHP - Medical Plan Coverage 15
- CCHP - Notification and Penalties 16
- CCHP - Prescription Drug Plan 17
- CCHP - Cigna Healthcare PPO Networks 19
- CCHP - Hospital Preferred Provider Organizations (PPO) 20
- CCHP - Health Insurance Portability and Accountability Act (HIPAA) 24

**Dental Plan** 28

**Plan Administrators** 35

**CIP Benefit Recipient Group Insurance Form** 37-38

**CIP Dependent Beneficiary Group Insurance Form** 39-40

# Participant Responsibilities

**It is each Participant's responsibility to know the benefits.** Read the information on the plan in which you are currently enrolled or in which you are considering enrolling.

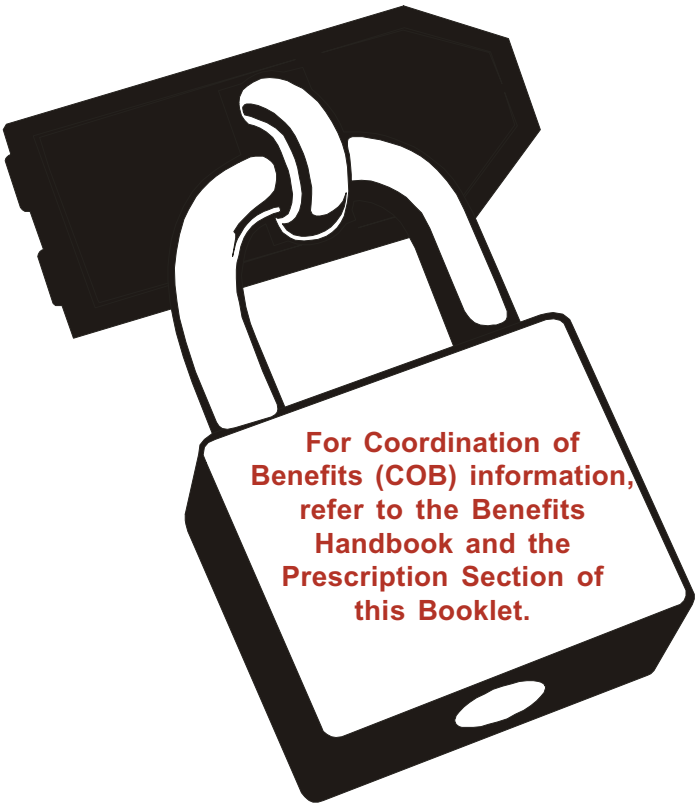
If you are unsure if an event occurs that the SURS needs to know about, it is in your best interest to contact them for assistance. **Corrections to eligibility that result in a premium change will only be processed up to six months retroactively. There are no exceptions to this policy.**

**Notify SURS immediately when the following life changing events occur:**

- You and/or your dependents have a change of address.
- You experience life changing events that may impact eligibility for you or your dependent(s) such as:
  - birth/adoption of a child,
  - marriage, divorce,
  - death of a covered dependent.
- You have other group insurance coverage, or gain other coverage during the plan year. Provide your Coordination of Benefit (COB) information to SURS as soon as possible.

**To ensure that all information is up-to-date, Participants should periodically review the following:**

- Annual Benefit Choice Booklet which details changes affecting all benefit programs each plan year.
- Health and dental information from plans you are currently enrolled in or are considering enrolling in.
- Prescription formulary list. **Remember:** Formularies are subject to change during the plan year without notice.
- Your annuity deductions for health premiums are accurate, based on the coverage you have enrolled in for the plan year.



# Benefit Choice Period is May 1-31, 2003

Benefit Choice Period is the time of year to review and/or make changes to your health plan. Benefit Choice is the **only** time, other than a qualifying change in status, that Participants can change plans (see Benefits Handbook). Benefit Choice is also the only time when those who have never been enrolled in a plan offered by CIP may initially enroll in one of its health plans.

Benefit Choice runs from **May 1 through May 31, 2003.** The plan selections elected during this period will be in force for the plan year July 1, 2003 through June 30, 2004.

All Benefit Choice changes can be processed through SURS. Participants 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. It is each Participant's responsibility to review this Benefit Choice Options Booklet in its entirety.**

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

Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Premium costs and possible geographic limitations
- Healthcare provider selection process
- Prescription drug coverage

The College Choice Health Plan (CCHP) is available regardless of your place of residence. Managed care plans have geographic and provider limitations. Participants 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 plan. Specific questions regarding coverage should be directed to each respective plan administrator.

- **Managed Care Plans**
  HMO – Health Maintenance Organization
  OAP – Open Access Plan
- **College Choice Health Plan**
  CCHP – a medical indemnity plan

For information specific to participating managed care plans, contact the individual plans listed on page 35. For detailed information on the CCHP, refer to your Benefits Handbook. **It is your responsibility to know your benefits.** Read all information on the plan in which you are currently enrolled or in which you are considering enrolling.

# Frequently Asked Questions (FAQs) about Benefits

**1) Will the deductibles I have paid under my current healthcare plan transfer to the plan I select if I enroll in CIP?**

No, deductibles do not transfer. The CIP Plan Year begins July 1 and so do all deductibles and out-of-pocket maximums, where applicable.

**2) Since the Program is co-administered by SURS and CMS, who do I call with questions?**

Contact SURS regarding enrollment, eligibility or to change your address. If SURS does not have your current address on file, you could miss important benefit information. Contact CMS for general information on coverage and benefits. For specific information on managed care plans, contact the respective plan, see page 35.

**3) Do I get a new medical and prescription drug identification card every plan year?**

Normally, the only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card, you may request a replacement card from your plan administrator listed on page 35.

**4) I know managed care plans have geographic limitations. What if I move?**

If your current plan is available at your new location, you will remain under that plan unless your PCP is no longer available there. If your PCP is not available, you will need to select a new PCP or you may change plans. If you move to a county where your current plan is not offered, you will have to choose a new plan. If you move out-of-state or out of the country, you will most likely have to enroll in CCHP. Contact the plan administrator for specifics and, as always, notify SURS of your new address.

**5) If I am seeing a specialist or a woman's health care provider in my managed care plan's network and that professional leaves the network, can I change plans?**

No. You will have to wait until the next Benefit Choice Period. The only time you may change plans is if your PCP leaves the network .

**6) I am on Medicare and enrolled in CCHP. Do I have to use the CCHP Preferred Provider Organization networks for hospitals and physicians?**

It is recommended that you use a PPO in case you have exhausted your Medicare benefits. Remember to call the Notification Administrator for all hospital/extended care facility admissions when your Medicare benefits exhaust or you will be subject to a $1,000 penalty for failure to notify.

**7) I (or my dependent) have just become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD), but I am not yet 65 or retired. What should I do and how will this affect my coverage?**

First, send a copy of your Medicare card to SURS indicating whether you are receiving Medicare Disability or Medicare ESRD. Depending on the type of Medicare you are eligible for and the length of time you have been entitled to it, your College Insurance Program coverage may or may not be your primary payer. If you have questions about the coordination of benefits process with Medicare, call the Group Insurance Division, Member Services Section at (217) 558-4486.

**8) What if I want to terminate either my or my enrolled dependents' coverage under CIP?**

Notify SURS 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.**

# Monthly Premium Information

Premiums are monthly charges and include the cost of health, dental and vision coverage. Benefit Recipients and/or Dependent Beneficiaries who enroll in a managed care plan will pay lower monthly premiums. **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.**

| | Not Medicare Primary | Not Medicare Primary | Not Medicare Primary | Medicare Primary |
|---|---|---|---|---|
| **Type of Plan** | **Under Age 23** | **Age 23-64** | **Age 65 & Above** | **All Ages** |
| **Benefit Recipient** Managed Care Plans | $55.19 | $135.78 | $203.18 | $57.09 |
| **Benefit Recipient** Indemnity Plan (CCHP) | $79.85 | $174.67 | $251.97 | $73.77 |
| **Dependent Beneficiary** Managed Care Plans | $220.76 | $543.10 | $812.71 | $228.36 |
| **Dependent Beneficiary** Indemnity Plan (CCHP) | $332.73 | $655.03 | $997.39 | $288.92 |

# Managed Care Plans

There are 7 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive 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. The minimum levels of coverage HMO plans are required to provide are described on page 9.

## Open Access Plan (OAP)

The unique feature of the OAP is that there are three benefit levels as shown in the table on page 10. The program offers two managed care networks, a Tier I network and a Tier II network. In addition, Tier III benefits (out-of-network ) are available, so you can have great flexibility in selecting care providers. The important thing to remember is the level of benefits you receive is determined by the selection of care providers.

