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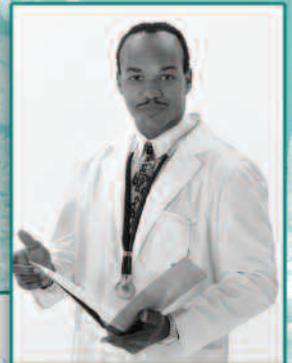


**BENEFIT CHOICE OPTIONS**

# College Insurance Program



*Your Benefits  
for Good Health*



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

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

# TABLE OF CONTENTS

<b>Important Changes for Plan Year 2007</b> .....	2
College Choice Health Plan (CCHP) Changes .....	2
HMO Changes .....	2
OAP Changes .....	2
College Choice Dental Plan (CCDP) .....	2
Medicare Part D .....	2
<b>Your Responsibilities</b> .....	3
<b>Benefit Choice Period</b> .....	4
<b>Monthly Premiums</b> .....	5
<b>Managed Care Plans</b> .....	5
HMO Benefits .....	6
Open Access Plan (OAP) Benefits .....	7
Managed Care Plans in Illinois Counties (Map) .....	8
Important Reminders about Managed Care Plans .....	9
<b>The College Choice Health Plan (CCHP)</b> .....	10
CCHP - Medical Plan Coverage .....	11
CCHP Notification and Penalties .....	12
<b>Prescription Drug Benefit</b> .....	13
Managed Care Plan Prescription Drug Benefit .....	13
Medco-Administered Prescription Drug Benefit .....	14
<b>Dental Plan</b> .....	15
<b>Vision Plan</b> .....	15
<b>Notice of Creditable Coverage</b> .....	16
<b>Notice of Privacy Practices (HIPAA)</b> .....	17
<b>Plan Administrators</b> .....	19
<b>Benefit Recipient Group Insurance Form</b> .....	21
Benefit Recipient Instruction Sheet .....	22
<b>Dependent Beneficiary Group Insurance Form</b> .....	23
Dependent Beneficiary Instruction Sheet .....	24

# Important Changes For Plan Year 2007

(July 1, 2006 through June 30, 2007)

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

## College Choice Health Plan (CCHP) Changes

- In-network, out-of-pocket maximum (individual) increases to \$1,000
- Prescription co-payments increase to \$10/\$20/\$40
- Emergency room visit co-payment increases to \$300
- Non-PPO hospital deductible increases to \$300 per admission
- Chiropractic visits limited to 30 visits per plan year

## HMO Changes

- Inpatient hospital co-payment increases to \$200
- Emergency room visit co-payment increases to lesser of 50% or \$150
- Prescription co-payments increase to \$10/\$20/\$40
- Physician office visit co-payment increases to \$15
- Home health visit co-payment increases to \$15

## OAP Changes

- Prescription co-payments increase to \$10/\$20/\$40
- Emergency room visit co-payment increases to \$150
- Tier I: Inpatient hospital co-payment increases to \$200
- Tier I: Physician office visit co-payment increases to \$15
- Tier I: Home health visit co-payment increases to \$15
- Tier II: Inpatient hospital co-payment increases to \$250
- Tier III: Inpatient hospital co-payment increases to \$350

## College Choice Dental Plan (CCDP)

- Plan participant deductible increases to \$100 per plan year
- Plan participant annual benefit maximum increases to \$2000 per plan year

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

# YOUR RESPONSIBILITIES

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

**Notify the State Universities Retirement System (SURS) immediately when any of the following occur:**

- Change of address
- Qualifying change in status:
  - birth/adoption of a child;
  - marriage, divorce, annulment;
  - death of spouse or dependent;
- Gain or loss of other group coverage
- Change in Medicare status

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

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

# BENEFIT CHOICE PERIOD IS MAY 1-31, 2006

The Benefit Choice Period is **May 1 through May 31, 2006** for all Benefit Recipients. Elections will be effective July 1, 2006. The Benefit Choice Period is the **only** time of the year, other than when a qualifying change in status occurs, that Benefit Recipients may change their coverage elections.

Before making benefit changes, compare:

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

There are three health benefit coverage options available:

- Health Maintenance Organizations (HMOs)
- Open Access Plan (OAP)
- College Choice Health Plan (CCHP)

See pages 5-12 to review the features for each type of plan.

All Benefit Choice changes should be made on the forms located in the back of this booklet. Benefit Recipients should complete the form **only** if changes are being made. Dependent Beneficiaries must be enrolled in the same plan as the Benefit Recipient. SURS will process the changes based upon the information indicated on the form.

## **During the annual Benefit Choice Period, Benefit Recipients may:**

- Change health plans
- Add or drop dependent coverage

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

## **Documentation Requirements**

Documentation is required when adding dependent coverage. Benefit Recipients should contact SURS for documentation requirements.

## MONTHLY PREMIUMS

Monthly premiums include the cost of health, dental and vision coverage. Benefit Recipients and/or Dependent Beneficiaries enrolled in a managed care plan will pay lower monthly premiums.

Type of Plan	Not Medicare Primary Under Age 23	Not Medicare Primary Age 23-64	Not Medicare Primary Age 65 and Above	Medicare Primary* All Ages
<b>Benefit Recipient</b> Managed Care Plans	\$71.03	\$177.57	\$244.11	\$73.43
<b>Dependent Beneficiary</b> Managed Care Plans	\$284.11	\$710.28	\$877.30	\$293.73
<b>Benefit Recipient</b> Indemnity Plan (CCHP)	\$96.86	\$242.14	\$337.62	\$97.84
<b>Dependent Beneficiary</b> Indemnity Plan (CCHP)	\$387.43	\$968.57	\$1,241.49	\$350.69

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

## MANAGED CARE PLANS

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

### Health Maintenance Organizations (HMOs)

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

### Open Access Plan (OAP)

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

# HMO BENEFITS

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

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after \$200 co-payment per admission
Alcohol and substance abuse* (maximum number of days determined by the plan)	100% after \$200 co-payment per admission
Psychiatric admission* (maximum number of days determined by plan)	100% after \$200 co-payment per admission
Outpatient surgery	100%
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after the lesser of 50% or \$150 co-payment per visit
Professional and Other Services	
Office visit (including physical exams and immunizations)	100% after \$15 co-payment per visit
Psychiatric care* (maximum number of days determined by the plan)	100% of the cost after a 20% co-payment (not to exceed \$20) per visit
Alcohol and substance abuse care* (maximum number of days determined by the plan)	100% of the cost after a 20% co-payment (not to exceed \$20) per visit
Prescription drugs (formulary is subject to change during plan year)	\$10 co-payment for generic \$20 co-payment for preferred brand \$40 co-payment for non-preferred brand
Durable Medical Equipment	80% of network charges
Home Health Care	\$15 co-payment per visit

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

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





## IMPORTANT REMINDERS ABOUT MANAGED CARE PLANS

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

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

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

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

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

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

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

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

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

# THE COLLEGE CHOICE HEALTH PLAN (CCHP)

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

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

Plan Year Maximums and Deductibles	
Plan Year Maximum	\$1,000,000
Lifetime Maximum	\$1,000,000
Plan Year Deductible	\$500 CCHP Primary Participant (Non-Medicare) \$300 Medicare Primary Participant
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit \$300 Non-PPO hospital admission \$300 <b>Note: There is no additional deductible for admission to a PPO hospital</b>

## Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100% of eligible charges for the remainder of the plan year. There are two separate out-of-pocket maximums: a general one and one for non-PPO hospital charges. Coinsurance and deductibles apply to one or the other, but not both.

General: \$1,000 per individual	Non-PPO Hospital: \$4,000 per individual
<p><b>The following do not apply toward out-of-pocket maximums:</b></p> <ul style="list-style-type: none"> <li>• Prescription Drug benefits or co-payments.</li> <li>• Behavioral Health benefits, coinsurance or co-payments.</li> <li>• Notification penalties.</li> <li>• Ineligible charges (amounts over Usual and Customary (U &amp; C) and charges for non-covered services).</li> <li>• After Medicare pays, CCHP pays 80% of the balance after the CCHP deductible.</li> </ul>	