The benefit level for hospitals, physicians and other services will be highest if you select a Tier I provider - often a 100% benefit after a copayment. The Tier II network is generally a 90% benefit. The Tier III benefits (out-of-network) is generally 80% of Usual &Customary (U&C). See the table on page 10 for more details. The plan provider directory contains separate listings of providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive. Another advantage of selecting the network providers is that they have met strict accreditation standards.

It is important to know that you can mix and match providers. For example, you can utilize a Tier II physician and receive care in a Tier I hospital. In this example, your physician claim would be payable under Tier II at a 90% benefit and the hospital would be paid at the Tier I 100% benefit.

In considering the OAP, compare all benefits to other options. There are important similarities and differences in benefits for prescription drug coverages and mental health/substance abuse services, as well as hospital, physician and other services.

# 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. It is your responsibility to know and follow the specific requirements of the HMO plan you select.

| HMO Plan Design | |
|---|---|
| **Plan year maximum benefit** | Unlimited |
| **Lifetime maximum benefit** | Unlimited |
| **Hospital Services** | |
| **Inpatient hospitalization** | 100% after $150 copayment per admission |
| **Alcohol/substance abuse*** *(maximum number of days determined by the plan)* | 100% after $150 copayment per admission |
| **Psychiatric admission*** *(maximum number of days determined by the plan)* | 100% after $150 copayment per admission |
| **Outpatient surgery** | 100% |
| **Diagnostic lab & X-ray** | 100% |
| **Emergency room hospital services** | 100% after $100 or 50% copayment, whichever is less |
| **Professional and Other Services** | |
| **Physician visits** *(including physical exams & immunizations)* | 100%, $10 copayment may apply |
| **Well Baby Care** | 100% |
| **Psychiatric care*** *(maximum number of days determined by the plan)* | 100% after $20 or 20% copayment per visit |
| **Alcohol and substance abuse care*** *(maximum number of days determined by the plan)* | 100% after $20 or 20% copayment per visit |
| **Prescription drugs** | $5 generic, $10 brand, $25 brand (non-formulary) copayment. Formulary restrictions may apply. Formulary is subject to change during the plan year. |
| **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.*

***Some HMOs may provide benefit limitations on a calendar year.***

# Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage the OAP is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the OAP plan.

| Benefit | Tier I<br>100% Benefit | Tier II<br>90% Benefit | Tier III (Out-of-Network)<br>80% Benefit |
|---|---|---|---|
| **Plan Year Maximum Benefit** | Unlimited | Unlimited | $1,000,000 |
| **Lifetime Maximum Benefit** | Unlimited | Unlimited | $1,000,000 |
| **Annual Out-of-Pocket Maximum**<br>• Per Individual Enrollee | $0 | $ 600 | $1,500 |
| **Annual Plan Deductible**<br>*Must be satisfied for all services* | $0 | $200 Per Enrollee* | $300 Per Enrollee* |
| **Hospital Services** | | | |
| **Inpatient** | Full coverage after $150 copayment per admission | 90% of network charges for covered services after $200 copayment per admission | 80% of U&C for covered services after $300 copayment per admission |
| **Inpatient Psychiatric** | Benefits available for care received by providers under Tier II and Tier III | Full coverage after $150 copayment per admission, up to 30 days per plan year | 90% of U&C for covered services after $150 copayment per admission, up to 30 days per plan year |
| **Inpatient Alcohol and Substance Abuse** | Benefits available for care received by providers under Tier II and Tier III | Full coverage after $150 copayment per admission, up to 10 days rehabilitation per plan year | 90% of U&C for covered services after $150 copayment per admission, up to 10 days rehabilitation per plan year |
| **Emergency Room** | Full coverage after $100 copayment per admission | 90% of network charges for covered services after $100 copayment per admission | 80% of U&C for covered services after lesser of $100 copayment per admission, or 50% of U&C |
| **Outpatient Surgery** | Full coverage | 90% of network charges for covered services | 80% of U&C for covered services |
| **Outpatient Psychiatric and Substance Abuse** | Benefits available for care received by providers under Tier II and Tier III | Full coverage after $10 copayment, up to 30 visits per plan year | 90% of U&C for covered charges after $10 copayment, up to 30 visits per plan year |
| **Diagnostic Lab & X-Ray** | Full coverage | 90% of network charges for covered services | 80% of U&C for covered services |
| **Physician and Other Professional Services** | | | |
| **Physician Office Visits** | Full coverage after $10 copayment | 90% of network charges for covered services | 80% of U&C for covered services |
| **Preventative Services, including Immunizations** | Full coverage after $10 copayment | 90% of network charges for covered services | Covered In-network only |
| **Well Baby Care** | Full coverage after $10 copayment | 90% of network charges for covered services | Covered In-network only |
| **Other Services** | | | |
| **Prescription Drugs - Covered in-network only through Wellpoint Pharmacy Management**<br>• **Generic -** Full coverage after $5 copayment<br>• **Brand -** Full coverage after $10 copayment<br>• **Non-Formulary -** Full coverage after $25 copayment | | | |
| **Durable Medical Equipment** | Full coverage | 90% of network charges for covered services | 80% of U&C for covered services |
| **Skilled Nursing Facility** | Full coverage | 90% of network charges for covered services | Covered In-network only |
| **Transplant Coverage** | Full coverage | 90% of network charges for covered services | Covered In-network only |

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

## Important Reminders About Managed Care Plans

**Provider Network Changes:** Managed care plan provider networks are subject to change. Always call the respective plan to verify participation of particular providers - even if the information is printed in the plan's directory. The provider network is subject to change.

**PCPs Leaving a Network:** If your PCP leaves the managed care plan's network, you have three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the College Choice Health Plan. The opportunity to change plans applies only to **Primary Care Physicians leaving the network.** It does not apply to specialists or women's healthcare providers who are not designated Primary Care Physicians.

**Out-of-County Managed Care Plans:** If you are interested in enrolling in a managed care plan that is not available in your county of residence, contact the plan directly for more information.

**Dependents:** Eligible dependents who live apart from the Participant's residence for any part of a plan year may be subject to limited service coverage. If you have such a dependent, it is critical to contact the managed care plan that you are considering to understand the plan's guidelines on this type of coverage.

**June/July Hospitalizations:** If you change health plans and you or your dependents are hospitalized in June, it is recommended you contact both your current plan/PCP and future plan/PCP well in advance.

**Psychiatric/Substance Abuse Treatment:** 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.

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

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

**Transition of Services:** If you know you are switching plans and you or your dependents are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, it is imperative that you contact the new plan to coordinate the transition of services for your care.

## NCQA Accreditation and Managed Care Plans in Bordering States

One way the quality of managed care plans can be judged is through accreditation by an outside agency. **The National Committee for Quality Assurance (NCQA)** is a leader in accrediting managed care plans. The not-for-profit NCQA prides itself on providing purchasers and consumers of managed care with comparative data on plan quality and value.

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 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 requirements for consumer protection and quality improvement.

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

**Provisional:** Is an indication that a plan's service and clinical quality meet some, but not all, of NCQA basic requirements.