# CCHP - MEDICAL PLAN COVERAGE

Hospital Services	
Preferred Provider Organization (PPO) Hospitals	80% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (Non-PPO) Hospitals	<ul style="list-style-type: none"> <li>• \$300 per admission deductible.</li> <li>• If the Benefit Recipient resides in Illinois or within 25 miles of a PPO hospital and they choose to use a non-PPO and/or voluntarily travel in excess of 25 miles when a PPO hospital is available within the same travel distance, the plan pays 60% after the annual plan deductible.</li> <li>• If the Benefit Recipient resides in Illinois and has no PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest PPO hospital, the plan pays 60% after the annual plan deductible.</li> <li>• If the Benefit Recipient does not reside in Illinois or within 25 miles of a PPO hospital, the plan pays 70% after the annual plan deductible.</li> </ul>
Outpatient Services	
Lab/X-ray	80% of Usual & Customary (U&C) after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible.
Licensed Ambulatory Surgical Treatment Centers	80% of negotiated fee or 80% of U&C, as applicable, after plan deductible.
Professional and Other Services	
CIGNA Healthcare Physician PPO Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician and Surgeon Services not included in CIGNA's PPO Network	80% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services - medical necessity required (limit of 30 visits per plan year)	90% of negotiated fee or 80% of U&C, as applicable, after plan deductible.

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

# CCHP - NOTIFICATION AND PENALTIES

## Health Plan Notification Requirements

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

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

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

### Notification is required for the following:

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

## Behavioral Health Services Notification and Authorization Requirements

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

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

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

## PRESCRIPTION DRUG BENEFIT

Plan participants enrolled in CIP have prescription drug coverage available. All prescription medications are compiled on a preferred list (“formulary list”) maintained by each managed care plan or Medco. Formulary lists categorize brand drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount. For plan year 2007 (July 1, 2006 - June 30, 2007), all health plans apply the same co-payments for each level of prescription medication for a 30-day fill.

### PRESCRIPTION DRUG CO-PAYS FOR ALL HEALTH PLANS

Generic	\$10
Preferred Brand (Formulary Brand)	\$20
Non-Preferred Brand	\$40

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

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

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

## MANAGED CARE PLAN PRESCRIPTION DRUG BENEFIT

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

# MEDCO-ADMINISTERED PRESCRIPTION DRUG BENEFIT

The following information provides a brief overview of Medco benefits. See the Benefits Handbook or the Benefits website for more information.

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

## In-Network Pharmacy

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

## Out-of-Network Pharmacy

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

## Mail Order Pharmacy

The Mail Order Pharmacy provides participants the opportunity to receive medications directly from Medco at a discounted price. To utilize the Mail Order Pharmacy, plan participants must submit an original prescription from the attending physician. The prescription should be written for a 61-90 day supply, and include up to three (3) 90-day refills, totaling one-year of medication. The original prescription must be attached to a completed Medco Mail Order form and sent to the address indicated on the form. Order forms and refills can be obtained by contacting Medco at (800) 899-2587, or by accessing the Medco website at [www.medco.com](http://www.medco.com). Order forms are also available on the Benefits website at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov).

## DENTAL PLAN

All plan participants have the same dental benefits available regardless of the health plan selected. Dental plan questions should be directed to the Dental Plan Administrator, CompBenefits, at (800) 999-1669 or (312) 829-1298 (TDD/TTY).

### College Choice Dental Plan (CCDP)

Plan participants enrolled in CCDP may go to any dentist. **The CCDP reimburses only those services that are listed on the Dental Schedule of Benefits.** Listed services are reimbursed at a pre-determined maximum scheduled amount (see the Dental Schedule of Benefits at [www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)). A \$100 individual plan deductible applies for all services other than those listed as preventive and diagnostic in the Dental Schedule of Benefits. Plan participants are responsible for all charges over the scheduled amount.

The maximum benefit per plan participant per plan year for all dental services, including orthodontic and periodontic, is \$2,000. The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations.

## VISION PLAN

All plan participants have the same vision coverage regardless of the health plan selected. All vision benefits are available once every 24 months from the last date used. Co-payments are required. For information regarding the vision plan, contact the plan administrator, EyeMed Vision Care at (866) 723-0512, (800) 526-0844 (TTD/TTY) or by visiting their website and logging in as a member at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com).

Service	Network Provider Benefit	Out-of-Network Provider Benefit
<b>Eye Exam</b>	\$10 co-payment	\$20 allowance
<b>Spectacle Lenses</b> (single, bifocal and trifocal)	\$10 co-payment	\$20 allowance for single vision lenses  \$30 allowance for bifocal and trifocal lenses
<b>Standard Frames</b>	\$10 co-payment (for frames within the benefit selection)	\$20 allowance
<b>Contact Lenses</b> (All contact lenses are in lieu of standard frames and spectacle lenses)	\$20 co-payment for medically necessary  \$50 co-payment for elective contact lenses  \$70 allowance for all other lenses not mentioned above	\$70 allowance

# NOTICE OF CREDITABLE COVERAGE

## Prescription Drug Information for College Insurance Program (CIP) Medicare Eligible Plan Participants

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

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

If you keep your existing group coverage, it is **not** necessary to join a Medicare prescription drug plan this year.