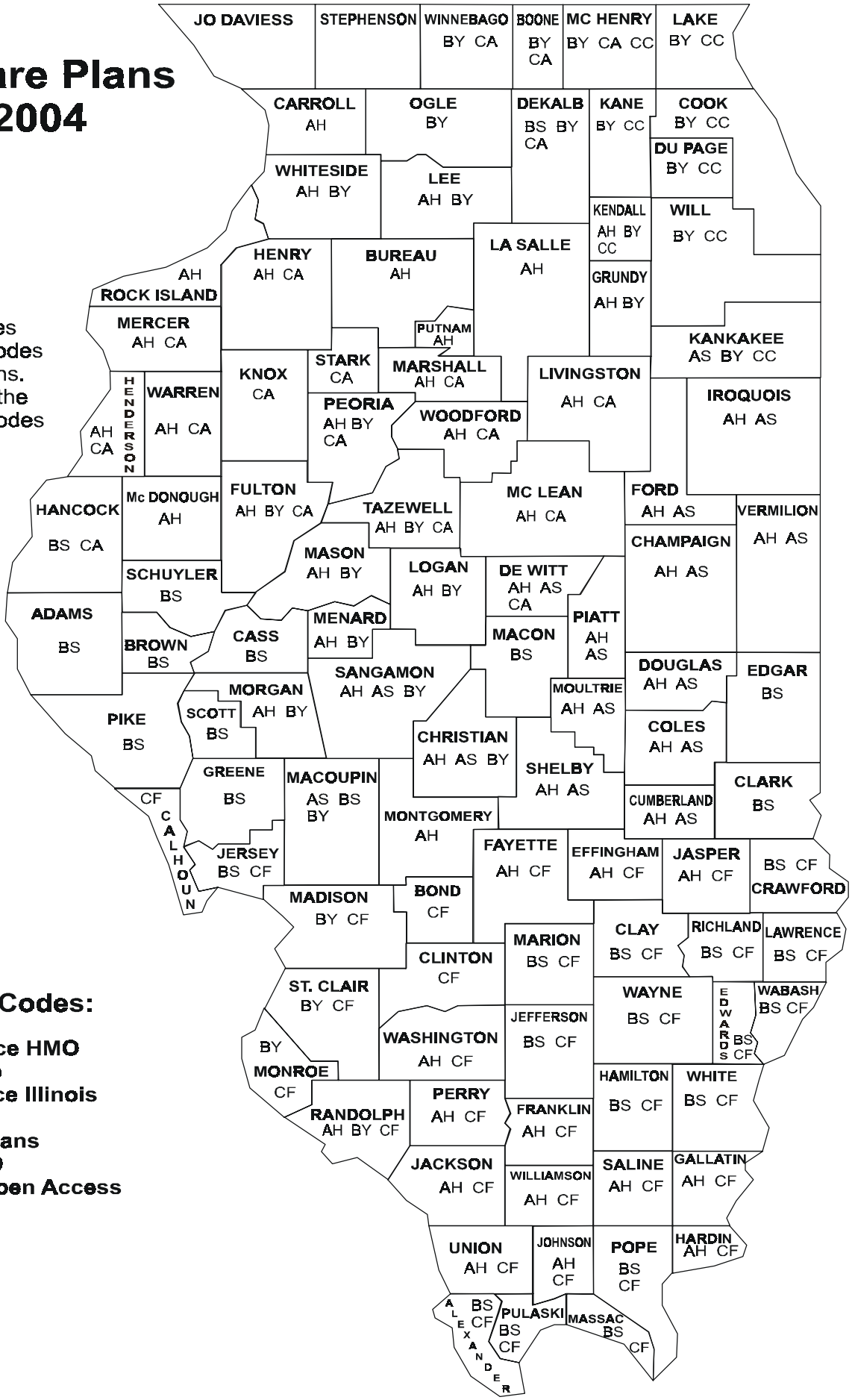
Further information regarding NCQA accreditation, see the chart below or contact NCQA directly at (888) 275-7585 or at their website (http://www.ncqa.org).

| Plan Name and Code | Counties in Indiana | Counties in Iowa | Counties in Kentucky | Counties in Missouri | Counties in Wisconsin | NCQA Accreditation |
|---|---|---|---|---|---|---|
| Health Alliance Illinois (Code: BS) | Daviess, Dubois, Gibson, Knox, Martin, Pike, Posey, Spencer, Vanderburgh, Warrick | Lee | | Marion, Lewis, Clark | | Excellent |
| Health Alliance HMO (Code: AH) | | Scott | | | | Excellent |
| HealthLink Open Access (Code: CF) | * | | * | * | | Not Reviewed |
| HMO Illinois (Code: BY) | Lake, Porter | | | | Kenosha | Excellent |
| OSF Health Plan (Code: CA) | | | | | | Excellent |
| PersonalCare (Code: AS) | | | | | | Excellent |
| Unicare HMO (Code: CC) | Lake, Porter | | | | | Excellent |

* Counties are too numerous to list. Please contact HealthLink for a complete listing.

# CIP Managed Care Plans For FY 2004

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 = OSF HealthPlans**
**CC = UniCare HMO**
**CF = HealthLink Open Access**

# The College Choice Health Plan (CCHP)

CCHP is a medical indemnity plan which offers a comprehensive range of benefits. The CCHP Medical Plan Administrator is CIGNA. Under CCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using a CCHP Preferred Provider Organization (PPO) hospital, the CIGNA Healthcare PPO Network, network pharmacies for prescription drugs and mental health/substance abuse network providers.

## Plan Year Maximums and Deductibles

| The benefits described in this summary represent the major areas of coverage under CCHP.<br>The plan year is July 1 through June 30 of the following year. | |
|---|---|
| Lifetime Maximum | $1,000,000 |
| Plan Year Deductible | CCHP Primary Participant (Non-Medicare) $500<br>Medicare Primary Participant $300 |
| Additional Deductibles*<br><br>***These are in addition to the plan year deductible.** | Each Emergency Room Visit $200<br>Non-PPO Hospital Admission $200<br>Transplant Deductible $100<br><br>Note: There is no additional deductible for admission to a PPO hospital. |
| Skilled Nursing Maximum | Benefits are available up to 100 days each plan year. Benefits cease after the 100th day. |

## Out-of-Pocket Maximums

| There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles listed below count toward one or the other, but not toward both. | |
|---|---|
| **General:<br>$800 per individual, per plan year** | **Non-PPO:<br>$4,000 per individual, per plan year** |
| Plan Year Deductible<br>Professional and Physician Coinsurance<br>PPO Facility Coinsurance (20%)<br>Transplant Deductible ($100)<br>Transplant Inpatient and Outpatient Coinsurance (20%)<br>*Standard Hospital Coinsurance (30%)<br>*Standard Hospital Admission Deductible ($200)<br>All Emergency Room Deductibles ($200)<br>Emergency Room Coinsurance (20%)<br><br>***When the Notification Administrator grants an exception for a non-PPO admission, or when the plan participant does not reside within 25-miles of a CCHP PPO hospital.** | Non-PPO Hospital Deductible ($200)<br><br>Non-PPO Inpatient Coinsurance (40%)<br><br>Non-PPO Outpatient Facility Coinsurance (40%) |

**The following do not apply toward out-of-pocket maximums:**

- Prescription Drug benefits or copayments.
- Mental Health/Substance Abuse benefits, coinsurance or copayments.
- Notification penalties.
- Ineligible charges (amounts over U&C and charges for non-covered services).

# CCHP - Medical Plan Coverage

| Hospital Services | |
|---|---|
| CCHP Preferred Provider Organization Hospitals and CIGNA Healthcare PPO Network | 80% after annual plan deductible. No admission deductible. |
| Non-Preferred Provider Organization (PPO) Hospital | • $200 per admission deductible.<br>• If the Participant resides in Illinois or within 25-miles of a CCHP PPO and the Participant chooses to use a non-PPO and/or voluntarily travels in excess of 25-miles when a CCHP PPO is available within the same travel distance the Plan pays 60% after the annual plan deductible.<br>• If the Participant resides in Illinois and has no CCHP PPO available within 25-miles and voluntarily chooses to travel further than the nearest CCHP PPO, the Plan pays 60% after the annual plan deductible.<br>• If the Participant does not reside in Illinois or within 25-miles of a CCHP PPO the plan pays 70% after the annual plan deductible. |
| **Outpatient Services** | |
| Lab/X-Ray | 80% of Usual & Customary (U&C) after annual plan deductible. |
| Approved Durable Medical Equipment and Prosthetics | 80% of U&C after annual plan deductible. Contact the plan administrator for approval prior to obtaining items. |
| Licensed Ambulatory Surgical Treatment Center | 80% after annual plan deductible. |
| **Professional and Other Services** | |
| CIGNA Healthcare PPO Network | 90% of negotiated fee after the annual plan deductible. U&C charges do not apply. |
| Physician & Surgeon Services | 80% of U&C after the annual plan deductible for inpatient, outpatient & office visits. |
| Preventive Services | Pap smears (includes office visit), mammograms and prostate screenings are covered per the applicable coverages listed in the Benefits Handbook. No deductibles apply. |
| **Transplant Services** | |
| Organ and Tissue Transplants | 80% of contracted rate after $100 transplant deductible. Benefits are not available unless approved by the Notification Administrator (Intracorp). To assure coverage, the transplant candidate **must** contact the Notification Administrator prior to beginning evaluation services. |

# CCHP - Notification and Penalties

## Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for a specified outpatient procedure. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits.

For notification procedures for mental health/substance abuse services, see the Benefits Handbook section entitled Mental Health/Substance Abuse.

**Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare.** Allow a minimum of two business days for review. Failure to notify the Notification Administrator within the required time limits will result in a $1,000 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

A "reference number" will be assigned and should be maintained in the plan participant's records. This number serves as a reference should there be any questions regarding notification. However, it is not a guarantee of benefits.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the procedure, setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

**Notification is required for the following:**

- **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
- **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. Notification of a maternity admission is not automatic enrollment of the newborn. Contact the SURS to enroll the newborn.
- **Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home** - At least seven days before admission, call the Notification Administrator. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission** - The plan participant or physician must phone the Notification Administrator within two business days after the admission.
- **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
- **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the first indication that a transplant may be necessary. Benefits are available only if authorized by the Notification Administrator.
- **Infertility Treatment** - A written predetermination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment. This applies to both medical and prescription benefits. Upon submission of the required documentation, a letter of denial or approval will be mailed to the plan participant. Refer to page 47 of your Benefits Handbook for more information. Please allow a minimum of 5 business days from receipt of all necessary documentation by the Notification Administrator to determine if the treatment is approved or denied.

To satisfy the notification requirement, you can call seven days a week, 24 hours a day:

**INTRACORP/CIGNA** (800) 962-0051
(800) 526-0844
(TDD/TTY)

# CCHP - Prescription Drug Plan

Prescription drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. The Prescription Drug Plan includes both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription.

**Infertility Prescription Benefits** - A written pre-determination of benefits must be obtained from the Medical Plan Administrator (CIGNA) prior to beginning infertility treatment. This applies to both medical and prescription benefits (see page 47 of the Benefits Handbook). Upon submission of the required documentation, a letter of denial or approval will be mailed by the Medical Plan Administrator .

The Prescription Drug Plan Administrator must confirm that a pre-determination of benefits has been approved before infertility medication can be dispensed at a retail pharmacy. This may take additional time. If a pre-determination is not on file, the plan participant will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

When ordering infertility medication through the Mail Order Pharmacy, a copy of the pre-determination letter from the Medical Plan Administrator must accompany any prescription in order for these medications to be filled. If the approved pre-determination letter is not enclosed with the infertility medication prescription, the plan participant will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

## In-Network Benefits

The pharmacy network consists primarily of retail pharmacies which accept the copayment and electronically transmit the prescription claim for processing. The Member identification number, which ends in 1399, is printed on the ID card. For the most up-to-date information on network pharmacies, call the Prescription Drug Plan Administrator found on page 35.

**In-network benefits when using the Plan Participant ID Card/Number:**

- No plan year deductibles; no claim forms to file.
- Flat Copayments (1 to 30-day supply):
  - Generic $ 7.00
  - Formulary Brand $14.00
  - Non-Formulary Brand $28.00
- The maximum days supply available at one fill is 60 days. The copayments described above will double for any prescription exceeding 30 days.
- When the 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 of $7.00.
- If only a brand drug is available, the copayment will be $14.00 or $28.00.
- When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

**When medication is purchased at an in-network pharmacy <u>without</u> presentation of the ID Card/Number, the plan participant will be charged the full retail cost of the medication.** A paper claim for reimbursement of the cost must then be sent to the Prescription Drug Plan Administrator. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

## Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Plan participants must pay all charges at the time of purchase and file a paper claim form with the Prescription Drug Plan Administrator. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs

will be higher when not using network pharmacies. Claim forms are available from the Prescription Drug Plan Administrator.

### Mail Service Program

Maintenance medications are available through mail order at the following copayments:

– Flat Copayments (90-day supply):

- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Contact the Prescription Drug Plan Administrator for mail order forms and information.

## Specialty Pharmacy Services

Some medications are only dispensed from the Prescription Drug Plan's Specialty Pharmacy. This pharmacy specializes in the delivery of medications for specific diseases. The types of medications dispensed from the Specialty Pharmacy are for conditions such as: Multiple Sclerosis, Hepatitis B and C, Arthritis, Immune Deficiency and Hemophilia. Medication is usually shipped within 24 hours of receipt of the request; quantities are limited to 30-days or less. For additional information, contact the Prescription Drug Plan Administrator at www.caremark.com or call 1-800-237-2767.

## Coordination of Benefits

This Plan coordinates with Medicare and other group plans. However, the appropriate copayment will always be applied.

## Medicare Covered Prescriptions

When a plan participant is enrolled in Medicare Part B and Medicare is primary, Medicare provides coverage for certain prescriptions, including diabetic test strips and lancets. Medicare approved retail pharmacies will submit claims for Medicare covered prescriptions directly to Medicare. At the time of purchase, plan participants will generally be responsible for the 20% not covered by Medicare.

Caremark's Mail Order Pharmacy will also submit claims to Medicare for Medicare covered prescriptions, charging only the 20% of the Medicare allowed amount. This process cannot be initiated until the plan participant has signed an assignment of benefit form and mailed it to the Prescription Drug Plan Administrator. To obtain these forms, contact the Prescription Drug Plan Administrator at 1-866-804-5880.

Upon receipt of the Medicare Explanation of Benefits (EOMB), plan participants may submit a paper claim for any reimbursement due (usually a portion of the 20%). The applicable copayment is always applied.

The Prescription Drug Plan Administrator has established a special Medicare Customer Service Team (866-804-5880) to provide forms and answer questions regarding Medicare Coordination of Benefits. For answers to questions about eligibility for Medicare Part A, Part B, or to apply for Medicare, call the Social Security Administration at 1-800-772-1213 or 1-800-325-0778 (TDD/TTY).

## Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

# CCHP- CIGNA HealthCare PPO Networks

CCHP non-Medicare Participants have available **nationwide** CIGNA HealthCare PPO providers, hospitals and facilities. An enhanced 90% benefit for professional fees, hospital and facility services is available by using a participating network provider. The questions and answers below provide more information about this benefit feature. If you have additional questions, call the Group Insurance Division, see page 35.

## What is the CIGNA HealthCare PPO Network?

The CIGNA HealthCare PPO Network is a nationwide network of physicians, hospitals and facilities that have agreed to participate at negotiated rates offering members an enhanced benefit.

## What are the advantages of using a CIGNA HealthCare PPO Network provider?

The advantages of using providers participating in the network are that benefits for covered services are paid at 90% of a negotiated fee and usual and customary limits will not be applied.

## How do I access services from a CIGNA HealthCare PPO Network provider?

Just make an appointment with a network provider and present your CCHP identification card at the time of service.

## What if I do not use a CIGNA HealthCare PPO Network provider?

Standard plan benefits, coinsurance levels, and usual and customary limits apply.

## How can I find out which providers are participating in the CIGNA HealthCare PPO Network?

Access the participating provider list on the website at:

**http://provider.healthcare.cigna.com/soi.html.**
Or, call CIGNA at (800) 962-0051.

# CCHP - Hospital Preferred Provider Organizations

## Chicagoland Area (Cook, DuPage & Lake Counties)

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

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

Edward Hospital, Naperville
Elmhurst Memorial Hospital, Elmhurst
Evanston Northwestern Healthcare, Evanston

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

Highland Park Hospital, Highland Park
Hinsdale Hospital, Hinsdale
Holy Cross Hospital, Chicago
Holy Family Medical Center, Des Plaines

Ingalls Memorial Hospital, Harvey

Jackson Park Hospital, Chicago

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

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

Northwest Community Hospital, Arlington Heights
Northwestern Memorial Hospital, Chicago
Norwegian American Hospital, Chicago

Oak Forest Hospital of Cook County, Oak Forest
Oak Park Hospital, Oak Park
Our Lady of the Resurrection Med. Center, Chicago

Palos Community Hospital, Palos Heights
Provena St. Therese Medical Center, Waukegan
Provident Hospital of Cook County, Chicago

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

Schwab Rehabilitation Hospital, Chicago
South Shore Hospital, Chicago
SSM St. Francis Hosp. & Hlth. Ctr., Blue Island
St. Alexius Medical Center, Hoffman Estates
St. Anthony Hospital, Chicago
St. Bernard Hospital & Health Care Center, Chicago
St. Elizabeth Hospital, Chicago (closing in late 2003)
St. Francis Hospital, Evanston
St. James Hospital & Health Center, Chicago Hts.
St. James Hospital & Health Center, Olympia Fields
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

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

University of Chicago Hospital, Chicago
University of Illinois Medical Center, Chicago

Victory Memorial Hospital, Waukegan

West Suburban Hospital Medical Center, Oak Park
Westlake Community Hospital, Melrose Park

## CCHP - Hospital Preferred Provider Organizations

### Northern Illinois

CGH Medical Center, Sterling
Children's Hospital of Wisconsin, Milwaukee
Copley Medical Center, Aurora

Delnor Community Hospital, Geneva
DeWitt Community Hospital, DeWitt, IA

Freeport Memorial Hospital, Freeport

Genesis Medical Center East, Davenport, IA
Genesis Medical Center West, Davenport, IA

Hammond-Henry District Hospital, Geneseo
Harvard Memorial Hospital, Inc., Harvard

Illini Hospital, Silvis

Katherine Shaw Bethea Hospital, Dixon
Kishwaukee Community Hospital, DeKalb

Memorial Medical Center, Woodstock
Mendota Community Hospital, Mendota
Mercer County Hospital, Aledo
Mercy Medical Center, Clinton, IA
Morris Hospital, Morris
Morrison Community Hospital, Morrison