**REMEMBER: KEEP THIS NOTICE**

## NOTICE OF PRIVACY PRACTICES

For Individuals Enrolled in the College Choice Health Plan (CCHP) and the College Choice Dental Plan (CCDP)

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

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

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

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

#### **How We May Use or Disclose Your PHI:**

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

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

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

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

#### **Legal Requirements:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Your Rights:**

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

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

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

## WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

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

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
<b>Vision Plan Administrator</b>	<b>EyeMed</b> Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>
<b>Health/Dental Plans and the Medicare COB Unit</b>	<b>CMS Group Insurance Division</b> 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	<a href="http://www.benefitschoice.il.gov">www.benefitschoice.il.gov</a>
<b>General Eligibility and Enrollment Information</b>	<b>State Universities Retirement System (SURS)</b> P.O. Box 2710 Champaign, IL 61825-2710	(800) 275-7877 (217) 378-8800 (TDD/TTY)	<a href="http://www.surs.com">www.surs.com</a>

# WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
<b>College Choice Health Plan (CCHP) Medical Plan Administrator</b>	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits	<b>CIGNA</b> Group Number 2457490 <b>CIGNA HealthCare</b> P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>CCHP Notification and Medical Case Management Administrator</b>	Notification prior to hospital services  Non-compliance penalty of \$1,000 applies	<b>Intracorp, Inc.</b>	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://provider.healthcare.cigna.com/soi.html">http://provider.healthcare.cigna.com/soi.html</a>
<b>Prescription Drug Plan Administrator</b>  CCHP (1399CD3)  Health Alliance Illinois (1399CBS)  HealthLink OAP (1399CCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	<b>Medco</b> Group Number: 1399CD3, 1399CBS, 1399CCF <b>Paper Claims:</b> Medco Health Solutions P.O. Box 14711 Lexington, KY 40512  <b>Mail Order Prescriptions:</b> Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide)  (800) 759-1089 (TDD/TTY)  <a href="http://www.medco.com">www.medco.com</a>
<b>CCHP Behavioral Health Administrator</b>	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	<b>Magellan Behavioral Health</b> Group Number 2457490 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) <a href="http://www.MagellanHealth.com">www.MagellanHealth.com</a>
<b>College Choice Dental Plan (CCDP) Administrator</b>	Dental services, claim filing and ID cards	<b>CompBenefits</b> Group Number 970 P.O. Box 4721 Chicago, IL 60680-4721	(800) 999-1669 (312) 829-1298 (TDD/TTY) <a href="http://www.compbenefits.com">www.compbenefits.com</a>

## DISCLAIMER

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



# CIP - Instruction Sheet For Benefit Recipient Group Insurance Form

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 must be completed. For enrollment during the Benefit Choice Period, only the appropriate carrier or dependent beneficiary information, if dependents are added, need 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 coverage is effective (see page 1 of the Member Handbook for coverage effective dates). 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 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" field. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" fields.

## 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 field 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.** Plan codes are listed on page 8. **Enter the primary care provider 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.

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  3 Medicare Ineligible age 65+  4 Medicare Disability  5 End Stage Renal

2 Medicare Eligible age 65+

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  4 Stepchild\*  7 Adjudicated Child\*

2 Natural Child  5 Recognized Child  8 Student

3 Adopted Child  6 Legal Guardian\*  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 the 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 must be completed. For the Benefit Choice Period, only the appropriate carrier or dependent beneficiary information, if dependents are added, need 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 coverage is effective (see page 1 of the Member Handbook 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" field. If you want mail sent to both addresses, enter (Y) for yes in both "Send Mail to this Address" fields.

## 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 - Stepchild:** 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 field 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. Plan codes are listed on page 8. Enter the primary care provider number, which can be found in the managed care provider directory of your chosen plan. *Enrolling in a health plan automatically enrolls you in the 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  
PO Box 19208  
Springfield, IL 62794-9208**

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