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

Saint Anthony Medical Center, Rockford
Sherman Hospital, Elgin
Silver Cross Hospital, Joliet
St. Anthony Medical Center, Crown Point, IN
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

## CCHP - Hospital Preferred Provider Organizations

### Central Illinois

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

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 Rackley Perry Memorial Hospital, Princeton

Keokuk Area Hospital, Keokuk, IA

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

Saint Francis Medical Center, Peoria
Saint James Hospital, Pontiac
Sarah Bush Lincoln Health Center, Mattoon
Sarah D. Culbertson Mem. Hosp., Rushville
Shelby Memorial Hospital, Shelbyville
St. Francis Hospital, Litchfield
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

## CCHP - Hospital Preferred Provider Organizations

### Southern Illinois and Metro-East

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

Christian Hospital, NE, St. Louis
Christian Hospital, NW, Florissant
Clay County Hospital, Flora
Crawford Memorial Hospital, Robinson
Crossroads Comm. Hospital, Mt. Vernon

Des Peres Hospital, St. Louis

Edward A. Utlaut Hospital, Greenville

Fairfield Memorial Hospital, Fairfield
Fayette County Hospital, Vandalia
Ferrell Hospital, Eldorado
Forest Park Hospital, St. Louis

Gateway Regional Medical Center, Granite City
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
Heartland Regional Medical Center, Marion
Herrin Hospital, Herrin

Lawrence County Memorial Hospital, Lawrenceville
Lourdes Hospital, Paducah, KY

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

Red Bud Hospital, Red Bud
Richland Memorial Hospital, Olney

Saint Anthony's Health Center, Alton
Saint Clare's Hospital, Alton
Saint Francis Medical Center, Cape Girardeau, MO
Salem Township Hospital, Salem
South Pointe Hospital, St. Louis
Southeast Missouri Hospital, Cape Girardeau, MO
Sparta Community Hospital, Sparta
SSM Cardinal Glennon Children's Hosp., St. Louis
SSM DePaul Health Center, Bridgeton, MO
SSM Rehabilitation Institute, St. Louis (all sites)
SSM St. Mary's Health Center, Richmond Heights
St. Alexius Hospital, St. Louis
St. Anthony's Medical Center, St. Louis
St. Anthony's Memorial Hospital, Effingham
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 Episcopal Presbyterian Hosp., Chesterfield
St. Mary's Hospital, Centralia
St. Mary's Hospital of E. St. Louis, E. St. Louis, IL

Touchette Regional Hospital, Centreville

Union County Hospital District, Anna

Wabash General Hospital, Mt. Carmel
Washington County Hospital, Nashville
White County Medical Center, Carmi

# Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

## NOTICE OF PRIVACY PRACTICES

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

**Effective April 14, 2003**

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act of 1971 including the College Choice Health Plan and the College Choice Dental Plan. The term "we" in this Notice means the Bureau and our Business Associates (health plan administrators).

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

The Bureau contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. You may not have coverage with all of our Business Associates. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on behalf of the Bureau in performing their respective functions. When we seek help from individuals or entities who are not part of the Bureau in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Caremark is the Pharmacy Benefit Plan Administrator. Magellan Behavioral Health is the Mental Health and Substance Abuse Plan Administrator. CompBenefits is the Dental Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a Notice from the respective plan administrator regarding its Privacy Practices.

### How We May Use or Disclose Your PHI

**Treatment:** We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party.

We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

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

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

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

## Legal Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Your Rights

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

**For the Medical Plan Administrator and Notification/Medical Case Management Benefits:**

CIGNA HealthCare
Privacy Office
P.O. Box 5400
Scranton, PA 18503
800-762-9940

**For Pharmacy Benefits:**

Caremark, Inc.
Privacy Officer
2211 Sanders Road
Northbrook, IL 60062
800-559-4700

**For Mental Health and Substance Abuse Benefits:**

Magellan Behavioral Health
Privacy Official
10 S. Riverside Plaza
11th Floor
Chicago, IL 60604
800-424-4020

**For Dental Plan Benefits:**

CompBenefits
Privacy Officer
100 E. Mansell Court E.
Suite 400
Roswell, GA 30076
800-342-5209

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

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

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

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

your records, we may also charge you a fee for mailing the records.

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

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

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

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

# Dental Plan

### College Choice Dental Plan (CCDP)

All CIP members are automatically enrolled in CCDP. **CCDP is administered by CompBenefits, formerly known as CompDent.** Under CCDP, you may go to any dentist and receive benefits for an extensive range of services. CCDP reimburses covered services at a pre-determined maximum allowable scheduled amount. Members are responsible for any charges over the scheduled amount. For a detailed description of your dental plan benefits, see the schedule of benefits on the following pages. Dental plan questions should be directed to **CompBenefits, at (800) 999-1669, or (312) 829-1298 (TDD/TTY).**

| Plan Design | College Choice Dental Plan (CCDP) |
|---|---|
| Annual Deductible | $50 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits in the Benefits Handbook. |
| Maximum Benefit Limit | $1,200 per person per plan year after plan deductible.<br>$2,000 combined maximum, after deductible, on prosthetic, periodontic, surgical extraction and general anesthesia services accumulated every five years. |
| Maximum Benefit Level for Child Orthodontics (under age 19) | $1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above.<br>**Contact CompBenefits for a pre-treatment estimate.** |
| Claim forms | Required |
| Dentist selection | Choice of provider |

**Maximum benefits apply after required deductibles are met. All benefits are subject to CCDP exclusions (see page 77 of the Benefits Handbook).**

# FY2004 CCDP - Schedule of Benefits

| Diagnostic Services | Maximum Benefit | Code |
|---|---|---|
| Periodic Oral Examination | $ 15 | D0120 |
| Limited Oral Evaluation (specific oral health problem) | $ 15 | D0140 |
| Comprehensive Oral Examination | $ 23 | D0150 |
| **Radiographs/Diagnostic Imaging** | | |
| Intraoral Complete Series (once in a period of three plan years, including bitewings) | $ 50 | D0210 |
| Intraoral - Periapical First Film | $ 11 | D0220 |
| Intraoral - Periapical Each Additional Film | $ 8 | D0230 |
| Bitewing Single Film | $ 9 | D0270 |
| Bitewing Two Films | $ 17 | D0272 |
| Bitewing Four Films | $ 26 | D0274 |
| Panoramic Film, (once in a period of three plan years) | $ 42 | D0330 |
| **Preventive Services** | **Maximum Benefit** | **Code** |
| Prophylaxis Adult - Twice each plan year | $ 34 | D1110 |
| Prophylaxis Child - Twice each plan year | $ 23 | D1120 |
| Topical Application of Fluoride - Child **(including** prophylaxis) (once each plan year, covered through age 18 only) | $ 37 | D1201 |
| Topical Application of Fluoride - Child **(not including** prophylaxis) (once each plan year, covered through age 18 only) | $ 14 | D1203 |
| Sealant - per tooth, covered through age 18 only | $ 23 | D1351 |
| **Space Maintainers (Passive Appliances)** | | |
| Fixed Unilateral | $ 72 | D1510 |
| Fixed Bilateral | $ 81 | D1515 |
| Removable Unilateral | $ 72 | D1520 |
| Removable Bilateral | $ 81 | D1525 |

| Restorative Services | Maximum Benefit | Code |
|---|---|---|
| **Amalgam Restorations** | | |
| Amalgam One Surface, Primary or Permanent | $ 39 | D2140 |
| Amalgam Two Surfaces, Primary or Permanent | $ 56 | D2150 |
| Amalgam Three Surfaces, Primary or Permanent | $ 64 | D2160 |
| Amalgam Four or more Surfaces, Primary or Permanent | $ 71 | D2161 |
| **Resin-Based Composite Restorations** | | |
| One Surface, Anterior | $ 46 | D2330 |
| Two Surfaces, Anterior | $ 59 | D2331 |
| Three Surfaces, Anterior | $ 73 | D2332 |
| Four or more Surfaces or involving incisal angle (anterior) | $ 79 | D2335 |
| One Surface Posterior | $ 81 | D2391 |
| Two Surface Posterior | $112 | D2392 |
| Three Surface Posterior | $139 | D2393 |
| Four or More Surfaces, Posterior | $172 | D2394 |
| **Crowns/Single Restorations Only** | | |
| Crown-Resin (laboratory) | $ 86 | D2710 |
| Crown-Resin with high noble metal | $250 | D2720 |
| Crown-Resin predominantly base metal | $215 | D2721 |
| Crown-Resin with noble metal | $241 | D2722 |
| Crown-Porcelain/Ceramic Substrate | $253 | D2740 |
| Crown-Porcelain fused to high noble metal | $254 | D2750 |
| Crown-Porcelain fused to predominantly base metal | $237 | D2751 |
| Crown-Porcelain fused to noble metal | $246 | D2752 |
| Crown-3/4 cast predominately base metal | $252 | D2781 |
| Crown-Full cast high noble metal | $227 | D2790 |
| Crown-Full cast predominantly base metal | $233 | D2791 |
| Crown-Full cast noble metal | $246 | D2792 |
| **Other Restorative Services** | | |
| Recement Inlay | $ 17 | D2910 |
| Recement Crown | $ 18 | D2920 |
| Prefabricated stainless steel Crown (primary tooth) | $ 58 | D2930 |
| Prefabricated stainless steel Crown (permanent tooth) | $ 62 | D2931 |
| Prefabricated Resin Crown | $ 54 | D2932 |

| Endodontics | Maximum Benefit | Code |
|---|---|---|
| **Pulp Capping** | | |
| Pulp Cap - Direct (excluding final restoration) | $ 26 | D3110 |
| Pulp Cap - Indirect (excluding final restoration) | $ 20 | D3120 |
| Pulpotomy - Therapeutic (excluding final restoration) | $ 62 | D3220 |
| **Root Canal Therapy (include intra-operative radiographs)** | | |
| Anterior (excludes final restoration) | $244 | D3310 |
| Bicuspid (excludes final restoration) | $304 | D3320 |
| Molar (excludes final restoration) | $410 | D3330 |
| **Retreatment of Previous Root Canal Therapy** | | |
| Anterior | $266 | D3346 |
| Bicuspid | $316 | D3347 |
| Molar | $432 | D3348 |

| Periodontics | Maximum Benefit | Code |
|---|---|---|
| **Gingivectomy/Gingivoplasty** | | |
| Per quadrant | $155 | D4210 |
| Per tooth | $ 33 | D4211 |
| **Gingival Flap Procedure** | | |
| Per quadrant - includes root planning | $155 | D4240 |
| Gingival Flap - including root planning, 1-3 teeth per quadrant | $117 | D4241 |
| **Osseous Surgery (including flap entry and closure)** | | |
| Per quadrant | $224 | D4260 |
| **Bone Replacement Graft** | | |
| First site in quadrant | $228 | D4263 |
| Each additional site in quadrant | $173 | D4264 |
| **Pedicle Soft Tissue Graft** | $138 | D4270 |
| **Free Soft Tissue Graft** | $178 | D4271 |
| **Provisional Splinting** | | |
| Intracoronal | $ 73 | D4320 |
| Extracoronal | $ 84 | D4321 |
| **Periodontal Scaling and Root Planing** | | |
| Per quadrant | $ 70 | D4341 |

| Periodontics (continued) | Maximum Benefit | Code |
|---|---|---|
| **Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis** | $ 35 | D4355 |
| **Periodontal Maintenance Procedure** | | |
| Following active therapy | $ 28 | D4910 |
| Unscheduled Dressing Change | $ 14 | D4920 |

| Prosthodontics | Maximum Benefit | Code |
|---|---|---|
| **Removable Prosthetics** | | |
| Complete Denture - Maxillary | $523 | D5110 |
| Complete Denture - Mandibular | $523 | D5120 |
| Immediate Denture - Maxillary | $442 | D5130 |
| Immediate Denture - Mandibular | $460 | D5140 |
| **Partial Dentures (removable)** | | |
| Maxillary Partial Denture - resin base (conventional clasps, rests and teeth) | $442 | D5211 |
| Mandibular Partial Denture - resin base (conventional clasps, rests and teeth) | $501 | D5212 |
| Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth) | $529 | D5213 |
| Mandibular Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth) | $540 | D5214 |
| Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth) | $173 | D5281 |
| **Adjustments to Dentures** | | |
| Adjust complete denture - Maxillary | $ 25 | D5410 |
| Adjust complete denture - Mandibular | $ 25 | D5411 |
| Adjust partial denture - Maxillary | $ 25 | D5421 |
| Adjust partial denture - Mandibular | $ 25 | D5422 |
| **Repairs to Complete Dentures** | | |
| Repair broken complete denture base | $ 48 | D5510 |
| Replace missing or broken teeth - complete denture (each tooth) | $ 44 | D5520 |
| **Repairs to Partial Dentures** | | |
| Repair resin denture base | $ 48 | D5610 |
| Repair cast framework | $ 62 | D5620 |
| Repair or replace broken clasp | $ 54 | D5630 |
| Replace broken teeth - per tooth | $ 41 | D5640 |
| Add tooth to existing partial denture | $ 59 | D5650 |
| Add clasp to existing partial denture | $ 77 | D5660 |
| **Denture Rebase Procedure** | | |
| Rebase complete maxillary denture | $179 | D5710 |
| Rebase complete mandibular denture | $179 | D5711 |
| Rebase maxillary partial denture | $179 | D5720 |
| Rebase mandibular partial denture | $179 | D5721 |

| Prosthodontics (continued) | Maximum Benefit | Code |
|---|---|---|
| **Denture Reline Procedure** | | |
| Reline complete maxillary denture (chairside) | $ 109 | D5730 |
| Reline complete mandibular denture (chairside) | $ 109 | D5731 |
| Reline maxillary partial denture (chairside) | $ 109 | D5740 |
| Reline mandibular partial denture (chairside) | $ 109 | D5741 |
| Reline complete maxillary denture (laboratory) | $154 | D5750 |
| Reline complete mandibular denture (laboratory) | $154 | D5751 |
| Reline maxillary partial denture (laboratory) | $154 | D5760 |
| Reline mandibular partial denture (laboratory) | $154 | D5761 |
| **Fixed Partial Denture Pontics** | | |
| (Each retainer and each pontic constitutes a unit in a fixed partial denture) | | |
| Pontic-Cast high noble metal | $248 | D6210 |
| Pontic-Cast predominantly base metal | $219 | D6211 |
| Pontic-Cast noble metal | $224 | D6212 |
| Pontic-Porcelain fused to high noble metal | $249 | D6240 |
| Pontic-Porcelain fused to predominantly base metal | $227 | D6241 |
| Pontic-Porcelain fused to noble metal | $237 | D6242 |
| Pontic-Resin with high noble metal | $234 | D6250 |
| Pontic-Resin with predominantly base metal | $227 | D6251 |
| Pontic-Resin with noble metal | $257 | D6252 |
| **Fixed Partial Denture Retainers - Crowns** | | |
| Crown-Resin with high noble metal | $245 | D6720 |
| Crown-Resin with predominantly base metal | $230 | D6721 |
| Crown-Resin with noble metal | $211 | D6722 |
| Crown-Porcelain fused to high noble metal | $250 | D6750 |
| Crown-Porcelain fused to predominantly base metals | $232 | D6751 |
| Crown-Porcelain fused to noble metal | $231 | D6752 |
| Crown-3/4 cast high noble metal | $240 | D6780 |
| Crown-Full cast high noble metal | $245 | D6790 |
| Crown-Full cast predominantly base metal | $230 | D6791 |
| Crown-Full cast noble metal | $234 | D6792 |
| **Other Fixed Partial Denture Services** | | |
| Recement Fixed Partial Denture | $ 23 | D6930 |
| Fixed Partial Denture Repair, by report | $ 45 | D6980 |

| Oral Surgery | Maximum Benefit | Code |
|---|---|---|
| **Extractions** | | |
| Coronal Remnants - Deciduous Tooth | $74 | D7111 |
| Extraction, Erupted Tooth or Exposed Root (elevation or forceps removal) | $70 | D7140 |
| **Surgical Extraction** | | |
| (Includes local anesthesia, suturing if needed, and routine postoperative care) | | |
| Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $ 50 | D7210 |
| Removal of impacted tooth - soft tissue | $ 67 | D7220 |
| Removal of impacted tooth - partially bony | $ 90 | D7230 |
| Removal of impacted tooth - completely bony | $107 | D7240 |
| Removal of impacted tooth - completely bony with unusual surgical complications | $121 | D7241 |
| Surgical removal of residual tooth roots (cutting procedure) | $ 46 | D7250 |
| **Other Surgical Procedures** | | |
| Biopsy of oral tissue - hard (bone/tooth) | $ 66 | D7285 |
| Biopsy of soft tissue - soft (all others) | $ 57 | D7286 |
| Alveoloplasty in conjunction with extractions, per quadrant | $ 46 | D7310 |
| Alveoloplasty not in conjunction with extractions, per quadrant | $ 62 | D7320 |
| Frenulectomy - separate procedure | $ 83 | D7960 |

| Adjunctive General Services | Maximum Benefit | Code |
|---|---|---|
| **Surgical Incision** | | |
| Palliative (emergency) treatment of dental pain (minor procedure) | $ 12 | D9110 |
| **Miscellaneous Services** | | |
| Occlusal guards, by report | $110 | D9940 |
| Occlusal adjustment, limited | $ 39 | D9951 |
| Occlusal adjustment, complete | $ 77 | D9952 |
| **Anesthesia** | | |
| **General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.** | | |
| General anesthesia - first 30 minutes | $156 | D9220 |
| General anesthesia - each additional 15 minutes | $ 61 | D9221 |
| Intravenous sedation/analgesia - first 30 minutes | $180 | D9241 |
| Intravenous sedation/analgesia - each additional 15 minutes | $ 75 | D9242 |

# Plan Administrators

Only **general** plan questions should be directed to the CMS Group Insurance Division or SURS. Direct all specific claim inquiries to the plan administrators.

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

| Plan Component | Contact For: | Administrator's Name and Address | Customer Service Phone Numbers |
|---|---|---|---|
| **College Choice Health Plan (CCHP) Medical Plan Administrator** | Medical service information, claim forms, ID cards, claim filing/resolution , and pre-determination of benefits. | **CIGNA**<br>Group Number 2457490<br>CIGNA HealthCare<br>P.O. Box 5200<br>Scranton, PA 18505-5200 | (800) 962-0051<br>(nationwide)<br>(800) 526-0844<br>(TDD/TTY)<br>http://provider.healthcare.cigna.com.soi.html |
| **CCHP Notification and Medical Case Management Administrator** | Notification prior to hospital services. Non-compliance penalty of $1,000 applies. See page 16 for more information. | **Intracorp, Inc.**<br>(no address required) | (800) 962-0051<br>(nationwide)<br>(800) 526-0844<br>(TDD/TTY)<br>http://provider.healthcare.cigna.com.soi.html |
| **CCHP Prescription Drug Plan Administrator** | Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing. | **Caremark, Inc.**<br>Group Number 1399<br>**Paper Claims:**<br>P.O. Box 686005<br>San Antonio, TX 78268-6005<br>**Mail Order Prescriptions:**<br>P.O. Box 7624<br>Mt. Prospect, IL 60056-7624 | (866) 212-4751<br>(nationwide)<br>(800) 231-4403<br>(TDD/TTY)<br>www.caremark.com |
| **Member Assistance Program - CCHP MH/SA Plan Administrator** | Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution. | **Magellan Behavioral Health**<br>Group Number 2457490<br>P.O. Box 909782<br>Chicago, IL 60690 | (800) 513-2611<br>(nationwide)<br>(800) 526-0844 (TDD/TTY)<br>www.MagellanAssist.com |
| **College Choice Dental Plan (CCDP) Administrator** | Dental services, claim forms, ID cards and filing. | **CompBenefits, Inc.**<br>Group Number 970<br>P.O. Box 4677<br>Chicago, IL 60680-4677 | (800) 999-1669<br>(312) 829-1298 (TDD/TTY)<br>www.compbenefits.com |
| **General Information** | General information on the CIP health plans. | **CMS Group Insurance Division**<br>600 Stratton Building<br>Springfield, IL 62706 | (217) 782-2548<br>(800) 442-1300<br>(800) 526-0844<br>(TDD/TTY) |
| | General eligibility and enrollment information. | **State Universities Retirement System (SURS)**<br>P.O. Box 2710<br>Springfield, IL 61825-2710 | (800) 275-7877<br>(217) 378-8800<br>(TDD/TTY) |

# Notes

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

# College Insurance Program
# Benefit Recipient Group Insurance Form

SURS

Benefit Recipient Name: _____ SSN: _____-____-_____
Last First Middle

**Initial Enrollment** ☐ **Benefit Choice** (July 1 effective date) ☐

**SECTION I** Personal Information: (Please print or type) Effective Date of Enrollment: ___-____-____

Marital Status: (S/M) ___ Birthdate: (mm/dd/ccyy): ___-___-____ Sex: (M/F) ___

**SECTION II** Medicare Status: (check one)

1 Non Medicare ☐
2 Medicare Eligible age 65+ ☐
3 Medicare Ineligible age 65+ ☐
4 Medicare Disability ☐
5 End Stage Renal ☐

Medicare Number: _____

If 2, 4, or 5 was checked, complete the following and submit a copy of your Medicare Card(s):

Part A (Begin Date) _____-_____-_____
Part B (Begin Date) _____-_____-_____
Part C (Begin Date) _____-_____-_____
Part A Free (Y)___(N) ___ Part C Type Code:____

**SECTION III** Address Information:

Benefit Recipient Residential Address

_____
_____
_____
City: _____
State: _____ ZIP Code: _____ +_____
County of Residence: _____
Country:_____
(for foreign address only)
Send Mail to this Address (Y/N):_____

*If you have a Power of Attorney, legal guardian, trustee or custodial parent, please complete the Other Addressee Information. If you want mail sent to both addresses, put "Y" in both "Send Mail to this Address" spaces.

*Other Addressee Name and Address:
Name: _____
Address: _____
City: _____
State: _____ ZIP Code _____ +_____
Country: _____
(for foreign address only)
Addressee SSN: _____ - _____ - _____
Relationship Code:_____
Date of Relationship: _____-_____-_____
Send Mail to this Address (Y/N): _____

**SECTION IV** Type of Enrollee: (Check One)

Benefit Recipient ☐ Survivor ☐ COBRA ☐

Reason for Enrollment: ____

To be completed by SURS office staff
Type of Enrollee:_____ _____ _____ _____

**SECTION V** If you are a survivor, complete this Section:

SSN of deceased member: ____-___-_____ Relationship to Deceased Member: Spouse/Child/Parent _____

**SECTION VI** *Health Plan: (Check One)

College Choice Health Plan (CCHP) 1 ☐
HMO or OAP Plan 2 ☐

***Enrolling in a health plan automatically enrolls you in the dental and vision plans.**

**If you are choosing an HMO or OAP Plan, please provide the following:**
Plan Name: _____
Plan Code: _____
Primary Care Provider #: _____

**SECTION VII** Coordination of Benefits:

If you are enrolled in another group health or dental plan, please complete the following:

| Health/Dental | Begin Date | Plan Name |
|---|---|---|
| _____ | _____ - _____ - _____ | _____ |
| _____ | _____ - _____ - _____ | _____ |

The authorization for my insurance elections is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all rules and to furnish any additional information requested. My signature confirms that I understand all above options selected and authorize the release of information to the health plan I select and the State of Illinois.

CIP Benefit Recipient Signature: _____ Date: _____ - _____ - _____
**(Signature required)**

# Instruction Sheet For Benefit Recipient
# College Insurance Program

**Complete this form and mail to:**
**State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710**

This form is used for initial enrollment into the program, or to process changes requested during the annual Benefit Choice Period. For initial enrollment, the entire form is to be completed. For Benefit Choice Period, only the appropriate carrier information or the dependent beneficiary information, if dependents are added, needs to be completed. Enter complete name and social security number (SSN). Check the appropriate box for initial enrollment or Benefit Choice, or both if enrolling during Benefit Choice Period.

## SECTION I – Personal Information. Please type or print clearly.

**Effective date of enrollment**: Enter the date that coverage is effective. Please see the column entitled, "When will my coverage be effective?" located on page 1 of the Member Handbook. Enrollments requested during the Benefit Choice Period will always be effective July 1. **Marital Status**: S=Single, M=Married. **Birthdate**: Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945. **Sex**: M=Male, F=Female.

## SECTION II – Medicare Status

**Medicare Status** – Check the box that correctly reflects your Medicare status.
**Medicare Box 1** – You are under 65 years of age and ineligible for Medicare due to age.
**Medicare Box 2, 4 or 5** – Provide specific Part A and Part B dates, and indicate whether Part A of Medicare is free. A copy of your Medicare Card(s) must accompany this form.
**Medicare Box 3** – You are 65+ and ineligible for Medicare. A letter from Medicare stating ineligibility should accompany this form.

If you have **Medicare Part C**, indicate the type code from the following: **1. HMO 2. POS 3. PSO 4. PPO 5. Religious Fraternal Benefit Society Plan 6. Private Fee-for-Service Plan 7. Medical Savings Account (MSA) Plan.**

## SECTION III – Address Information

**Benefit Recipient Residential Address**: Enter your address on the left-hand side of this section.
**Other Addressee**: If another person handles your personal affairs, complete the "Other Addressee" column.
The relationship space should be filled with one of the following codes:
**1. Custodial Parent 2. Trustee 3. Power-of-Attorney 4. Legal Guardian**
**Date of Relationship**: Enter the date that the other addressee was effective. **Send Mail to this address** (Y/N). You can choose to have mail sent to your other addressee by entering (Y) for yes in the "Send Mail to this Address" space. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" spaces.

## SECTION IV – Type of Enrollee

Check the box that reflects your appropriate eligibility status: **Benefit Recipient, Survivor of a Benefit Recipient, COBRA** (only applicable if you have had coverage under the College Insurance Program as a benefit recipient, or a dependent beneficiary).
**Reason for Enrollment**: This space should be completed with one of the following codes:
**1. Application for Annuity 2. Benefit Recipient Turns 65 3. Coverage Terminated by Employer 4. Benefit Choice**
Additional information on these four enrollment periods is located on page 1 of the Member Handbook.
**Type of Enrollee**: SURS Staff will complete this information.

## SECTION V – Survivor Information

If you are enrolling as a survivor, please complete this section.

## SECTION VI – Health Plan

If you are choosing: **College Choice Health Plan (CCHP) check box 1**; an **HMO or OAP Plan, check box 2. If you checked box 2, please indicate the name of the plan and enter the plan code.** The plan codes are listed in the Benefit Choice Booklet on page 14. **Enter the primary care provider's six-digit number**, which can be found in the managed care provider directory of your chosen plan.

## SECTION VII – Coordination of Benefits

If you are enrolled in another group health or dental plan, please complete the information requested in this section.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

# College Insurance Program
# Dependent Beneficiary Group Insurance Form

SURS

CIP Benefit Recipient Name_____ SSN: _____-____-_____

**Initial Enrollment** ☐ **Benefit Choice** (July 1 effective date) ☐

Complete this form if you are enrolling an eligible dependent beneficiary. If you need additional dependent forms, please contact SURS.

**SECTION I** Dependent's Personal Information: (Please print or type)

Dependent SSN: _____-____-_____ Effective Date of Enrollment: ____-____-_____

Last Name _____ First _____ Middle _____

Birthdate: (mm/dd/ccyy) ____-____-____ Sex: (M/F) ____ Retirement Date: (mm/dd/ccyy): ___-___-____

**SECTION II** Dependent's Medicare Status: (check one)

1 Non Medicare ☐
2 Medicare Eligible age 65+ ☐
3 Medicare Ineligible age 65+ ☐
4 Medicare Disability ☐
5 End Stage Renal ☐

Medicare Number: _____

If 2,4, or 5 was checked, complete the following and submit a copy of the Medicare Card:

Part A (Begin Date) _____-_____-_____
Part B (Begin Date) _____-_____-_____
Part C (Begin Date) _____-_____-_____
Part A Free (Y)__ (N)__ Part C Type Code:___

**SECTION III** Dependent's Address Information:

Dependent Beneficiary Residential Address
(If different than Benefit Recipient)

_____
_____
City: _____
State: _____ ZIP Code: _____+_____
County of Residence: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Other Addressee Name and Address:
Name: _____
Address: _____
City: _____
State: _____ ZIP Code: _____ + _____
Country: _____
(for foreign address only)
Addressee SSN: _____ - _____ - _____
Relationship Code: _____
Date of Relationship: _____-_____-_____
Send Mail to this Address (Y/N): _____

**SECTION IV** Relationship: (Check One) *Supporting documentation required.

1 Spouse ☐
2 Natural Child ☐
3 Adopted Child ☐
4 Step Child* ☐
5 Recognized Child ☐
6 Legal Guardian* ☐
7 Adjudicated Child* ☐
8 Student ☐
9 Handicapped ☐
10 Parent ☐

Reason for Enrollment: _____

**SECTION V** Health Plan: (Check Plan of Benefit Recipient)

College Choice Health Plan (CCHP) 1 ☐
HMO or OAP Plan 2 ☐

If choosing an HMO or OAP Plan, please provide the following:

Plan Name: _____
Plan Code: _____
Primary Care Provider #: _____

**SECTION VI** Coordination of Benefits:

If you are enrolled in another group health or dental plan, please complete the following:

| Health/Dental | Begin Date | Carrier Name |
|---|---|---|
| _____ | ____ - ____ - _____ | _____ |
| _____ | ____ - ____ - _____ | _____ |

The authorization for my dependent beneficiary coverage election is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all rules and to furnish any additional information requested. My signature below confirms that I understand all above options selected and authorize the release of information to the health plan I select and the State of Illinois.

CIP Benefit Recipient Signature: _____ Date: ____ - ____ - _____

**(Signature required)**

# Instruction Sheet for Dependent Beneficiary
# College Insurance Program

**Complete this form and mail to:**
**State Universities Retirement System, P.O. Box 2710, Champaign, IL 61825-2710**

This form is used for initial enrollment of a dependent beneficiary into the program, or to process changes requested during the annual Benefit Choice Period. For initial enrollment of the dependent beneficiary, the entire form is to be completed. For Benefit Choice Period, only the appropriate carrier information or the dependent beneficiary information, if dependents are added, needs to be completed. Enter the name and social security number of the CIP participant. (This is not the dependent beneficiary you are enrolling but the person receiving the annuity). Check the appropriate box of Initial Enrollment or Benefit Choice, or both if enrolling during Benefit Choice Period.

## SECTION I - Dependent's Beneficiary Personal Information

**Dependent SSN:** Enter the dependent's nine digit social security number. **Effective date of enrollment:** Enter the date that coverage is effective. Please see the Member Handbook Page 1, Enrollment Periods, for coverage effective dates. **Name:** Enter the dependent's complete name. **Birthdate:** Enter two-digit month, two-digit day and four-digit year. Example: 07/28/1945. **Sex:** M=Male, F=Female. **Retirement Date:** If your dependent is retired from a place of employment, enter the retirement date.

## SECTION II - Dependent's Medicare Status

**Medicare Status** - Check the box that correctly reflects the dependent recipient's Medicare status.
**Medicare Box 1**- The Dependent Beneficiary is under 65 years of age and ineligible for Medicare due to age.
**Medicare Box 2, 4 or 5** - Provide specific Part A and Part B dates and indicate whether Part A of Medicare is free. A copy of the Medicare Card(s) must accompany this form.
**Medicare Box 3** - The Dependent Beneficiary is 65+ and ineligible for Medicare. A letter from Medicare stating the dependent's ineligibility should accompany this form.

If your dependent has Medicare Part C, indicate the type code from the following:
**1. HMO 2. POS 3. PSO 4. PPO 5. Religious Fraternal Benefit Society Plan**
**6. Private Fee-for-Service Plan 7. Medical Savings Account (MSA) Plan.**

## SECTION III - Dependent's Address

**Dependent Beneficiary Residential Address:** Enter the dependent beneficiary's address only if it is different from the member's address. **Other Addressee:** If another person handles the dependent beneficiary's personal affairs, complete the "Other Addressee" column. The relationship space should be filled with one of the following codes:
**1. Custodial Parent 2. Trustee 3. Power of Attorney 4. Legal Guardian**
**Date of Relationship:** Enter the date that the dependent's relationship with the other addressee was effective. **Send Mail to this address** (Y/N). You can choose to have mail sent to your other addressee by entering (Y) for yes in the "Send Mail to this Address" space. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" spaces.

## SECTION IV - Dependent's Relationship

Check the box that reflects the correct relationship of the dependent beneficiary to the participant receiving an annuity. For the following relationships additional documentation is needed:
**4 - Step-child:** Written documentation from the benefit recipient that the child lives with the benefit recipient in a parent-child relationship.
**6 - Legal Guardian:** A copy of the court decree which established the benefit recipient as legal guardian for a child under 18 years of age.
**7 - Adjudicated Child:** A copy of the court decree which establishes the benefit recipient's financial responsibility for the child's health care.
**Reason for Enrollment:** This space should be completed with one of the following codes: **1. Benefit Recipient Application for Annuity 2. Dependent Beneficiary turns 65 3. Coverage terminated by employer 4. Benefit Choice**

## SECTION V - Health Plan

**Dependents must be enrolled in the same plan as the benefit recipient.**

If you are choosing: **College Choice Health Plan (CCHP) check box 1**; an **HMO or OAP, check box 2. If you checked box 2, please indicate the name of the plan and enter the plan code.** The plan codes are listed in the Benefit Choice Booklet on page 14. **Enter the primary care provider's six-digit number,** which can be found in the managed care provider directory of your chosen plan. *Enrolling in a health plan automatically enrolls you in dental and vision plans.*

## SECTION VI - Dependent Coordination of Benefits

If you are enrolled in another group health or dental plan, please complete the information requested in this section.

Illinois Department of Central Management Services
Bureau of Benefits
600 Stratton Building
Springfield, IL 62706

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